City Council

Agenda

Tuesday, March 8, 2016
City Hall, Council Chambers
749 Main Street
7:00 PM

Note: The time frames assigned to agenda items are estimates for guidance only. Agenda items may be heard earlier or later than the listed time slot.

1. CALL TO ORDER

2. PLEDGE OF ALLEGIANCE

3. APPROVAL OF AGENDA

4. PUBLIC COMMENTS ON ITEMS NOT ON THE AGENDA

Council requests that public comments be limited to 3 minutes. When several people wish to speak on the same position on a given item, Council requests they select a spokesperson to state that position.

5. CONSENT AGENDA

The following items on the City Council Agenda are considered routine by the City Manager and shall be approved, adopted, accepted, etc., by motion of the City Council and roll call vote unless the Mayor or a City Council person specifically requests that such item be considered under "Regular Business." In such an event the item shall be removed from the "Consent Agenda" and Council action taken separately on said item in the order appearing on the Agenda. Those items so approved under the heading "Consent Agenda" will appear in the Council Minutes in their proper order.

A. Approval of Bills
B. Approval of Minutes: February 16, 2016
C. Approval of Contract for Kaiser Permanente Heath Insurance
D. Reject Bids for Recreation Center Campus and Heritage Park A.D.A. Restroom Improvements Projects
E. Approval of Interim Appointments to the Cultural Council
F. Approve Resolution No. 11, Series 2016 – A Resolution Approving and Adopting of the Boulder County, Colorado Multi-Hazard Mitigation Plan 2016

6. COUNCIL INFORMATIONAL COMMENTS ON PERTINENT ITEMS NOT ON THE AGENDA (Council general comments are scheduled at the end of the Agenda.)

Citizen Information

If you wish to speak at the City Council meeting, please fill out a sign-up card and present it to the City Clerk.

Persons with disabilities planning to attend the meeting who need sign language interpretation, assisted listening systems, Braille, taped material, or special transportation, should contact the City Manager's Office at 303 335-4533. A forty-eight-hour notice is requested.

7. CITY MANAGER'S REPORT

8. REGULAR BUSINESS

7:15 – 7:25 pm

A. PRESENTATION OF THE COLORADO CITY AND COUNTY MANAGER'S ASSOCIATION MANAGER OF THE YEAR AWARD TO MALCOLM FLEMING

- Presentation

7:25 – 7:35 pm

B. NATIONAL NUTRITION MONTH PROCLAMATION

- Presentation

7:35 – 7:45 pm

C. UPDATE: ONE ACTION 2016: ARTS + IMMIGRATION PROJECT

- Staff Presentation
- Public Comments (Please limit to three minutes each)
- Council Questions & Comments

7:45 – 8:15 pm

D. RESOLUTION NO. 12, SERIES 2016 – A RESOLUTION DESIGNATING THE MUDROCK HOUSE AT 613 GRANT AVENUE A HISTORIC LANDMARK

- Staff Presentation
- Public Comments (Please limit to three minutes each)
- Council Questions & Comments
- Action

8:15 – 9:15 pm

E. DISCUSSION/DIRECTION/ACTION – 2016 CITIZEN SURVEY INSTRUMENT

- Staff Presentation
- Public Comments (Please limit to three minutes each)
- Council Questions & Comments
- Action

9:15 – 9:45 pm

F. ORDINANCE NO. 1716, SERIES 2016 – AN ORDINANCE AMENDING TITLE 17 OF THE LOUISVILLE MUNICIPAL CODE TO ADD HEALTH OR ATHLETIC CLUBS, SPAS, DANCE STUDIOS AND FITNESS STUDIOS AS A LISTED USE GROUP AND SPECIFYING IN WHICH ZONE DISTRICTS THESE USES MAY BE DEVELOPED – 2nd Reading –Public Hearing – Advertised *Daily Camera* 02/21/2016

- Mayor Opens Public Hearing
- Staff Presentation
- Public Comments (Please limit to three minutes each)
- Council Questions & Comments

- Additional Public Comments
- Mayor Closes Public Hearing
- Action

9:45 - 10:00 pm **G. RESOLUTION NO. 13, SERIES 2016 – A RESOLUTION APPROVING THE 9557 PARADISE LANE AMENDMENT TO THE SOUTHEAST BOULDER COUNTY, SOUTH 96TH STREET, DILLON ROAD AND US 287 AREA COMPREHENSIVE DEVELOPMENT PLAN INTERGOVERNMENTAL AGREEMENT**

- Staff Presentation
- Public Comments (Please limit to three minutes each)
- Council Questions & Comments
- Action

9. CITY ATTORNEY'S REPORT

10. COUNCIL COMMENTS, COMMITTEE REPORTS, AND IDENTIFICATION OF FUTURE AGENDA ITEMS

11. ADJOURNMENT

City of Louisville
Cash Disbursement Edit List

Batch: 93684 Period: 02/18/16

FOR BANK ACCOUNT: 4 FIRST NATIONAL BANK OF COLORAD Control Disbursement Account

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
640-1	BOULDER COUNTY					
	013116A	JAN 16 BOULDER COUNTY USE TAX	01/31/16	03/01/16	49,160.12	49,160.12
1115-1	COLONIAL INSURANCE					
	0201291	#9711888 FEB 16 EMPLOYEE PREM	02/03/16	03/04/16	555.15	555.15
12930-1	DAVID SZABADOS					
	020916	AUTOMATED LOGIC MODULE RSC	02/09/16	03/10/16	450.00	450.00
5255-1	FAMILY SUPPORT REGISTRY					
	021216	EMPLOYEE GARNISHMENT PP#03	02/12/16	03/13/16	100.00	100.00
9813-1	HEATHER BALSER					
	021516	TRAVEL ADVANCE 2/24-2/26/16	02/15/16	03/16/16	286.68	286.68
14002-1	KANSAS PAYMENT CENTER					
	021216	EMPLOYEE GARNISHMENT PP#03	02/12/16	03/13/16	270.46	270.46
5432-1	LOUISVILLE FIRE PROTECTION DISTRICT					
	013116A	JAN 16 FIRE PROTECT DIST FEES	01/31/16	03/01/16	5,555.00	5,555.00
8016-1	NATIONAL RESEARCH CENTER INC					
	5764	2016 CITIZEN SURVEY	01/27/16	02/26/16	12,000.00	12,000.00
55	BRIAN & ASHLEY MAROTTA					
	U!00001023	18446/314037101: 2537 EVANS AV	02/08/16	02/08/16	64.64	64.64
55	SCOTT PESSIN					
	U!00001024	16316/452051601: DONNA PESSIN	02/15/16	02/15/16	1.57	
	U!00001024	16316/452051601: DONNA PESSIN	02/15/16	02/15/16	37.32	
	U!00001024	16316/452051601: DONNA PESSIN	02/15/16	02/15/16	2.91	41.80
11094-1	WESTERN DISPOSAL SERVICES					
	013116RES	JAN 16 RESIDENTIAL TRASH SERV	02/01/16	03/02/16	116,859.93	116,859.93
3875-1	XCEL ENERGY					
	488339319	JAN 16 STREET LIGHTS	02/01/16	03/02/16	37,920.80	
	488354124	JAN 16 FLASHERS	02/01/16	03/02/16	5.74	
	488821622	JAN 16 TRAFFIC SIGNALS	02/04/16	03/05/16	1,257.11	39,183.65
	BANK TOTAL PAYMENTS				224,527.43	224,527.43
	GRAND TOTAL PAYMENTS				224,527.43	224,527.43

City of Louisville
Cash Disbursement Edit List

Batch: 93795 Period: 02/25/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
	FOR BANK ACCOUNT:	4 FIRST NATIONAL BANK OF COLORAD			Control Disbursement Account	
14164-1	ALPINE BANK					
	021916	COMMUNITY SOLAR PANEL LEASE	02/19/16	03/20/16	757.47	
	021916	COMMUNITY SOLAR PANEL LEASE	02/19/16	03/20/16	3,229.23	3,986.70
11298-1	DELTA DENTAL OF COLORADO					
	DELTA0316	#007562-0000 MAR 16 EMPL PREM	02/24/16	03/25/16	13,102.88	13,102.88
6455-1	KAISER PERMANENTE					
	0018253287	05920-01-16 MAR 16 EMPL PREM	02/08/16	03/09/16	129,012.22	129,012.22
7735-1	LINCOLN FINANCIAL GROUP					
	LIFE0316	000010008469 MAR 16 LIFE/AD&D	03/01/16	03/31/16	6,056.83	
	LTD0316	000010008470 MAR 16 LTD PREM	03/01/16	03/31/16	3,143.38	9,200.21
207-1	LISA MERLY					
	022516	TRAVEL ADVANCE 3/1-3/19/16	02/25/16	03/26/16	2,187.43	2,187.43
10297-1	MGPEC					
	010116	2016 MGPEC MEMBERSHIP	01/01/16	01/31/16	50.00	50.00
5	SUSAN YANKOVICH					
	021516	EXPENSE REPORT 1/14/16	02/15/16	03/16/16	63.55	63.55
99	CHRIS BARRECA					
	022516	SUMMER CAMP REFUND	02/25/16	03/26/16	450.00	450.00
55	MICHAEL & SUZAN MYERS					
	U!00001025	17005/144014502: UTILITY REFUN	02/18/16	02/18/16	61.35	61.35
55	FIDELITY NATIONAL TITLE					
	U!00001026	18248/135030601: UTILITY REFUN	02/18/16	02/18/16	64.67	64.67
8442-1	VISION SERVICE PLAN					
	VSP0316	12 059727 0001 MAR 16 EMP PREM	02/28/16	03/29/16	2,671.17	2,671.17
3875-1	XCEL ENERGY					
	489742342	JAN 16 GROUP ENERGY	02/10/16	03/11/16	24,849.03	
	489742342	JAN 16 GROUP ENERGY	02/10/16	03/11/16	1,417.65	
	489742342	JAN 16 GROUP ENERGY	02/10/16	03/11/16	8,089.91	
	489742342	JAN 16 GROUP ENERGY	02/10/16	03/11/16	18,469.89	
	489742342	JAN 16 GROUP ENERGY	02/10/16	03/11/16	2,221.62	55,048.10
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	BANK TOTAL PAYMENTS				215,898.28	215,898.28
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	GRAND TOTAL PAYMENTS				215,898.28	215,898.28

City of Louisville
Cash Disbursement Edit List

Batch: 93854 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
	FOR BANK ACCOUNT:	4 FIRST NATIONAL BANK OF COLORAD			Control Disbursement Account	
13567-1	CONSOLIDATED ELECTRICAL DISTRIBUTORS INC					
	0770-192659	CREDIT WRONG ITEM	11/25/15	12/25/15	2,093.82-	
	0770-669431	SURETRACE CIRCUIT TRACER	11/16/15	12/16/15	2,213.27	119.45
13998-1	CYNTHIA J THOMAS					
	020216	1245 GRANT PRESERVATION GRANT	02/02/16	03/03/16	11,161.03	11,161.03
2070-1	FLOOD & PETERSON INSURANCE INC					
	46564	COMMERCIAL PROPERTY GC	12/30/15	01/29/16	62.00	
	55675	GENERAL LIABILITY - LIQUOR	02/25/16	03/26/16	107.00	169.00
13098-1	G4S SECURE SOLUTIONS INC					
	7592410	BAILIFF SERVICES 12/17/15	12/13/15	01/12/16	110.00	110.00
14228-1	HOPE FOODS LLC					
	022616	BUSINESS ASSISTANCE REBATE	02/26/16	03/27/16	767.47	
	022616	BUSINESS ASSISTANCE REBATE	02/26/16	03/27/16	383.73	1,151.20
11304-1	NORAA CONCRETE CONSTRUCTION					
	PP4113015	CONCRETE REPLACEMENT	01/11/16	02/10/16	75,945.47	
	PP5123115	CONCRETE RETAINAGE	01/11/16	02/10/16	27,197.71	103,143.18
14090-1	OCX NETWORK CONSULTANTS LLC					
	7455	ADDL CONFERENCE PHONE/EXT MIC	11/18/15	12/18/15	729.88	
	7456-1	ADDL IP480 PHONE/WALL MOUNTS	11/18/15	12/18/15	285.99	
	7456-2	IP480 PHONE WALLMOUNT KIT	11/18/15	12/18/15	16.51	1,032.38
4795-1	UTILITY TECHNICAL SERVICE INC					
	7726	LEAK DETECTION SURVEY	12/02/15	01/01/16	5,250.00	5,250.00
	BANK TOTAL PAYMENTS				122,136.24	122,136.24
	GRAND TOTAL PAYMENTS				122,136.24	122,136.24

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
	FOR BANK ACCOUNT:	4 FIRST NATIONAL BANK OF COLORAD			Control Disbursement Account	
14121-1	ACUSHNET COMPANY					
	901941442	RESALE MERCHANDISE/RANGE BALLS	02/08/16	03/09/16	6,186.44	
	901948435	CUSTOM JAR BALLS	02/09/16	03/10/16	237.00	6,423.44
14150-1	ADAM CHISZAR					
	021816	SCREENING FENCE GC	02/18/16	03/19/16	1,800.00	1,800.00
1006-1	ALL CURRENT ELECTRIC INC					
	3342	INSTALL LED FIXTURES GC	02/09/16	03/10/16	236.23	
	3343	CONNECT WATER HEATER NWTP	02/09/16	03/10/16	337.58	573.81
13979-1	ALLIED RECYCLED AGGREGATES					
	259055	ROADBASE	02/22/16	03/23/16	643.50	
	259056	ROADBASE	02/22/16	03/23/16	560.79	1,204.29
9891-1	AMBIANCE					
	10208	FEB 16 PLANT MAINT	02/10/16	03/11/16	195.00	195.00
13479-1	AMERICAN MECHANICAL SERVICES OF DENVER LLC					
	903762	HVAC SERVICE SWTP	01/31/16	03/01/16	462.50	462.50
13659-1	AVID4 ADVENTURE INC					
	E201673	TOUCH A TRUCK CLIMBING WALL	02/04/16	03/05/16	372.50	
	E201674	SUMMER CAMP FIELD TRIP	02/04/16	03/05/16	625.00	997.50
14201-1	AXIOM STRATEGIES INC					
	7730	MAR 16 LEGISLATIVE SERVICES	02/18/16	03/19/16	3,000.00	3,000.00
13235-1	B & G EQUIPMENT INC					
	619119	TRACTOR PARTS UNIT 5313	02/22/16	03/23/16	1,900.40	1,900.40
13855-1	BIG AIR JUMPERS INC					
	O19727	NITE AT REC INFLATABLES	02/19/16	03/20/16	544.00	
	O19728	NITE AT REC INFLATABLES	02/26/16	03/27/16	619.00	
	O20018	TOUCH-A-TRUCK INFLATABLE	02/25/16	03/26/16	286.00	1,449.00
11605-1	BOBCAT OF THE ROCKIES LLC					
	11223090	DOOR UNIT 3214	02/12/16	03/13/16	309.65	309.65
640-1	BOULDER COUNTY					
	12662	SHERIFF WORK MARATHON 1/17/16	02/03/16	03/04/16	570.00	570.00
13344-1	BROWN HILL ENGINEERING & CONTROLS LLC					
	10833	SCADA SUPPORT WTP	01/15/16	02/14/16	1,175.00	
	10945	SCADA SUPPORT WTP	02/12/16	03/13/16	1,175.00	2,350.00
13046-1	BRUCE A BUSH CONSULTING LLC					
	1601	RMP ADMIN UPDATE WTP	02/25/16	03/26/16	225.00	225.00
14046-1	CCNC INC					
	2016-000-444	2016 CCNC MEMBERSHIP	01/26/16	02/25/16	100.00	100.00
248-1	CDW GOVERNMENT					
	BPX3437	MERAKI ACCESS POINT RSC	01/01/16	01/31/16	758.77	

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
	BWB8158	VMWARE SOFTWARE RENEWAL	01/27/16	02/26/16	1,094.22	
	CBB7804	TYLER AP LABEL PRINTER/SCANNER	02/09/16	03/10/16	974.99	
	CBB7804	TYLER AP LABEL PRINTER/SCANNER	02/09/16	03/10/16	208.93	
	CBB7804	TYLER AP LABEL PRINTER/SCANNER	02/09/16	03/10/16	208.92	
	CBL9766	TYLER AP SCANNER CARRIER SHEET	02/11/16	03/12/16	16.48	
	CBL9766	TYLER AP SCANNER CARRIER SHEET	02/11/16	03/12/16	3.53	
	CBL9766	TYLER AP SCANNER CARRIER SHEET	02/11/16	03/12/16	3.53	3,269.37
935-1	CENTENNIAL PRINTING CO					
	58663	65 BUDGET BOOKS	01/29/16	02/28/16	1,530.90	1,530.90
980-1	CENTURY CHEVROLET INC					
	45027000	PARTS UNIT 5351	02/24/16	03/25/16	68.66	68.66
12674-1	CGAIT					
	1217	2016 CGAIT MEMBERSHIP	02/19/16	03/20/16	660.00	660.00
13964-1	CHANDLER ASSET MANAGEMENT					
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	325.63	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	23.95	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	1.61	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	0.31	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	120.56	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	33.95	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	25.10	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	7.88	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	43.62	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	275.39	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	71.99	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	420.08	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	219.41	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	86.72	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	14.39	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	8.03	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	36.97	
	19462	JAN 16 INVESTMENT FEES	02/02/16	03/03/16	32.41	1,748.00
14226-1	CHARGEPOINT INC					
	28720	EVSE SUBSCRIPTION	02/19/16	03/20/16	560.00	560.00
2220-1	CHEMTRADE CHEMICALS US LLC					
	91735746	ALUMINUM SULFATE WTP	01/28/16	02/27/16	4,548.36	4,548.36
14047-1	CITY OF NORTHGLENN					
	1004	LAB ANALYSIS FEES WTP	01/31/16	03/01/16	210.00	210.00
10382-1	COBITCO INC					
	44734	TACK OIL	02/08/16	03/09/16	139.86	139.86

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
10329-1	COLORADO DEPT OF HUMAN SERVICE					
	021216	STATE CAMP LICENSE FEE #25283	02/12/16	03/13/16	195.00	195.00
11353-1	COLORADO LIBRARY CONSORTIUM					
	19904	COURIER SERVICE	12/11/15	01/10/16	17,760.19	
	C3561	SKYRIVER SUBSCRIPTION	02/18/16	03/19/16	3,896.00	21,656.19
283-1	COLORADO SEAMLESS GUTTERS INC					
	79236	GUTTER HEAT RSC	02/11/16	03/12/16	831.00	831.00
13897-1	COMPASS MINERALS AMERICA INC					
	71447617	BULK QWIKSALT	02/01/16	03/02/16	4,060.81	
	71448953	BULK QWIKSALT	02/03/16	03/04/16	8,248.30	
	71452666	BULK QWIKSALT	02/10/16	03/11/16	4,095.73	16,404.84
13567-1	CONSOLIDATED ELECTRICAL DISTRIBUTORS INC					
	1872-558980	SR LIFT STATION REPAIR	01/25/16	02/24/16	3,550.00	3,550.00
10842-1	COZY CORNER TOWING					
	71562	TOW UNIT 2168	02/09/16	03/10/16	101.00	101.00
13370-1	CRIBARI LAW FIRM, PC					
	020916	PROSECUTING ATTORNEY	02/09/16	03/10/16	2,811.75	2,811.75
1570-1	DANA KEPNER COMPANY INC					
	1421743-00	CURB BOX EXTENSIONS	02/16/16	03/17/16	91.80	91.80
11411-1	DEBORAH FAHEY					
	020316	CPI CONFERENCE REG FAHEY	02/03/16	03/04/16	195.00	195.00
13392-1	DESIGN MECHANICAL INC					
	4064795	HVAC SERVICE MUSEUM	01/29/16	02/28/16	252.00	252.00
1505-1	DPC INDUSTRIES INC					
	737000583-16	CHLORINE WTP	02/16/16	03/17/16	798.00	798.00
14227-1	DUFFY CRANE & HAULING					
	110407	HVAC EQUIP TO ROOF CH	01/25/16	02/24/16	504.90	504.90
13790-1	EAGLE-NET ALLIANCE					
	160583	FEB 16 INTERNET SERVICE	02/01/16	03/02/16	870.20	870.20
1780-1	EBSCO					
	45206	PRINT PERIODICALS	02/13/16	03/14/16	44.00	44.00
13009-1	EIDE BAILLY LLP					
	EI00345816	2015 AUDIT PROGRESS BILLING	02/23/16	03/24/16	7,596.00	
	EI00345816	2015 AUDIT PROGRESS BILLING	02/23/16	03/24/16	5,538.75	
	EI00345816	2015 AUDIT PROGRESS BILLING	02/23/16	03/24/16	2,690.25	15,825.00
13963-1	ENSCICON CORPORATION					
	90124	ENGINEERING SERV SULLIVAN	02/10/16	03/11/16	740.00	
	90124A	ENGINEERING SERV SULLIVAN	02/10/16	03/11/16	740.00	1,480.00
1945-1	FALCON ENVIRONMENTAL CORP					
	5718	SUBMERSIBLE TRANSDUCER	01/21/16	02/20/16	730.21	730.21

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
13916-1	FERGUSON WATERWORKS					
	848840	METER ACCESSORIES	01/29/16	02/28/16	1,972.45	1,972.45
12819-1	FRANCOTYP-POSTALIA INC					
	RI102720864	POSTAGE METER RESETS RSC	02/02/16	03/03/16	95.85	95.85
13098-1	G4S SECURE SOLUTIONS INC					
	7650370	BAILIFF SERVICES 2/1/16	02/07/16	03/08/16	137.50	
	7659672	BAILIFF SERVICES 2/8/16	02/26/16	03/27/16	110.00	247.50
14137-1	GEAR FOR SPORTS INC					
	41091782	RESALE MERCHANDISE	02/01/16	03/02/16	473.15	473.15
6847-1	GENERAL AIR SERVICE & SUPPLY					
	91769258-1	CYLINDER RENTAL SHOPS	01/31/16	03/01/16	64.13	64.13
2310-1	GRAINGER					
	9005108072	ELEC HEATER/BELT TENSION CHECK	02/24/16	03/25/16	133.41	
	9005108072	ELEC HEATER/BELT TENSION CHECK	02/24/16	03/25/16	397.54	
	9005423927	CORROSION INHIBITOR RSC	01/22/16	02/21/16	24.63	
	9011245363	CORDLESS TOOL KIT WTP	01/28/16	02/27/16	1,998.70	2,554.28
11214-1	GRAYLING					
	P008944	FEB 16 PROFESSIONAL SERVICES	02/11/16	03/12/16	2,500.00	2,500.00
14081-1	GUARDIAN TRACKING LLC					
	2016-0086	EMPLOYEE TRACKING SOFTWARE PD	02/01/16	03/02/16	1,473.00	1,473.00
14157-1	HAWKSLEY CONSULTING					
	1704433	LSVL/SUP INTEGRATION STUDY	02/03/16	03/04/16	758.85	758.85
2475-1	HILL PETROLEUM					
	540246R-DM	UNLEADED FUEL GC	02/04/16	03/05/16	52.23	52.23
10806-1	INFOGROUP					
	10002883407	2016 REFERENCE USA	12/15/15	01/14/16	2,353.00	2,353.00
2615-1	INGRAM LIBRARY SERVICES INC					
	90973280	TEEN BOOKS AND MEDIA	12/24/15	01/23/16	10.44	
	90973884	CHILDRENS BOOKS AND MEDIA	12/24/15	01/23/16	9.34	
	91317440	ADULT BOOKS AND MEDIA	01/13/16	02/12/16	343.98	
	91317441	ADULT BOOKS AND MEDIA	01/13/16	02/12/16	172.75	
	91317442	CHILDRENS BOOKS AND MEDIA	01/13/16	02/12/16	264.12	
	91402271	ADULT BOOKS AND MEDIA	01/15/16	02/14/16	48.39	
	91402272	CHILDRENS BOOKS AND MEDIA	01/15/16	02/14/16	37.56	
	91403711	TEEN BOOKS AND MEDIA	01/15/16	02/14/16	61.90	
	91404449	ADULT BOOKS AND MEDIA	01/15/16	02/14/16	460.42	
	91433133	CHILDRENS BOOKS AND MEDIA	01/18/16	02/17/16	81.06	
	91466022	TEEN BOOKS AND MEDIA	01/19/16	02/18/16	21.57	
	91470722	ADULT BOOKS AND MEDIA	01/19/16	02/18/16	31.89	
	91470723	CHILDRENS BOOKS AND MEDIA	01/19/16	02/18/16	22.26	

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
	91482079	ADULT BOOKS AND MEDIA	01/20/16	02/19/16	22.95	
	91508289	ADULT BOOKS AND MEDIA	01/21/16	02/20/16	487.24	
	91550629	ADULT BOOKS AND MEDIA	01/22/16	02/21/16	48.23	
	91550630	ADULT BOOKS AND MEDIA	01/22/16	02/21/16	343.20	
	91550631	CHILDRENS BOOKS AND MEDIA	01/22/16	02/21/16	33.60	
	91550632	CHILDRENS BOOKS AND MEDIA	01/22/16	02/21/16	307.41	
	91550848	ADULT BOOKS AND MEDIA	01/22/16	02/21/16	257.81	
	91613801	ADULT BOOKS AND MEDIA	01/26/16	02/25/16	27.86	
	91624117	ADULT BOOKS AND MEDIA	01/27/16	02/26/16	29.44	
	91670287	ADULT BOOKS AND MEDIA	01/28/16	02/27/16	354.71	
	91670288	ADULT BOOKS AND MEDIA	01/28/16	02/27/16	112.96	
	91670289	ADULT BOOKS AND MEDIA	01/28/16	02/27/16	326.46	
	91670290	CHILDRENS BOOKS AND MEDIA	01/28/16	02/27/16	413.97	
	91673120	CHILDRENS BOOKS AND MEDIA	01/29/16	02/28/16	228.54	
	91687168	ADULT BOOKS AND MEDIA	01/29/16	02/28/16	81.58	
	91687169	CHILDRENS BOOKS AND MEDIA	01/29/16	02/28/16	25.16	
	91696914	ADULT BOOKS AND MEDIA	01/31/16	03/01/16	85.25	
	91735628	CHILDRENS BOOKS (STATE GRANT)	02/02/16	03/03/16	10.15	
	91739636	ADULT BOOKS AND MEDIA	02/02/16	03/03/16	303.98	
	91739637	CHILDRENS BOOKS AND MEDIA	02/02/16	03/03/16	278.35	
	91760396	CHILDRENS BOOKS AND MEDIA	02/03/16	03/04/16	15.38	
	91781144	ADULT BOOKS AND MEDIA	02/04/16	03/05/16	23.83	
	91784031	TEEN BOOKS AND MEDIA	02/04/16	03/05/16	6.19	
	91784032	TEEN BOOKS AND MEDIA	02/04/16	03/05/16	69.23	
	91785214	ADULT BOOKS AND MEDIA	02/04/16	03/05/16	330.78	
	91785215	CHILDRENS BOOKS AND MEDIA	02/04/16	03/05/16	8.34	
	91785391	ADULT BOOKS AND MEDIA	02/04/16	03/05/16	27.88	
	91805016	TEEN BOOKS AND MEDIA	02/07/16	03/08/16	10.42	
	91808279	ADULT BOOKS AND MEDIA	02/07/16	03/08/16	16.50	
	91808280	CHILDRENS BOOKS AND MEDIA	02/07/16	03/08/16	11.98	
	91823578	ADULT BOOKS AND MEDIA	02/08/16	03/09/16	455.15	
	91823579	ADULT BOOKS AND MEDIA	02/08/16	03/09/16	530.17	
	91823580	CHILDRENS BOOKS AND MEDIA	02/08/16	03/09/16	39.57	
	91823581	CHILDRENS BOOKS AND MEDIA	02/08/16	03/09/16	124.60	
	91844983	CHILDRENS BOOKS AND MEDIA	02/09/16	03/10/16	78.20	
	91855903	ADULT BOOKS AND MEDIA	02/10/16	03/11/16	47.57	
	91855904	CHILDRENS BOOKS AND MEDIA	02/10/16	03/11/16	94.44	
	91859166	ADULT BOOKS AND MEDIA	02/10/16	03/11/16	105.44	
	91859167	ADULT BOOKS AND MEDIA	02/10/16	03/11/16	14.27	
	91859168	ADULT BOOKS AND MEDIA	02/10/16	03/11/16	38.34	

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
	91859169	ADULT BOOKS AND MEDIA	02/10/16	03/11/16	89.17	
	91859170	CHILDRENS BOOKS AND MEDIA	02/10/16	03/11/16	170.29	
	91880874	ADULT BOOKS AND MEDIA	02/11/16	03/12/16	305.70	
	91880875	CHILDRENS BOOKS AND MEDIA	02/11/16	03/12/16	230.37	
	91881416	ADULT BOOKS AND MEDIA	02/11/16	03/12/16	10.99	
	91886530	ADULT BOOKS AND MEDIA	02/12/16	03/13/16	122.95	
	91886531	CHILDRENS BOOKS (STATE GRANT)	02/12/16	03/13/16	55.66	
	91888921	ADULT BOOKS AND MEDIA	02/12/16	03/13/16	331.10	
	91888922	CHILDRENS BOOKS AND MEDIA	02/12/16	03/13/16	289.86	
	91894042	ADULT BOOKS AND MEDIA	02/12/16	03/13/16	13.79	
	91899880	ADULT BOOKS AND MEDIA	02/14/16	03/15/16	58.25	
	91899881	CHILDRENS BOOKS AND MEDIA	02/14/16	03/15/16	27.83	
	91929918	ADULT BOOKS AND MEDIA	02/16/16	03/17/16	14.29	
	91929919	CHILDRENS BOOKS AND MEDIA	02/16/16	03/17/16	19.23	
	91933483	ADULT BOOKS AND MEDIA	02/16/16	03/17/16	339.70	
	91933484	CHILDRENS BOOKS AND MEDIA	02/16/16	03/17/16	86.83	
	91951798	ADULT BOOKS AND MEDIA	02/17/16	03/18/16	218.61	
	91951799	CHILDRENS BOOKS AND MEDIA	02/17/16	03/18/16	156.12	
	91977387	ADULT BOOKS AND MEDIA	02/19/16	03/20/16	113.94	
	91977388	CHILDRENS BOOKS AND MEDIA	02/19/16	03/20/16	97.81	
	91979827	TEEN BOOKS AND MEDIA	02/19/16	03/20/16	47.35	
	91979828	TEEN BOOKS AND MEDIA	02/19/16	03/20/16	99.00	
	91979829	TEEN BOOKS AND MEDIA	02/19/16	03/20/16	124.81	
	91980923	ADULT BOOKS AND MEDIA	02/19/16	03/20/16	341.50	
	91980925	CHILDRENS BOOKS AND MEDIA	02/19/16	03/20/16	6.58	
	92024928	TEEN BOOKS AND MEDIA	02/23/16	03/24/16	30.59	10,795.13
11267-1	INSIDE OUT HEALTH AND FITNESS					
	2016-02	CONTRACTOR FEES TABATA	02/12/16	03/13/16	378.00	
	2016-03	CONTRACTOR FEES PIYO	02/12/16	03/13/16	814.88	1,192.88
13471-1	INTEGRATED CONTROL SYSTEMS INC					
	16-239	HVAC SERVICE CH	02/23/16	03/24/16	450.00	450.00
10772-1	INTEGRATED SAFETY SERVICES LLC					
	15-3020	ALARM SERVICE PC	02/06/16	03/07/16	296.00	
	15-3025	FIRE EXTINGUISHER INSPECT PRKS	02/06/16	03/07/16	299.97	595.97
13817-1	ISRAEL ALVARADO					
	2016-33	ZUMBA PARTY DJ SERVICES	02/12/16	03/13/16	175.00	
	2016-34	NITE AT REC DJ SERVICES	02/19/16	03/20/16	275.00	
	2016-35	NITE AT REC DJ SERVICES	02/26/16	03/27/16	275.00	725.00
2780-1	KAISER LOCK & KEY SERVICE INC					
	103383	REKEY LOCKS CS	12/02/15	01/01/16	107.00	

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
	103696	DUPLICATE KEYS GC	02/03/16	03/04/16	169.00	276.00
14206-1	KEYSTONE OFFICE PRODUCTS CORP					
	11617395	FIRE PROOF FILE CABINET	02/12/16	03/13/16	2,764.00	2,764.00
14219-1	KIMLEY-HORN AND ASSOCIATES INC					
	7474033	CONTRACT SERV PLANNING RUSS	01/31/16	03/01/16	11,666.66	11,666.66
12861-1	KIRSTEN BEEMER					
	SSF00001	CONTRACTOR FEES DANCE	02/07/16	03/08/16	4,060.00	4,060.00
3005-1	LEWAN & ASSOCIATES INC					
	871410	FOREIGN INTERFACE MX4767129	02/16/16	03/17/16	56.25	56.25
14171-1	LISA STONE					
	89	CONTRACTOR FEES YOGA	02/13/16	03/14/16	235.90	235.90
3070-1	LL JOHNSON DISTRIBUTING CO					
	1704576-00	USED TORRO GM7210 W/POLAR TRAC	01/29/16	02/28/16	20,598.00	
	1704576-00	USED TORRO GM7210 W/POLAR TRAC	01/29/16	02/28/16	20,598.00	41,196.00
8059-1	LOUISVILLE DOLPHINS SWIM TEAM					
	2016-FEB	CONTRACTOR FEES STROKE CLINIC	02/27/16	03/28/16	1,673.00	1,673.00
13468-1	MANGO LANGUAGES					
	L10313	LANGUAGE LEARNING	10/15/15	11/14/15	3,038.49	3,038.49
14071-1	MARY RITTER					
	3	CONTRACTOR FEES FLUID RUNNING	02/28/16	03/29/16	394.10	
	4	CONTRACTOR FEES FLUID RUNNING	02/28/16	03/29/16	621.60	1,015.70
8	FRESCA FOODS INC					
	021116	BUSINESS ASSISTANCE REBATE	02/11/16	03/12/16	12,837.60	
	021116	BUSINESS ASSISTANCE REBATE	02/11/16	03/12/16	19,431.50	32,269.10
15	JESSICA FASICK					
	020316	CPI CONFERENCE REG FASICK	02/03/16	03/04/16	195.00	195.00
15	CYNDI THOMAS					
	020316A	CPI CONFERENCE REG THOMAS	02/03/16	03/04/16	195.00	195.00
15	LYNDA HALEY					
	020416	CPI CONFERENCE REG HALEY	02/04/16	03/05/16	195.00	195.00
10	WESTERN ENVIRONMENT & ECOLOGY					
	964	BULK WATER METER REFUND	02/09/16	03/10/16	2,450.00	2,450.00
6168-1	MOTION & FLOW CONTROL PRODUCTS INC					
	6280788	PARTS UNIT 5301	02/24/16	03/25/16	45.00	45.00
13942-1	MURRAY DAHL KUECHENMEISTER & RENAUD LLP					
	12832	URBAN RENEWAL LEGAL FEES	01/31/16	03/01/16	62.50	62.50
11365-1	NATIONAL METER & AUTOMATION INC					
	S1067950.001	WATER METERS & ACCESSORIES	02/12/16	03/13/16	9,047.04	9,047.04
13597-1	NORTH LINE GIS LLC					
	1282	ESRI ARCGIS SUPPORT	02/02/16	03/03/16	1,650.00	1,650.00

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
3630-1	NORTH STAR WINDOW CLEANING					
	29940	WINDOW CLEANING RSC	02/24/16	03/25/16	725.00	725.00
13649-1	OVERDRIVE INC					
	1100-184220090	AUDIO & EBOOKS (STATE GRANT)	02/12/16	03/13/16	1,083.50	1,083.50
6849-1	OVERHEAD DOOR COMPANY INC					
	1-35112477	BAY DOOR REPAIR CS	01/28/16	02/27/16	910.00	910.00
11477-1	P.R.O.S. INC					
	LO1603	YOUTH BASKETBALL REFEREES	02/21/16	03/22/16	1,566.00	1,566.00
13898-1	PEAK FACILITATION GROUP INC					
	1622	COUNCIL RETREAT	02/25/16	03/26/16	2,165.00	2,165.00
11329-1	POLYDYNE INC					
	1024546	CE-879 POLYMER	02/01/16	03/02/16	10,580.00	
	1026017	CLARIFLOC C-4420	02/08/16	03/09/16	540.00	11,120.00
9105-1	POSTMASTER					
	022016	BULK MAIL PERMIT #15	02/20/16	03/21/16	225.00	225.00
13893-1	REBECCA TSUI					
	2016-2	CONTRACTOR FEES TAI CHI	02/27/16	03/28/16	554.40	554.40
6500-1	RECORDED BOOKS LLC					
	75279147	ADULT BOOKS AND MEDIA	02/02/16	03/03/16	280.20	280.20
9909-1	REGIONAL AIR QUALITY COUNCIL					
	13458	2016 WORK PROGRAM CONTRIBUTION	02/11/16	03/12/16	900.00	900.00
11306-1	SAFEWARE INC					
	3499291	GAS DETECTOR CALIBRATION SHOPS	02/05/16	03/06/16	479.10	479.10
12843-1	SCL HEALTH SYSTEM					
	10033	NEW HIRE TESTING	02/14/16	03/15/16	320.40	
	9311	NEW HIRE TESTING	02/04/16	03/05/16	527.40	847.80
5369-1	SGS ACCUTEST INC					
	D2-72605	LAB ANALYSIS FEES WWTP	02/26/16	03/27/16	49.50	
	D2-72606	LAB ANALYSIS FEES WWTP	02/26/16	03/27/16	59.50	
	D2-72607	LAB ANALYSIS FEES WWTP	02/26/16	03/27/16	256.00	
	D2-72608	LAB ANALYSIS FEES WWTP	02/26/16	03/27/16	573.50	
	D2-72609	LAB ANALYSIS FEES WWTP	02/26/16	03/27/16	717.50	1,656.00
1161-1	SHARI L GRISWOLD					
	1612118-1	CONTRACTOR FEES MUSIC TOGETHER	02/18/16	03/19/16	980.00	980.00
11136-1	SINK COMBS DETHLEFS					
	001534.00-3	RSC EXPANSION PROJECT	02/17/16	03/18/16	15,246.66	15,246.66
14207-1	SMALL AXE TREE CARE					
	022216	TREE PRUNING	02/22/16	03/23/16	2,120.00	2,120.00
13293-1	STAPLES ADVANTAGE					
	8037804697	OFFICE SUPPLIES PD	01/30/16	02/29/16	537.85	537.85

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
11151-1	SUMMIT CHEMICALS					
	W160068-IN	ALUMINUM CHLOROHYDRATE WTP	02/11/16	03/12/16	11,871.82	11,871.82
14091-1	SUPER-TECH FILTER					
	254189	HVAC FILTERS PC	01/29/16	02/28/16	61.00	61.00
1201-1	SUPPLYWORKS					
	358431799	JANITORIAL SUPPLIES RSC	02/09/16	03/10/16	2,668.31	
	358431807	JANITORIAL SUPPLIES PC	02/09/16	03/10/16	220.26	
	358431815	JANITORIAL SUPPLIES CH	02/09/16	03/10/16	501.72	
	358431823	JANITORIAL SUPPLIES AC	02/09/16	03/10/16	266.04	
	358431831	JANITORIAL SUPPLIES LIB	02/09/16	03/10/16	669.24	
	358431849	JANITORIAL SUPPLIES CS	02/09/16	03/10/16	131.92	
	358981405	BREAK ROOM SUPPLIES CH	02/16/16	03/17/16	394.24	4,851.73
4100-1	TERMINIX					
	5373518-2016	2016 PEST CONTROL LIB	02/03/16	03/04/16	1,105.80	1,105.80
14213-1	THE ANTIGUA GROUP INC					
	4371743	RESALE MERCHANDISE	02/04/16	02/04/16	450.17	450.17
7917-1	THE AQUEOUS SOLUTION INC					
	68732	POOL CHEMICALS	02/08/16	03/09/16	650.93	650.93
14224-1	THE NOVAK CONSULTING GROUP					
	983	PLANNING DIRECTOR RECRUITMENT	02/01/16	03/02/16	6,345.00	6,345.00
14042-1	TRIENDURANCE LLC					
	2408	TRIATHLON GROUP SWIM	01/27/16	02/26/16	303.80	303.80
14065-1	TYLER TECHNOLOGIES INC					
	045-151119	TYLER MUNIS OSDBA SUPPORT	02/01/16	03/02/16	11,359.00	
	045-152025	TYLER SOFTWARE	02/02/16	03/03/16	1,400.00	
	045-152025	TYLER SOFTWARE	02/02/16	03/03/16	300.00	
	045-152025	TYLER SOFTWARE	02/02/16	03/03/16	300.00	
	045-152216	TYLER SOFTWARE	02/03/16	03/04/16	11,331.85	
	045-152216	TYLER SOFTWARE	02/03/16	03/04/16	2,428.25	
	045-152216	TYLER SOFTWARE	02/03/16	03/04/16	2,428.26	29,547.36
13426-1	UNIQUE MANAGEMENT SERVICES INC					
	420564	COLLECTION SERVICES	02/01/16	03/02/16	80.55	80.55
11087-1	UNITED SITE SERVICES					
	114-3693449	TOILET RENTAL SKATE PARK	01/25/16	02/24/16	204.65	
	114-3751872	TOILET RENTAL CENTENNIAL PARK	02/15/16	03/16/16	209.60	414.25
6509-1	USA BLUEBOOK					
	69261	LAB SUPPLIES WWTP	02/08/16	03/09/16	19.80	
	870444	SONOSCOPE LEAK DETECTOR	02/10/16	03/11/16	389.54	409.34
13891-1	VERIS ENVIRONMENTAL LLC					
	J002649	BIOSOLIDS HAULING	01/13/16	02/12/16	2,302.20	

Batch: 93856 Period: 03/08/16

Vendor/ Remit#	Invoice Number	Description	Invoice Date	Due Date	Invoice Amount	Check Amount
	J002680	BIOSOLIDS HAULING	01/20/16	02/19/16	1,792.60	
	J002713	BIOSOLIDS HAULING	01/28/16	02/27/16	1,713.19	
	J002755	BIOSOLIDS HAULING	01/31/16	03/01/16	1,841.87	
	J002773	BIOSOLIDS HAULING	02/10/16	03/11/16	1,796.92	
	J002811	BIOSOLIDS HAULING	02/17/16	03/18/16	2,288.19	11,734.97
8035-1	VSR CORPORATION					
	7014	SEWER LINE VIDEO INSPECTION	01/29/16	02/28/16	587.50	587.50
6210-1	W BRUCE JOSS					
	021216	FEB 16 MUNICIPAL JUDGE SALARY	02/12/16	03/13/16	2,600.00	2,600.00
12997-1	WHITESTONE CONSTRUCTION SERVICES INC					
	3477	LAKE PARK SHELTER REPAIR	02/26/16	03/27/16	12,756.00	12,756.00
10884-1	WORD OF MOUTH CATERING INC					
	2016-03	SR MEAL PROGRAM 2/8-2/26/16	02/26/16	03/27/16	4,027.00	4,027.00
11586-1	XCELIGENT INC					
	244214	REAL ESTATE DATABASE	03/01/16	03/31/16	999.99	999.99
13555-1	YOUNG REMBRANDTS - NW DENVER & BOULDER					
	2620388	CONTRACTOR FEES DRAWING	02/07/16	03/08/16	122.50	122.50
13558-1	ZIONS CREDIT CORP					
	627466	FEB 16 SOLAR POWER EQUIP LEASE	02/19/16	03/20/16	1,767.62	
	627466	FEB 16 SOLAR POWER EQUIP LEASE	02/19/16	03/20/16	883.81	2,651.43
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	BANK TOTAL PAYMENTS				371,998.34	371,998.34
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	GRAND TOTAL PAYMENTS				371,998.34	371,998.34

City of Louisville
COLORADO • SINCE 1878

City Council

Meeting Minutes

February 16, 2016
City Hall, Council Chambers
749 Main Street
7:00 PM

Call to Order – Mayor Pro Tem Lipton called the meeting to order at 7:00 p.m.

Roll Call was taken and the following members were present:

City Council:	***Mayor Muckle (arrived at 7:04 p.m.)*** ***Mayor Pro Tem Jeff Lipton, City Council members, Dennis Maloney, Chris Leh, Susan Loo, Jay Keany and Ashley Stolzmann***
Staff Present:	***Malcolm Fleming, City Manager*** ***Heather Balser, Deputy City Manager*** ***Kevin Watson, Finance Director*** ***Sean McCartney, Principal Planner*** ***Lauren Trice, Planner I*** ***Nancy Varra, City Clerk***
Others Present:	***Sam Light, City Attorney***

PLEDGE OF ALLEGIANCE

All rose for the pledge of allegiance.

APPROVAL OF AGENDA

Mayor Pro Tem Lipton called for changes to the agenda and hearing none, moved to approve the agenda, seconded by Council member Maloney. All were in favor. Absent: Mayor Muckle.

PUBLIC COMMENTS ON ITEMS NOT ON THE AGENDA

John Willson, Fire Chief, Louisville Fire Protection District, 895 Via Appia, Louisville, CO provided his quarterly update and to respond to Council's questions. He reported on a fire two weeks ago near Monarch, which spread to 27 acres. Several surrounding fire departments responded including North Metro, Lafayette, Rocky Mountain and Boulder

Rural. He also announced the Fire District will be conducting election for officers on the Fire Protection Board this May. The applications are available for those desiring to serve.

Debbie Fahey, 1118 W. Enclave Circle, Louisville, CO recognized the contributions made by the late Don Buffo. She reported the Heat Relief Dinner is Thursday, February 18th at the Louisville Recreation/Senior Center, from 5:00 to 7:30 p.m. Tickets are $15.00 each for adults and $10.00 for children (20 years and younger). All proceeds from the dinner and silent auction are used for energy assistance, aid in scholarships and emergency funds for seniors. She had tickets available for those who wished to purchase them. She donated two tickets to the City Clerk, Nancy Varra, in honor of her retirement.

A two-year Louisville resident named Bob, addressed efforts made by Police Officer Logan Haymore, who helped his daughter across Main Street to get to the Louisville Middle School. He noticed at the beginning of this year, police officers parked in front of the Middle School and wrote speeding tickets instead of helping children cross the street. He was unhappy with the priority of writing tickets. He spoke with a police sergeant about the problem, who said he would speak to the school resource officer. The next day at the middle school, the principal and the teachers were at the intersection, but not the police officer. In the following days the police officers returned to writing tickets, but not to assist students cross the street. He requested Council consider asking the police officers to assist the students in lieu of writing tickets.

Jean Morgan, 1131 Spruce Street, Louisville, CO stated one year ago she, Claudia Lund, from the Lafayette Miner's Museum, Lafayette resident Lyle Laughlin, and Mining Engineer Louie Gaz, drove along the area of the mines in Lafayette and along South Boulder Road. Their recollection of the mines was recorded and transcribed by Ms. Morgan. Last month the group met with Erie resident Bob Canaday for a tour of the Erie mines. She noted those transcriptions are available at the Louisville, Lafayette and Erie Libraries. She presented a copy of the transcripts to the Mayor and Council and to City Clerk Varra, in honor of her retirement.

APPROVAL OF THE CONSENT AGENDA

Mayor Muckle called for changes to the consent agenda. Council member Stolzmann requested a change to the minutes as follows: Page 9: Under Council Discussion: Council member Stolzmann: "She did feel a new property appraisal would be necessary."

MOTION: Mayor Muckle moved to approve the consent agenda as amended, seconded by Council member Stolzmann. All were in favor**.**

A. Approval of the Bills
B. Approval of Minutes; January 26, 2016; February 2, 2016

C. Approve Resolution No. 6, Series 2016 – A Resolution Approving an Intergovernmental Agreement (IGA) Between the Colorado Department of Transportation (CDOT) and the City of Louisville Concerning the Maintenance of the Diverging Diamond Interchange (DDI) at US 36 and McCaslin Boulevard

D. Approve Contract Between the City of Louisville and Glacier Construction for the Construction of the Side Copeland Chlorine Contact Chamber Improvements

E. Award Landscape Maintenance Service Contract

F. Approve Resolution No. 7, Series 2016 – A Resolution Approving the Fifth Interim Agreement between the Municipal Subdistrict, Northern Colorado Conservancy District Windy Gap Firming Project Water Activity Enterprise, and the City of Louisville for Participation in the Windy Gap Firm Project

COUNCIL INFORMATIONAL COMMENTS ON PERTINENT ITEMS NOT ON THE AGENDA

Mayor Muckle agreed with the resident about the police monitoring to see students safely cross Main Street.

CITY MANAGER'S REPORT

City Manager Fleming reported on the following:

- Downtown Flowers: The City contracted with Valley Crest for the downtown flowers. The Parks Department issued an RFP and received two responses. Valley Crest has significant experience in this area. The flowers will go out after Mother's Day, weather permitting.
- The South Boulder Road Area Plan: The Planning Commission reviewed it last week and will review it again before Council consideration.
- McCaslin Boulevard Small Area Plan: The McCaslin Placemaking Workshop #3 is scheduled for Thursday, February 25th, at the City Hall from 6:30 p.m. to 8:00 p.m. Three options will be considered and the public input from the Workshop will assist in developing a preferred alternative.
- Planning & Building Safety Director Update: Phone conference with the consultants to review the 35 applications on February 15. The 35 will be narrowed down to a short list of 10 very promising candidates. Staff will work with the consultants to narrow the list to the finalists. The assessments will be on March 15 and 16. A Public Open House to meet the candidates is planned for the evening of March 15. There will be a full series assessment on candidates, followed by an announcement of the best candidate.
- February 15 - Clean Sweep Day: Employees took advantage of facility closures to organize files and properly dispose of documents meeting the records retention according to the State Archivist.

- Tactical Training: 128 public safety representatives took part in training at the Louisville Police Department. It was a great turnout and a great training session. He thanked Chief Hayes for organizing the training.
- Dillon Road Underpass: The Dillon Road Underpass will be operational on Wednesday, February 17th.

Mayor Muckle clarified the Dillon Road underpass is a flood repair on Dillon Road.

REGULAR BUSINESS

RECOGNIZATION OF CITY CLERK NANCY VARRA

Mayor Muckle reported the City Clerk, Nancy Varra, is retiring after 43 years of service to the City of Louisville. He outlined Nancy's employment history with the City. The Mayor and City Council recognized Nancy for her service.

The City Council took a 15-minute break for a reception in Nancy's honor at 7:18 p.m., and reconvened at 7:41 p.m.

RESOLUTION No. 8, SERIES 2016 – A RESOLUTION APPROVING AN INTERGOVERNMENTAL AGREEMENT WITH SUPERIOR METROPOLITAN DISTRICT No. 1 FOR A LIFT STATION EMERGENCY OVERFLOW CONNECTION

Mayor Muckle requested a staff presentation.

City Manager Fleming explained Resolution No. 8, Series 2016 approves an Intergovernmental Agreement (IGA) with Superior Metropolitan District No. 1 (SMD1) for the connection of an emergency wastewater lift station overflow connection from the Superior Town Center. It is modeled after an agreement the City has with the City of Lafayette, which provides for emergency overflow from Louisville to Lafayette. Both IGA's have similar provisions. Those provisions include fees ($100 per day and $25 per industrial tap) in the event the emergency overflow is used. There are requirements for Superior to report any potential sources of industrial toxins on an annual basis. Any intentional release of toxins is an illegal, prosecutable offense.

COUNCIL COMMENT

Council member Stolzmann explained she sits on the Louisville/Superior Joint Interest Board along with Council member Maloney. She felt this was a nice effort to have the relationship worked out before an emergency happens. She noted there is already a pipe in place under US 36, which will be utilized. She felt it was a neighborly thing to do. She appreciated the effort of having all the terms spelled out. She felt it was good to move forward with the IGA.

Council member Lipton addressed the $25 per day per tap and asked if it is specified in the agreement. City Manager Fleming explained it is addressed in the agreement on page 2, d, as follows: "An extra charge of $25 per day per tap shall be incurred for each SMD1 tap directly contributing non-domestic sewage flow to the flows routed through the emergency overflow connection to Louisville's sanitary sewer collection system. SMD1 shall on an annual basis submit a written report to Louisville identifying all potential toxic pollutants and or hazardous waste and the sources thereof located within the area to be served by the emergency overflow connection." Similar to the IGA with the City of Lafayette, the City has identified all the industrial taps in Louisville requiring pre-treatment services and reporting on an annual basis on the potential pollutants they handle.

Council member Lipton asked if this would rule out all residential, commercial or retail. City Manager Fleming explained Superior must specifically identify commercial per tap. The residential component is covered by the $25 per day fee and the commercial is covered under the $100 per tap fee.

Council member Maloney supported reciprocal agreements with surrounding communities. He asked what kind of risks the City would assume if the service could not be provided and what is the liability. City Manager Fleming stated staff believes the amount of sewer flow anticipated could be accommodated by the City's wastewater treatment plant. The tap has been sized accordingly and the plant can handle those flows on a temporary basis.

City Attorney Light explained the overflow connection is intended to minimize the risk if the lift station failed. It is a contingency to assist Superior if the lift station failed and they did not have a backup plan. It is primarily a feature of Superior's system, which allows them an overflow connection. The operation/maintenance risk is primarily related to Superior system. It is intended to be a temporary backup system until their system comes back online.

Council member Loo stated if there was a massive flood, the Town of Superior would still be required to notify the City. She was comfortable there was a failsafe mechanism in place. City Attorney Light explained it is noted in Sub Section 1g of the agreement.

MOTION: Council member Maloney moved to approve Resolution No. 8, Series 2016, seconded by Council member Stolzmann. Roll call vote was taken. The motion carried by a vote of 7-0.

RESOLUTION No. 9, SERIES 2016 – A RESOLUTION APPROVING A REPLAT TO SUBDIVIDE A SINGLE 20,569 SF LOT INTO TWO SEPARATE LOTS IN THE RESIDENTIAL LOW (RL) ZONE DISTRICT, LOCATED AT 1104 GARFIELD AVENUE, LOT 102, PARKWOOD MINOR SUBDIVISION

Mayor Muckle disclosed the subject property is directly behind his property and would likely affect him more economically than a larger group of people. He recused himself from the discussion and the vote and left the meeting room.

Mayor Pro Tem Lipton opened the public hearing and requested a staff presentation.

Principal Planner McCartney addressed the modification to Resolution No. 9 Series 2016, which modifies the language in the second paragraph as follows: WHEREAS**,** the City Staff has reviewed the information submitted and found it to comply with applicable provisions of Louisville Municipal Code Titles 16 and 17. He explained Resolution No. 9, Series 2015 approves a replat to subdivide a single 20,569 SF lot into two separate lots in the Residential Low (RL) Zone District, located at 1104 Garfield Avenue, Lot 102, Parkwood Minor Subdivision. The subject property is located on the northeast corner of Garfield and Short and is zoned Residential Low (RL).

The lot is 20,569 SF and contains a 1,763 SF house; a 450 SF attached garage; a 362 SF deck and a 566 SF patio for a total of 3,131 SF. All the structures would be retained on Lot 102A and would be 11,035 SF. The structures cover 28% of the lot (30% is permitted). The minimum lot area in RL is 7,000 SF with 30% lot coverage. Lot 102A would be 11,035 SF and allows 3,301 SF of coverage. Lot 102B would be 9,534 SF and allows 2,860 SF of coverage. The neighborhood average is 8,600 SF. New lots would be compatible with the neighborhood subdivision. The subdivision would create an additional dwelling unit. The request complies with the 2013 Comprehensive Plan for this area. There are no requests for waivers.

The Planning Commission unanimously recommended approval of the minor subdivision request. The Staff recommended the City Council approve Resolution No. 9, Series 2016.

COUNCIL QUESTIONS

Council member Maloney requested clarification the lots within the area averaged 8,600 SF lots. Principal Planner McCartney confirmed the staff performed an analysis around the property and in larger neighborhoods to determine the compatibility.

APPLICANT PRESENTATION

The applicants: Joni Fournier, 1727 Mapleton Avenue, Apt D, Boulder, CO and Eliot Marshall, 1019 Topaz Street, Superior, CO.

Ms. Fournier felt the Principal Planner did a good job of outlining the request. She stressed a new dwelling unit will be created and will be built according to the City's design and zoning standards.

COUNCIL COMMENT

Council member Stolzmann questioned the angle of the lot line. She referenced Section 16.16.050 F, which stipulates "Side lot lines shall be substantially at right angles or radial to street lines". She inquired how the lot line was derived. Principal Planner McCartney explained the lot is angled because of the way the house is askew on the lot. The lot line was set so the existing house complies with the 25' setbacks, and was taken parallel to the askew of the house so there would not be any request for waivers.

Council member Stolzmann asked if a new structure would be able to fit on the new lot given the odd shape. Principal Planner McCartney confirmed there would be sufficient space for a second structure.

Council member Stolzmann addressed the code referencing double frontage: Section 15.15.050 – Lots E. Double-frontage, reverse-frontage, and reverse-corner lots shall be prohibited. She asked Principal Planner McCartney to explain those types of frontages. Principal Planner McCartney explained this request is to create a single frontage and a single lot. A double coverage would have a through lot. A reverse corner would have an indent into the property. He explained the request is to create a subdivision plat to comply with the required zoning.

Mayor Pro Tem Lipton called for public comment and hearing none, closed the public hearing.

MOTION: Council member Loo moved to approve Resolution No. 9, Series 2016, seconded by Council member Keany.

City Attorney Light requested confirmation the vote was on the revised resolution. Council member Loo and Keany accepted the amendment for the revised resolution.

COUNCIL COMMENT

Mayor Pro Tem Lipton stated he would vote against the motion. He did not support subdividing properties within neighborhoods. He felt it is important to preserve the neighborhood lots. He did not want to open the door to development investors on oversized lots and replats.

Council member Keany voiced his appreciation of Mayor Pro Tem Lipton's comments, but felt until there is a discussion about changing the ordinance, the Council has to vote on what is presented to them. He noted the application met all the criteria.

Mayor Pro Tem Lipton stated the application did not meet all the criteria and Council has the legal right to vote against the request if it does not meet all the criteria.

VOTE: Roll call vote was taken. The motion carried by a vote of 5-1. Mayor Pro Tem Lipton voted no. Recused: Mayor Muckle.

APPROVE RESOLUTION No. 10, SERIES 2016 – A RESOLUTION APPROVING AN AMENDMENT TO THE LOUISVILLE PSYCHIATRIC HOSPITAL PUD TO ALLOW FOR A 12,560 SF ADDITION TO THE EXISTING HOSPITAL AND PARKING EXPANSION

Mayor Muckle requested a staff presentation.

Planner I Trice addressed the modification to Resolution No. 10, Series 2016, which changes the 5th paragraph to read as follows: NOW THEREFORE, BE IT RESOLVED that the City Council of the City of Louisville, Colorado does hereby approve an amendment to the Louisville Psychiatric Hospital PUD to allow for a 12,560 SF addition to the existing hospital and parking expansion, with the following condition: 1) The applicant must make the changes stated in the memo from Public Works, dated January 4, 2015 prior to recordation.

Planner I Trice explained the request is to approve an amendment to the Louisville Psychiatric Hospital PUD to allow for a 12,560 SF addition to the existing hospital and parking expansion. The subject property is located at 100 Health Park Drive between Avista Adventist Hospital to the west and assisted living, offices and Monarch School Campus across 88th Street to the east. The Coal Creek Ranch neighborhood is to the north.

Background: The Louisville Psychiatric Hospital PUD was approved by CC in 1987. The PUD was amended in 2012 to allow for the height of the fence to extend to 10 feet. The Zoned Planned Community Zone District – Commercial (P-C) is part of Avista Adventist GDP. The existing facility is 52,347 sf and 72-bed inpatient.

Request: The request is for an additional 12,560 SF (32 beds) to the northeast corner of the existing structure; the creation of a courtyard for patients and expand the parking area to the north. The site plan and security plan have been reviewed by the Police Department.

Current Parking: 116 standard spaces; 5 accessible; 3 bicycles. The required parking is 3 spaces/2 beds = 156 spaces. The proposed parking is 171 standard spaces; 9 accessible; 18 bike spaces (1bike/10 auto) to minimize neighborhood impact. Landscaping: 30% open space is required; 57% open space is proposed. Circulation: Proposed second entrance further north; Additional sidewalk in proposed parking expansion.

Architecture: Design elements of existing structure; 17’7” parapet, and 21’3” mechanical screen (below CDDSG requirement of 35’). The majority of addition is behind the privacy fence for minimal neighborhood impact.

The Planning Commission reviewed the proposal at its January 14, 2016 meeting and unanimously recommended approval with one condition. Staff recommended City Council approval of the revised copy of Resolution No. 10, Series 2016.

APPLICANT PRESENTATION

The applicants introduced themselves: Stacey Root, Public Architect, Boulder Associates, Inc., 1426 Pearl Street, #300, Boulder, CO, and Malissa Benson, Centennial Peaks Hospital Representative, 2255 S. 88th Street, Louisville, CO.

Ms. Root explained the proposal is to expand the hospital away from the neighborhood and Monarch High School and toward the Avista Campus. The land is owned by Avista Hospital and Centennial Peaks leases the land. She stressed Avista Hospital is very supportive of this project. With respect to architecture, they propose a combination of stucco and brick to be consistent with Avista Hospital. She reviewed a 1998 Site Plan Map, which showed the hospital site with a potential for an expansion of the campus. The current proposal requires 156 parking spaces. The hospital currently has 121 spaces, but there is a significant overflow problem, due to outpatient parking. The total amount of parking provided is 180 parking spaces, which exceeds the requirement by 24 spaces. A Neighborhood Meeting was held on December 22 for the purpose of updating the neighbors and residents of the project. Only 3 people showed up, but all were in full support of the project.

Ms. Benson addressed the mission of Centennial Peaks Hospital and why the expansion is required. She explained Centennial Peaks Hospital's community partnership includes PEN, Sister Carmen and Hope Arapahoe House. They provide a complimentary level of care assessment to the community 24 hours a day, 7 days a week and 365 days a year. Their call center responds to over 11,000 calls annually. She stressed one of the reasons for expansion is that Colorado ranks 50th in the United States in the number of beds per capita and nationally, Colorado ranked 9th in suicides per capita and in 2015. The Centennial Peaks Hospital is currently unable to serve approximately 200 patients per month due to the lack of beds. With the expansion Centennial Peaks Hospital expects to have the capacity to serve an additional 1,500 to 2,000 patients annually and estimates they will be providing 75 new jobs.

Ms. Root noted they have worked very closely with Police Chief Hayes to address all of his concerns and will be installing a metal detector. They have also worked with the Facilities Director at Avista Hospital and the project has his full support.

MOTION: Mayor Pro Tem Lipton moved to approve the revised Resolution No. 10, Series 2016, seconded by Council member Loo. All were in favor.

ORDINANCE No. 1716, SERIES 2016 – AN ORDINANCE AMENDING TITLE 17 OF THE LOUISVILLE MUNICIPAL CODE (LMC) TO ADD HEALTH OR ATHLETIC

CLUBS, SPAS, DANCE STUDIOS AND FITNESS STUDIOS AS A LISTED USE GROUP AND SPECIFYING IN WHICH ZONE DISTRICTS THESE MAY BE DEVELOPED – 1ST READING – SET PUBLIC HEARING 03/08/2016

Mayor Muckle requested a City Attorney introduction.

City Attorney Light introduced Ordinance No. 1716, Series 2016.

MOTION: Mayor Muckle moved to approve Ordinance No 1716, Series 2016, on first reading, ordered it published and set a public hearing for March 8, 2016 seconded by Mayor Pro Tem Lipton.

COUNCIL COMMENTS

Council member Stolzmann requested at the next meeting staff provide the following information: She noted the Use Group table in the ordinance does not match the Use Group Table in the Council Communication. She voiced her preference for the Use Group Table in the Council Communication. She also requested a discussion on using the word gymnasium in the Use Group.

Council member Maloney asked for information on how broad the definition is for gymnasium.

VOTE: All were in favor

DISCUSSION/DIRECTION/ACTION – CITY COUNCIL MEETING SCHEDULE

City Manager Fleming noted last year the Council had a six week break. He outlined the proposed Council Meeting Schedule and requested Council discussion and direction.

Option 1:
- May 31 – 5th Tuesday, no meeting
- June 7 – cancel regular meeting
- June 14 – cancel study session four weeks between meetings
- June 21 – regular meeting
- June 28 – regular meeting, budget retreat
- Regular - July schedule

Option 2:
- June 7 – regular meeting
- June 14 –regular meeting, budget retreat
- June 21 – cancel regular meeting
- June 28 – cancel study session
- July 5 – cancel regular meeting four weeks between meetings

- July 12 – regular meeting
- July 19 – study session
- July 26 - regular meeting

Option 3:
- May 31 – 5th Tuesday, no meeting
- June 7 – cancel regular meeting
- June 14 – study session three weeks between meetings
- June 21 – regular meeting
- June 28 – regular meeting, budget retreat
- Regular - July schedule

Option 4:
- May 31 – 5th Tuesday, no meeting
- June 7 – regular meeting, budget retreat
- June 14 – cancel study session two weeks between meetings
- June 21 – regular meeting
- June 28 – study session
- Regular - July schedule

COUNCIL DISCUSSION

Mayor Muckle voiced his support Option 2, but suggested the July 5th meeting not be skipped. This would provide a three week break.

Council member Loo stated in light of the Recreation/Senior Center Aquatic expansion and improvements, she was not sure the Council should take a summer break. She was concerned about the timelines for public hearing on the ballot measures. She agreed Option 2, without skipping the July 5th meeting is the best option. She noted the public hearing for the Recreation/Senior Center ballot issue was to be the first meeting in June. She did not feel the ballot issue and the budget should be put on the same meeting. Council member Maloney also supported the modified Option 2.

Council member Lipton was not sure Council should take a summer break, but felt there should be some flexibility within the summer sessions. He noted there is an anticipated public hearing for the Recreation/Senior Aquatic expansion in June.

City Manager Fleming and Mayor Muckle reviewed the revised Option 2 for the Council Summer Schedule. There was Council consensus. The schedule is as follows:

- June 7 – regular meeting, budget retreat
- June 14 –regular meeting (Tentative Public Hearing - Recreation Center)
- June 21 – cancel regular meeting
- June 28 – cancel study session

- July 5 – regular meeting
- July 12 – study session
- July 19 – regular meeting
- July 26 – study session

CITY ATTORNEY'S REPORT

City Attorney Light explained later on the City Council will have to adopt a motion for the adjusted summer meeting schedule. City Manager Fleming confirmed this will be on a future agenda.

COUNCIL COMMENTS, COMMITTEE REPORTS, AND IDENTIFICATION OF FUTURE AGENDA ITEMS

Council member Stolzmann reported on the Finance Committee meeting where the City's bill paying was discussed. Generally, the bills are not paid until the City Council approves them, but during the summer break there may be a significant amount of time between Council's approvals. These bills may be budgeted or under contract so the bills will be paid, rather than being held for the Finance Committee's review. This will appear as a future consent agenda item to be approved by Council.

Mayor Muckle stated Council approval of the bills provides accountability and transparency. The Finance Committee is planning on changing the strategy, but Council will still approve the bills. Mayor Pro Tem Lipton supported changing the bill paying process.

Council member Stolzmann reported on the Joint Louisville/Superior Committee and a presentation made by Drewberry Consulting. Due to EPA regulations, the City is making changes to their Waste Water Treatment Plant. Superior will also have to make changes to their wastewater plant, but on a different timeline. The engineers provided information to make a decision on whether there would be economic, environmental or efficiency reasons to join the two plants together. It does not appear there will be a large financial savings. Superior would have to pay approximately $3.5 Million more. There was discussion about the Superior staff discussing this with the Trustees to see if they wish to continue the discussion.

Council member Leh reminded everyone about the Senior Heat Relief Dinner and noted it is for a good cause. He also reported on the Valentine's Dinner at the Sweet Spot at the Golf Course. He encouraged everyone to support the golf course.

ADJOURN

MOTION: Mayor Muckle moved for adjournment, seconded by Mayor Pro Tem Lipton. All were in favor. The meeting was adjourned at 8:40 p.m.

_____
Robert P. Muckle, Mayor

_____
Carol Hanson, Acting City Clerk

SUBJECT: **APPROVAL OF CONTRACT FOR KAISER PERMANENTE HEALTH INSURANCE**

DATE: **MARCH 8, 2016**

PRESENTED BY: **KATHLEEN HIX, HUMAN RESOURCES DIRECTOR**

SUMMARY:
The City has contracted with Kaiser Permanente (Kaiser) to provide health care options for employees over the past fourteen years.

Each fall we work through our benefits broker, IMA, Inc. to coordinate and negotiate our health insurance renewal with Kaiser. Kaiser's initial renewal to the City of Louisville for 2016 was a 1.4% decrease. In addition to the exciting news about a rate decrease, we were pleased to learn that the City's plan design options remained the same for 2016.

The City has offered a Health Maintenance Organization (HMO) plan and a High Deductible Health Plan (HDHP) to employees for many years. Staff continues to receive employee feedback about wanting a health insurance option outside of Kaiser. Kaiser's Added Choice Deductible Coinsurance Plan (DHMO) was added to our insurance options for employees for 2016 which allows employees to go in and out of the Kaiser network as they choose.

The DHMO plan provides three options or Tiers and represents how employees can receive care including which doctors they see, where they have lab work done, and even where they fill prescriptions. Tier I is the Kaiser Permanente Network, Tier 2 is the Preferred Provider (PPO) Network, and Tier 3 is Out-of-Network. An employee can mix and match the three Tiers as they see fit so they are never locked into any one Tier all the time. An employee could see a doctor in Tier 2 (PPO network) for routine care, have lab work done and x-rays at a Tier 1 (Kaiser) facility, and fill a prescription at a Tier 3 pharmacy. The new DHMO provides employees with a significant amount of flexibility and an option to go outside the Kaiser network as requested.

A summary of all three plan designs or Evidence of Coverage (EOC) documents are attached for further information.

FISCAL IMPACT:
The estimated cost of the contract for 2016 will decrease by approximately $22,000 as compared to the 2015 estimated contract cost. Due to hiring, turnover rates, and employee plan choices during open enrollment, the actual cost will vary throughout the year. This cost has been budgeted for in the 2016 budget.

RECOMMENDATION: Staff recommends approval of the contract with Kaiser Permanente Health Insurance for 2016.

ATTACHMENT(S):

1. 2016 05920-001 HMO EOC City of Louisville
2. 2016 05920-002 HDHP EOC City of Louisville
3. 2016 05920-008 DHMO tier 1 EOC City of Louisville

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2016 contract year.

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

Benefits for CITY OF LOUISVILLE

5920 - 001

This Schedule of Benefits discusses:

I. **DEDUCTIBLES (if applicable)**

II. **ANNUAL OUT-OF-POCKET MAXIMUMS**

III. **COPAYMENTS AND COINSURANCE**

IV. **DEPENDENT LIMITING AGE**

V. **DEPENDENT STUDENT LIMITING AGE**

IMPORTANT INFORMATION PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC. Here is some ***important information*** to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. A Plan Physician ***must*** determine that the Service is ***Medically Necessary*** to prevent, diagnose or treat your medical condition. A Service is Medically Necessary ***only*** if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health; ***and***
   b. The Service ***must be*** provided, prescribed, authorized or directed by a Plan Physician; ***and***
   c. The Service ***must be*** a ***covered*** Service described in this EOC.
2. The Charges for your Services are ***not*** always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
6. You may be charged separate Deductibles, Copayments or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
7. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
8. For items ordered in advance, you pay the Deductibles, Copayments or Coinsurance in effect on the order date.
9. You, as the Subscriber, are responsible for any Deductibles, Copayments and/or Coinsurance, incurred by your Dependents enrolled in the Plan.
10. Dollar, day and visit limits, Deductibles and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

I. DEDUCTIBLES

There is no medical Deductible. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

A. For prescription drugs that **ARE** subject to the pharmacy Deductible:

1. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
2. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies and Supplements").
3. Your applicable Copayment, Coinsurance, and pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The following Out-of-Pocket Maximum (OPM) amounts apply under your plan:

This plan has an:

EMBEDDED OPM

$2,000/Individual per Accumulation Period

$4,500/Family per Accumulation Period

(see "C. Definitions of Aggregate and Embedded Individual and Family OPM")

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts over usual, reasonable and customary charges will not apply toward the OPM.

A. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

B. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

C. Definitions of Aggregate and Embedded Individual and Family OPM

1. **Aggregate OPM**:

   a. For plans with self only coverage (e.g., no dependents covered on the plan):

      i. The individual OPM amount applies.

      ii. After the individual OPM is met, the Member will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.

   b. For plans with two or more Members:

      i. There is no individual OPM.

      ii. The family OPM amount applies to the entire family as a whole (e.g. it is a cumulative family OPM, which the entire family must collectively meet).

      iii. After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for covered Services that apply to the OPM for the rest of the Accumulation Period.

2. **Embedded OPM:**

   a. Each individual family Member has his or her own OPM.

   b. If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.

   c. The entire family as a whole has a cumulative family OPM. After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.

Tracking Pharmacy Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will send you an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your pharmacy Deductible and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services**.

III. COPAYMENTS AND COINSURANCE

Out-of-Pocket Maximum	
	This plan has an: EMBEDDED OPM $2,000/Individual per Accumulation Period $4,500/Family per Accumulation Period

Outpatient Care	You Pay
Primary care visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Specialty care visits *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Consultations with clinical pharmacists *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Allergy injections *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit Copayment may apply for allergy serum
Allergy evaluation and testing *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Gynecology care visits *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Routine prenatal and postpartum visits *(Applies to Out-of-Pocket Maximum)*	No Charge
Outpatient surgery at designated outpatient facilities *(Applies to Out-of-Pocket Maximum)*	$200 Copayment each surgery

Hospital Inpatient Care	You Pay
(See III. "Benefits/Coverage (What Is Covered)", B. "Hospital Inpatient Care", in this EOC for the list of covered Services) *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per admission
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Ambulance Services	You Pay
(Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	You Pay
(Does not apply to Out-of-Pocket Maximum)	30% Coinsurance Includes inpatient and outpatient covered Services

Chemical Dependency Services	You Pay
Inpatient medical detoxification *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per admission
Inpatient professional Services for medical detoxification *(See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for Out-of-Pocket Maximum information)*	See above line under "Chemical Dependency Services" "Inpatient medical detoxification" for applicable Copayment or Coinsurance
Outpatient individual therapy *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit $30 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment
Residential rehabilitation *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per inpatient admission

Complementary and Alternative Medicine	You Pay
Spinal manipulation Services *(Does not apply to Out-of-Pocket Maximum)*	$30 Copayment each visit Up to 20 visits per Accumulation Period See Additional Provisions
Acupuncture Services *(Does not apply to Out-of-Pocket Maximum)*	$30 Copayment each visit Up to 20 visits per Accumulation Period See Additional Provisions

Dialysis Care	You Pay
(Applies to Out-of-Pocket Maximum)	$50 Copayment each visit

Drugs, Supplies and Supplements	You Pay
Office administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Travel immunizations	Not Covered
Outpatient prescription drugs Copayment/Coinsurance (except as listed below): *(Prescriptions are subject to the pharmacy Deductible except as otherwise listed in this "Drugs, Supplies and Supplements" section. Prescriptions: Do apply to Out-of-Pocket Maximum)*	$15 Generic/$40 Brand name Tobacco cessation and contraceptive drugs at No Charge
• Pharmacy Deductible *(Do apply to Out-of-Pocket Maximum*	Not Applicable
• Infertility drugs	Not Covered
• Over the counter items (OTC): *(Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to pharmacy Deductible)*	No charge
• Prescribed supplies *(Not subject to pharmacy Deductible)*	20% Coinsurance
• Sexual dysfunction drugs	Not Covered
• Specialty drugs	20% Coinsurance up to $250 per drug dispensed Insulin @ applicable Copayment/Coinsurance
	Supply Limit
Day supply limit	30 days
Mail-order supply limit	90 days @ 2 Copayments See Additional Provisions

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Annual maximum benefit paid by Health Plan	**Annual Maximum Benefit** Not Applicable
Durable medical equipment *(Applies to Out-of-Pocket Maximum)*	**You Pay** 20% Coinsurance
• Breast pumps *(**If covered**, must be obtained within 6 months (180 days) following delivery)* *(Applies to Out-of-Pocket Maximum)*	No Charge
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Hospital Inpatient Care" and "Outpatient Care" for Out-of-Pocket Maximum information)*	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment(s) and/or Coinsurance
• Prosthetic arm or leg *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
Oxygen *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Emergency Services and Non-Emergency, Non-Routine Care	You Pay
Plan and non-plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Applies to Out-of-Pocket Maximum)*	$250 Copayment each visit Excludes X-ray special procedures Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded above, see "X-ray, Laboratory and Special Procedures" for applicable Copayment or Coinsurance.
Non-emergency, non-routine visits at Plan Facilities **after** regular office hours *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit

Family Planning Services	You Pay
Family planning counseling *(See "Outpatient Care" for Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance
Associated outpatient surgery procedures *(See "Outpatient Care" for Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance

Health Education Services	You Pay
Training in self-care and preventive care *(See "Outpatient Care" for Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing aids for persons under the age of 18 *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Hearing aids for persons age 18 and over *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

HMO Plus	You Pay
Preventive care visits with a non-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Primary care and allergy injection visits, outpatient mental health and chemical dependency individual therapy and short-term outpatient physical, occupational and speech therapy visits with a non-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Specialty and gynecology care visits and allergy testing and evaluations with a non-Plan Provider *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
Covered Services received during an office visit with a non-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services and X-ray special procedures *(Does not apply to Out-of-Pocket Maximum)*	Not Covered
	Maximum Visit Limit
Maximum visit limit per Accumulation Period	Not Applicable

Home Health Care	You Pay
Health Services provided in your home and prescribed by a Plan Physician *(Applies to Out-of-Pocket Maximum)*	No Charge
Special Services program For hospice-eligible Members who have not yet elected hospice care *(Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Hospice care for terminally ill patients *(Applies to Out-of-Pocket Maximum)*	No Charge

Infertility Services	You Pay
All covered Services related to the diagnosis and treatment of infertility *(Does not apply to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Artificial insemination, including associated X-ray and laboratory Services *(Does not apply to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Applies to Out-of-Pocket Maximum)*	$500 Copayment per admission
• Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization *(See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for Out-of-Pocket Maximum information)*	See above line under "Mental Health Services" "Inpatient psychiatric hospitalization" for applicable Copayment or Coinsurance
Outpatient individual therapy *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit $30 Copayment per partial hospitalization day
Outpatient group therapy *(Applies to Out-of-Pocket Maximum)*	50% of individual therapy Copayment

Out-Of-Area Student	You Pay
• Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, prevention visit and a visit with the administration of allergy injections. Does not include: allergy evaluation, routine prenatal and postpartum visits, spinal manipulations, acupuncture services, hearing exams, home health visits, hospice services, physical, occupational, and speech therapy, and applied behavioral analysis (ABA).)* *Visit: (Applies to Out-of-Pocket Maximum)* *Other Services: (Do not apply to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period
• Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
• Outpatient prescription drugs *(Not subject to pharmacy Deductible; Prescriptions: Do apply to Out-of-Pocket Maximum)*	See "Drugs, Supplies and Supplements" for applicable Copayment or Coinsurance Limited to 5 prescription drug fills per Accumulation Period

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Applies to Out-of-Pocket Maximum)*	No Charge Up to 60 days per condition per Accumulation Period
Inpatient professional physical, occupational and speech therapy Services *(See "Hospital Inpatient Care" for Out-of-Pocket Maximum information)*	See “Hospital Inpatient Care” for applicable Copayment or Coinsurance
Short-term outpatient physical, occupational and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit Up to 20 visits per therapy per Accumulation Period
Pulmonary rehabilitation *(Applies to Out-of-Pocket Maximum)*	$5 Copayment each visit
Therapies for the treatment of Autism Spectrum Disorders	
• Outpatient physical, occupational and speech therapy visits *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
• Applied Behavioral Analysis (ABA) *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
• Annual benefit maximum for children ages 0 through 8	Minimum of 550 visits/year *
• Annual benefit maximum for children ages 9 up to 19	Minimum of 185 visits/year *
*Per Colorado law, we will provide the equivalent of what was required prior to May 13, 2013: total visits equivalent to a benefit of $34,000 annually in ABA therapy benefits for children from birth through age 8, and $12,000 annually in ABA therapy benefits for children age 9 to 19.	

Preventive Care Services	You Pay
• Preventive care visits *(Applies to Out-of-Pocket Maximum)* • Adult preventive care exams • Well-woman care exams • Immunizations	No Charge
• Colorectal cancer screenings *(Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge Additional charges may apply for pathology Services. For example lab Services performed on a removed polyp (see Diagnostic Laboratory Services under "X-ray, Laboratory and Special Procedures" section for applicable Copayment or Coinsurance)
• Adult preventive care screenings *(Applies to Out-of-Pocket Maximum)*	No Charge
• Well-woman care screenings *(Applies to Out-of-Pocket Maximum)*	No Charge
• Well-child care *(Applies to Out-of-Pocket Maximum)*	No Charge for children through age 17

Reconstructive Surgery	You Pay
(See "Hospital Inpatient Care" and "Outpatient Care" for Out-of-Pocket Maximum information)	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment or Coinsurance

Skilled Nursing Facility Care	You Pay
(Applies to Out-of-Pocket Maximum)	No Charge Up to 100 days per Accumulation Period

Transplant Services	You Pay
(See "Hospital Inpatient Care" and "Outpatient Care" for Out-of-Pocket Maximum information)	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	You Pay
Eye refraction test when performed by an Optometrist *(Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Eye refraction test when performed by an Ophthalmologist *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Optical hardware *(Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory and Special Procedures	You Pay
Diagnostic laboratory Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services *(Applies to Out-of-Pocket Maximum)*	No Charge
Therapeutic X-ray Services *(Applies to Out-of-Pocket Maximum)*	$50 Copayment
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Applies to Out-of-Pocket Maximum)*	$100 Copayment per procedure Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of this EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the “Eligibility” section in the EOC.

V. DEPENDENT STUDENT LIMITING AGE

The Dependent student limiting age as described under Dependents in the "Eligibility" section is the end of the month in which age 26 is reached.

Additional Provisions

Please see “Additional Provisions” for any supplmental information that applies to your coverage.

CONTACT US

Advice Nurses

CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members**:** **970-207-7171** or call toll-free **1-800-218-1059** ***Mountain Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

After-Hours Medical Needs

CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059** ***Mountain Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Appeals Program

CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Binding Arbitration

CALL	**Quality, Risk, and Patient Safety 303-344-7298**

Claims Department

CALL	***Denver/Boulder*** Members: **303-338-3600** or toll-free **1-800-382-4661** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-382-4661** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE	***Denver/Boulder*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Southern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 372910** **Denver, CO 80237-6910** ***Northern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Mountain Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Member Services

CALL	***Denver/Boulder*** Members: **303-338-3800** or toll-free **1-800-632-9700** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-632-9700** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**www.kp.org**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Patient Financial Services

CALL	***Denver/Boulder*** Members: **303-743-5900** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-632-9700** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Personal Physician Selection Services	
CALL	***Denver/Boulder*** Members: **303-338-4477** ***Southern Colorado*** Members: **1-855-208-7221** ***Northern Colorado*** Members**: 1-855-208-7221** ***Mountain Colorado*** Members: **1-855-208-7221**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**www.kp.org/chooseyourdoctor**

Transplant Administrative Offices	
CALL	**303-636-3226**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS (WHO PAYS WHAT)
TITLE PAGE (COVER PAGE)
CONTACT US
TABLE OF CONTENTS
I. ELIGIBILITY 1
A. Who Is Eligible 1
1. General 1
2. Subscribers 1
3. Dependents 1
B. Enrollment and Effective Date of Coverage 1
1. New Employees and their Dependents 1
2. Members Who are Inpatient on Effective Date of Coverage 1
3. Special Enrollment Due to Newly Acquired Dependents 1
4. Special Enrollment 2
5. Open Enrollment 3
6. Persons Barred From Enrolling 3
II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS 3
A. Your Primary Care Plan Physician 3
1. Choosing Your Primary Care Plan Physician 3
2. Changing Your Primary Care Plan Physician 3
B. Getting a Referral 4
1. Referrals 4
2. Specialty Self-Referrals 4
3. Second Opinions 5
C. Plan Facilities 5
1. Denver/Boulder Service Area 5
2. Southern, Northern and Mountain Colorado Service Areas 5
D. Getting the Care You Need 5
E. Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas 5
F. Out-of-Area Student Benefit 6
G. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area 6
H. Using Your Health Plan Identification Card 6
I. Cross Market Access 7
III. BENEFITS/COVERAGE (WHAT IS COVERED) 7
A. Outpatient Care 7
B. Hospital Inpatient Care 8
1. Inpatient Services in a Plan Hospital 8
2. Hospital Inpatient Care Exclusions: 8
C. Ambulance Services 8
1. Coverage 8
2. Ambulance Services Exclusion 8
D. Chemical Dependency Services 8
1. Inpatient Medical and Hospital Services 8
2. Residential Rehabilitation 8
3. Outpatient Services 9
4. Chemical Dependency Services Exclusion: 9
E. Clinical Trials (applies to non-grandfathered health plans only) 9
F. Dialysis Care 9
G. Drugs, Supplies and Supplements 10
1. Coverage 10
2. Limitations: 11
3. Drugs, Supplies and Supplements Exclusions: 11

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics 11
1. Durable Medical Equipment (DME) 11
2. Prosthetic Devices 12
3. Orthotic Devices 12

I. Early Childhood Intervention Services 12
1. Coverage 12
2. Limitations 12
3. Early Childhood Intervention Services Exclusions: 12

J. Emergency Services and Non-Emergency, Non-Routine Care 13
1. Emergency Services 13
2. Non-Emergency, Non-Routine Care 13
3. Payment 14

K. Family Planning Services 14

L. Health Education Services 15

M. Hearing Services 15
1. Persons Under the Age of 18 Years 15
2. Persons Age 18 Years and Older 15

N. Home Health Care 15
1. Coverage 15
2. Home Health Care Exclusions: 15
3. Special Services Program 15

O. Hospice Care 15

P. Infertility Services 16

Q. Mental Health Services 16
1. Coverage 16
2. Mental Health Services Exclusions: 16

R. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services 16
1. Coverage 16
2. Limitations: 17
3. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions: 17

S. Preventive Care Services 17

T. Reconstructive Surgery 18
1. Coverage 18
2. Reconstructive Surgery Exclusions: 18

U. Skilled Nursing Facility Care 18
1. Coverage 18
2. Skilled Nursing Facility Care Exclusion: 18

V. Transplant Services 18
1. Coverage 18
2. Related Prescription Drugs 18
3. Terms and Conditions 18
4. Transplant Services Exclusions and Limitations: 19

W. Vision Services 19
1. Coverage 19
2. Vision Services Exclusions: 19

X. X-ray, Laboratory and X-ray Special Procedures 19
1. Coverage 19
2. X-ray, Laboratory and X-ray Special Procedures Exclusions: 19

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED) 20

A. Exclusions 20

B. Limitations 22

C. Reductions 22
1. Coordination of Benefits (COB) 22
2. Injuries or Illnesses Alleged to be Caused by Other Parties 25
3. Surrogacy 26

V. MEMBER PAYMENT RESPONSIBILITY **26**
VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM) **26**
VII. GENERAL POLICY PROVISIONS **26**
A. Access Plan 26
B. Access to Services for Foreign Language Speakers 26
C. Administration of Agreement 26
D. Advance Directives 26
E. Agreement Binding on Members 27
F. Amendment of Agreement 27
G. Applications and Statements 27
H. Assignment 27
I. Attorney Fees and Expenses 27
J. Binding Arbitration 27
K. Claims Review Authority 27
L. Contracts with Plan Providers 27
M. Governing Law 28
N. Group and Members not Health Plan's Agents 28
O. No Waiver 28
P. Nondiscrimination 28
Q. Notices 28
R. Out-of-Pocket Maximum Takeover Credit 28
S. Overpayment Recovery 28
T. Privacy Practices 28
U. Value-Added Services 29
V. Women's Health and Cancer Rights Act 29
VIII. TERMINATION/NONRENEWAL/CONTINUATION **29**
A. Termination Due to Loss of Eligibility 29
B. Termination of Group Agreement 29
C. Termination for Cause 30
D. Termination for Nonpayment 30
E. Termination of a Product or all Products (applies to non-grandfathered health plans only) 30
F. Rescission of Membership 30
G. Continuation of Group Coverage Under Federal Law, State Law or USERRA 30
1. Federal Law (COBRA) 30
2. State Law 30
3. USERRA 31
H. Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area 31
IX. APPEALS AND COMPLAINTS **31**
X. INFORMATION ON POLICY AND RATE CHANGES **38**
XI. DEFINITIONS **38**
ADDITIONAL PROVISIONS

I. ELIGIBILITY

A. Who Is Eligible

1. General
   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. On the first day of membership, the Subscriber must live in our Service Area. Our Service Area is described in the "Definitions" section. You cannot live in another Kaiser Foundation Health Plan or allied plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia and Washington. For more information, please call **Member Services**.

2. Subscribers
   You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents
   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

   a. Your Spouse. (Spouse includes a partner in a valid civil union under State law.)
   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."
   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).
   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.
   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

   Students on Medical Leave of Absence. Dependent children over the dependent limiting age but under the dependent student limiting age as specified in the "Schedule of Benefits (Who Pays What)" who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

   If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents
   If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage
   If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

a. For newborn children, the moment of birth. A newborn child is covered for the first 31 days.
For existing Subscribers:
   i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
   ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:
   i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
   ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment" below.

4. Special Enrollment
If you have certain life events ("qualifying events"), you can enroll in or change your health insurance plan outside of the open enrollment period. You may apply for enrollment as a Subscriber, and existing Subscribers may apply to enroll eligible Dependents, by submitting an enrollment form to Health Plan within 30 days after one of the following events happens to one of the people applying:

a. You involuntarily lose existing minimum essential or creditable coverage due to the death of a covered employee; termination of employment or reduction in number of hours of the employment; covered employee becoming eligible for Medicare; divorce or legal separation from the covered employee's spouse or partner in a civil union; your Dependent child has a birthday and no longer qualifies as a Dependent on his/her parent's plan; your retiree coverage is terminated or substantially eliminated when your employer declares bankruptcy; termination of eligibility for coverage; involuntary termination of coverage; reduction or elimination of the employer's contributions toward coverage.

b. You gain a Dependent or become a Dependent through marriage; civil union; birth, adoption or placement for adoption; by entering into a designated beneficiary agreement pursuant to the Colorado Designated Beneficiary Agreement Act, if your carrier offers coverage for designated beneficiaries; or pursuant to a court or administrative order mandating coverage.

c. A parent or legal guardian dis-enrolls a Dependent from, or a Dependent becomes ineligible for the Children's Basic Health Plan, and the parent or legal guardian requests enrollment of the Dependent in a health plan within 60 days of the disenrollment or determination of ineligibility.

d. You lose coverage under the Colorado Medical Assistance Act and then request coverage under an employer's group health plan within 60 days of the loss of coverage.

e. You or a Dependent become eligible for premium assistance under the Colorado Medical Assistance Act or the Children's Basic Health Plan for which you will have a 60 day special enrollment period.

Additionally, if you are aware of a future qualifying event, you may apply for new coverage up to 30 days in advance of that event.

If Health Plan accepts your enrollment form, your membership effective date will be one of the following:

a. For birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption.

b. For other qualifying events, the first day of the following month after Health Plan receives a completed enrollment form.

5. Open Enrollment
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred From Enrolling
You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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

- "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)," in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.
- "Getting a Referral," in this section.
- "Cross Market Access" in this section.

Your home Service Area is printed on your Health Plan Identification (ID) card. For more information about your ID card, please refer to the "Using Your Health Plan Identification Card" section, below.

A. Your Primary Care Plan Physician

Your primary care Plan Physician (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Plan Physician
You may select a PCP from family medicine, pediatrics, or internal medicine within your home service area. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the "Second Opinions" section, below.

a. ***Denver/Boulder*** Service Area
You may choose your PCP from our provider directory. To review a list of Plan Physicians and their biographies, visit our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations." You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a Plan Physician, accepting new patients, based on your health care needs.

b. ***Southern, Northern and Mountain Colorado*** Service Areas
You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

Medical Group contracts with a panel of Affiliated Physicians, specialists, and other health care professionals to provide medical Services in the ***Southern, Northern and Mountain Colorado*** Service Areas. You may choose your PCP from our panel of ***Southern, Northern and Mountain Colorado*** Plan Physicians.

You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can review a list of ***Southern, Northern and Mountain Colorado*** Plan Physicians by visiting our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations." You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a Plan Physician, accepting new patients, based on your health care needs.

If you are seeking routine or specialty care in any ***Denver/Boulder*** Plan Hospital, you must have a referral from your local PCP. If you do not get a referral, you will be billed for the full amount of the office visit Charges. If you are visiting in the ***Denver/Boulder*** Service Area and need after-hours or emergency care, you can visit a ***Denver/Boulder*** Plan Facility without a referral. For care in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below.

2. Changing Your Primary Care Plan Physician
a. ***Denver/Boulder*** Service Area

Please call **Personal Physician Selection Services** to change your PCP. You may also change your physician when visiting a Plan Facility. You may change your PCP at any time.

b. ***Southern, Northern and Mountain Colorado*** Service Areas
Please call **Personal Physician Selection Services** to change your PCP. Notify us of your new PCP choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

B. Getting a Referral

1. Referrals

a. ***Denver/Boulder*** Service Area
Medical Group physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your Medical Group physician decides that you need covered Services not available from us, he or she will refer you to a non-Medical Group physician inside or outside our Service Area. You must have a written referral to the non-Medical Group physician in order for us to cover the Services.

A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a non-Medical Group physician. A written or verbal recommendation by a Medical Group physician or an Affiliated Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered.

For Services in Kaiser Permanente Plan Medical Offices in the ***Southern, Northern and Mountain Colorado*** Service Areas, please see "Cross Market Access," below. In order to receive Services from a Plan Facility, you must have a written referral. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Medical Group physician.

A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved in advance according to Medical Group procedures. We will not pay for any care rendered or recommended by a non-Medical Group physician beyond the limits of the original referral unless the care is: (i) specifically authorized by your Medical Group physician; and (ii) approved in advance in accord with Medical Group procedures.

b. ***Southern, Northern and Mountain Colorado*** Service Areas
Plan Physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery and dermatology. If your Plan Physician decides that you need covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have a written referral to the non-Plan Provider in order for us to cover the Services.

A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a designated non-Plan Provider. A written or verbal recommendation by a Plan Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Plan Provider.

Health Plan authorization is required for Services provided by: (i) non-Plan Providers or non-Plan Facilities; (ii) Services provided by any provider outside the ***Southern, Northern and Mountain Colorado*** Service Areas; and (iii) Services performed in any facility other than the physician's office. For Services in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below. A referral for these Services will be submitted to Health Plan by the Plan Physician. Health Plan will make a determination regarding authorization for coverage.

The provider to whom you are referred will receive a notice of Health Plan's authorization by fax. You will receive a written notice of Health Plan's 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.

2. Specialty Self-Referrals

a. ***Denver/Boulder*** Service Area
You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will still be required to get a written referral for laboratory or radiology Services and for specialty procedures such as a CT scan, MRI, or surgery. A written referral is also required for specialty-care visits to non-Medical Group physicians.

b. ***Southern, Northern and Mountain Colorado*** Service Areas
You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will find the specialty-care providers eligible to receive direct referrals in the Kaiser Permanente Provider Directory

for your specific home Service Area. It is available on our website, *www.kp.org*, by clicking on "Locate our services" then "Find doctors & locations." You can get help choosing a specialty-care provider by calling **Personal Physician Selection Services**.

A self-referral provides coverage for routine visits only. Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to Plan Physician specialty-care providers not eligible to receive direct referrals; and (iii) non-Plan Physicians. ***Southern, Northern and Mountain Colorado*** Members may be able to self-refer to Kaiser Permanente Plan Medical Offices in the ***Denver/Boulder*** Service Area (see "Cross Market Access," below). Services other than routine office visits with a Plan Physician specialty-care provider eligible to receive self-referrals will not be covered unless authorized by Kaiser Permanente before Services are rendered.

The request for these Services can be generated by either your PCP or by a specialty-care provider. The physician or facility to whom you are referred will receive a notice of the authorization. You will receive a written notice of 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 that the authorization is valid and the Services authorized.

3. Second Opinions
   Upon request and subject to payment of any applicable Copayments or Coinsurance, you may get a second opinion from a Plan Physician about any proposed covered Services.

C. Plan Facilities

Plan Facilities are Plan Medical Offices or Plan Hospitals in our Service Area that we contract with to provide covered Services to our Members.

1. ***Denver/Boulder*** Service Area
   We offer health care at Plan Medical Offices conveniently located throughout the ***Denver/Boulder*** Service Area. At most of our Plan Facilities, you can usually receive all the covered Services you need. This includes specialized care. You are not restricted to a certain Plan Facility. We encourage you to use the Plan Facility in your home service area that will be most convenient for you.

   Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations."

2. ***Southern, Northern and Mountain Colorado*** Service Areas
   When you select your PCP, you will receive your Services at that physician's office. You can find ***Southern, Northern and Mountain Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list from our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations."

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a life or limb threatening emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen, are covered at Plan Facilities during regular office hours. Your office visit Charge, as defined in the "Schedule of Benefits (Who Pays What)", will apply. If you need non-emergency, non-routine care after hours, you may use one of the designated after-hours Plan Facilities. The Charge for non-emergency, non-routine care received in Plan Facilities after regular office hours listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about non-emergency, non-routine care, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.

Non-emergency, non-routine care received at a non-Plan Facility inside our Service Areas is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside our Service Areas, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized non-emergency, non-routine care outside our Service Areas. Please see "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about out-of-Plan non-emergency, non-routine care Services.

E. Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily, you can get visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting

member care and your out-of-pocket costs may differ from the covered Services, Copayments and Coinsurance described in this EOC.

Please call **Member Services** to get more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may get visiting member care may change at any time.

You receive the same prescription drug benefit as your home service area benefit. This includes your Copayments or Coinsurance, exclusions and limitations.

F. Out-of-Area Student Benefit

A limited benefit is available to students attending school outside any Kaiser Foundation Health Plan service area.

The Out-of-Area Student Benefit coverage is limited to certain office visits, diagnostic X-rays, and prescription drug as covered under this EOC:

1. Office visit exam charge limited to:
   a. Primary care visit.
   b. Specialty care visit.
   c. Preventive care visit.
   d. Gynecology care visit.
   e. Mental health visit.
   f. Chemical dependency visit.
   g. Visits with the administration of allergy injections.
2. Diagnostic X-rays.
3. Prescription drug fills.

To qualify for the out-of-area student benefit, the student must provide verification of their student status. Students are covered up to the age of 26. For more information, please call **Member Services**.

See the "Schedule of Benefits (Who Pays What)" for more details.

Exclusions and Limitations:

This does not include, and is not limited to, the following Services:

1. Other Services provided during a covered office visit such as, but **not limited** to: lab, procedures, and office administered drugs and devices except for allergy injections.
2. Services received outside the United States.
3. Transplant Services.
4. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services, Non-Emergency, Non-Routine Care).
5. Allergy evaluation, routine prenatal and postpartum visits, spinal manipulations, acupuncture services, hearing exams, home health visits, hospice services, physical, occupational and speech therapy and applied behavioral analysis (ABA).

To qualify for the out-of-area student benefit, the student must provide verification of student status. For more information, please call **Member Services.**

Visiting member care will continue to apply to students attending school in other Kaiser Foundation Health Plan or allied plan service areas.

G. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to an area not within any Kaiser Foundation Health Plan or allied plan service area, you can keep your membership with Health Plan, if you continue to meet all other eligibility requirements. However, you must go to a Plan Facility in a Kaiser Foundation Health Plan or allied plan service area in order to receive covered Services (except out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care). If you go to another Kaiser Foundation Health Plan or allied plan service area for care, covered Services, Copayments or Coinsurance will be as described under "Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas" above.

H. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, claims for Emergency or non-emergency care Services from non-Plan Providers will be denied. If you let someone else use your Health Plan ID

card, we may keep your card and terminate your membership upon 30 days written notice that will include the reason for termination.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

I. Cross Market Access

Members may access certain Services at Kaiser Permanente Plan Medical Offices outside of their home Service Area.

1. ***Denver/Boulder*** Members:
   Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the ***Southern, Northern and Mountain Colorado*** Service Areas. ***Denver/Boulder*** Members do not have access to Affiliated Providers in ***Southern*** or ***Northern Colorado*** unless authorized by Health Plan.

2. ***Southern, Northern and Mountain Colorado*** Members:
   Southern, Northern and Mountain Colorado Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the ***Denver/Boulder*** Service Area.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; after-hours care; pharmacy; laboratory; X-ray; vision; and hearing Services. These Services may not be available at all Kaiser Permanente Plan Medical Offices and are subject to change. For more information on what Services you may access outside your designated home Service Area and at which designated Kaiser Permanente Plan Medical Offices, if applicable, you may receive Services at, please call **Member Services**.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- A Plan Physician determines that the Services are Medically Necessary to prevent, diagnose or treat your medical condition. A Service is Medically Necessary only if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health; and
- The Services are provided, prescribed, authorized or directed by a Plan Physician. This does not apply where specifically noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)"; and (b) "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care"; and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Getting a Referral" and "Specialty Self-Referrals"; and (b) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care").

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)."

A. Outpatient Care

Outpatient Care for Preventive Care, Diagnosis and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following outpatient care for preventive care, diagnosis and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists (***Denver/Boulder*** Members only).
5. Outpatient surgery.
6. Blood, blood products and their administration.
7. Second opinion.
8. House calls when care can best be provided in your home as determined by a Plan Physician.

9. Medical social Services.
10. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
11. Telemedicine visits (not including telephone conversations and electronic mail messages) are considered office visits and the applicable office visit copayment, coinsurance and/or deductible applies.

NOTE: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

B. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital
   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Areas:
   a. Room and board, such as semiprivate accommodations or, when a Plan Physician determines it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for child birth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn after your discharge are subject to all Health Plan provisions. This includes his/her own Copayments and/or Deductibles requirements.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   NOTE: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions***:***
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by State law.
   b. Cosmetic surgery related to bariatric surgery.

C. Ambulance Services

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide.

2. Ambulance Services Exclusion: Transportation by other than a licensed ambulance. This includes transportation by car, taxi, bus, gurney van, minivan and any other type of transportation, even if it is the only way to travel to a Plan Provider.

D. Chemical Dependency Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Physician.

We cover inpatient services and partial hospitalization in a residential rehabilitation program approved by Kaiser Permanente for the treatment of alcoholism, drug abuse or drug addiction.

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

   We cover chemical dependency services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary as determined by a Plan Physician and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

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

4. Chemical Dependency Services Exclusion**:**
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

E. Clinical Trials (applies to non-grandfathered health plans only)

We cover Services you receive in connection with a clinical trial if all of the following conditions are met:

1. We would have covered the Services if they were not related to a clinical trial.
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination.
   b. You provide us with medical and scientific information establishing this determination.
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
4. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   c. The study or investigation is approved or funded by at least one of the following:
      i. The National Institutes of Health.
      ii. The Centers for Disease Control and Prevention.
      iii. The Agency for Health Care Research and Quality.
      iv. The Centers for Medicare & Medicaid Services.
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
      vii. 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 U.S. Secretary of Health and Human Services determines meets all of the following requirements:
         1. It is comparable to the National Institutes of Health system of peer review of studies and investigations.
         2. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, you will pay the applicable cost share shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the cost share that applies to hospital inpatient care.

Clinical trials exclusions:

1. The investigational Service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet all medical criteria developed by Medical Group and by the facility providing the dialysis; and
3. The facility is certified by Medicare and contracts with Medical Group; and
4. A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover at no Charge: equipment; training; and medical supplies required for home dialysis.

G. Drugs, Supplies and Supplements

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

1. Coverage

   a. Limited Drug Coverage Under Your Basic Drug Benefit

   If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These base drugs are available only when prescribed by a Plan Physician and obtained at Plan Pharmacies, or in the ***Southern, Northern and Mountain Colorado*** Service Areas, at pharmacies designated by Health Plan. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

   If your coverage includes supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance applies for these types of drugs. For more information, please refer to the prescription drug benefit description in "Additional Provisions."

   Note: Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your group has limited or supplemental prescription drug coverage.

   b. Outpatient Prescription Drugs

   Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." If your prescription drug Copayment shown on the "Schedule of Benefits (Who Pays What)" exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

      i. Prescriptions by Mail

      If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. Refills of maintenance drugs prescribed by Plan Physicians or Affiliated Physicians may be obtained for up to the day supply by mail order, at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs have a significant potential for waste and diversion. Those drugs are not available by mail-order service. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

      ii. Specialty Drugs

      Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

   c. Administered Drugs

   We cover the following administered drugs as part of your Hospital Inpatient Care and Skilled Nursing Facility benefit. If the following are administered in a Plan Medical Office or during home visits if administration or observation by medical personnel is required, they are covered at the applicable office administered drug Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to your Outpatient Care Copayment or Coinsurance.

      Drugs and injectables; radioactive materials used for therapeutic purposes; vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and allergy test and treatment materials.

   d. Food Supplements

   Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism, elemental enteral nutrition and parenteral nutrition are provided under your hospital inpatient care benefit. Such

products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

e. Prescribed Supplies and Accessories
Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
   i. home glucose monitoring supplies;
   ii. disposable syringes for the administration of insulin;
   iii. glucose test strips;
   iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations:
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. ***Denver/Boulder, Northern and Mountain Colorado*** Service Areas: Compound medications are covered as long as they are on the compounding formulary.
   c. ***Southern Colorado*** Service Area: Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.

3. Drugs, Supplies and Supplements Exclusions:
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Individual drugs and/or drug classes determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. (***Denver/Boulder*** Members only).
   n. Prescription drugs necessary for Services excluded under this Evidence of Coverage.

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Physician as described below; when prescribed by a Plan Physician during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
   DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.

ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
iii. Infant apnea monitors are provided.

b. Durable Medical Equipment Exclusions:
i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
ii. Replacement of lost equipment.
iii. Repair, adjustments or replacements necessitated by misuse.
iv. More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
a. Coverage
We cover the following prosthetic devices, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan:
i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prostheses is no longer functional. Custom-made prostheses will be provided when necessary.
iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accord with this EOC. Including repairs and replacements, of such prosthetic devices.

Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

b. Prosthetic Devices Exclusions:
i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Physician can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

I. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law, are covered for the number of Early Intervention Services (EIS) visits as required by State law. EIS are not subject to any Copayments or Coinsurance; or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by State law is satisfied.

2. Limitations
The number of visits as required by State law does not apply to:
a. Rehabilitation or therapeutic Services that are necessary as a result of an acute medical condition; or
b. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal "Individuals with Disabilities Act"; or
c. Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended.

3. Early Childhood Intervention Services Exclusions:
a. Respite care;
b. Non-emergency medical transportation;
c. Service coordination, as defined by State or federal law; and
d. Assistive technology, not to include durable medical equipment that is otherwise covered under this Evidence of Coverage.

J. Emergency Services and Non-Emergency, Non-Routine Care

1. Emergency Services

Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition, call 911 or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and non-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them from Plan Providers.

You are also covered for medical emergencies anywhere in the world. For information about emergency benefits away from home, please call **Member Services**.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

a. Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)

"Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Physician. There may be times when you or a family member may receive Emergency Services from non-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Medical Offices or the emergency room of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

Please refer to "ii. Emergency Services Limitation for non-Plan Providers," below, if you are hospitalized for Emergency Services.

i. We cover out-of-Plan Emergency Services as follows:

A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis or premature delivery.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

ii. Emergency Services Limitation for non-Plan Providers

If you are admitted to a non-Plan Hospital, non-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** and/or **Quality Resource Coordinator**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible.

b. Emergency Services Exclusions:

Continuing or follow-up treatment. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a Plan Facility we designate either inside or outside our Service Area. When approved by Health Plan or by a Plan Physician in this Service Area or in another Kaiser Foundation Health Plan or allied plan service area, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

2. Non-Emergency, Non-Routine Care

a. Non-Emergency, Non-Routine Care Provided by Plan Providers

i. ***Denver/Boulder*** Service Area

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities **during** regular office hours. If you need non-emergency, non-routine care during office hours and you are a Member in the ***Denver/Boulder*** Service Area, you can visit one of our Plan Facilities.

Non-emergency, non-routine care needed **after hours** that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services**.

During regular office hours, please call **Advice Nurse** and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

After office hours, please call **After-Hours Medical Needs** for a recorded message about your options and/or to speak with the answering service who will redirect your call, 24 hours a day, 7 days a week.

ii. ***Southern, Northern and Mountain Colorado*** Service Areas

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities during regular office hours. If you are a ***Southern*** or ***Northern Colorado*** Member and need non-emergency, non-routine care during regular office hours, please call your Plan Physician's office.

Non-emergency, non-routine care needed **after hours** that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, *www.kp.org*, for information on designated after-hours facilities.

After office hours, please call your Plan Physician or go to the provider directory or to our website, *www.kp.org*, for information on our designated after-hours facilities. You may also call the nurse advice line at the telephone number listed in your provider directory or our website, *www.kp.org*.

b. Out-of-Plan Non-Emergency, Non-Routine Care

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

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

3. Payment

a. Health Plan's payment for covered out-of-Plan non-emergency, non-routine care Services is based upon fees that we determine to be usual, reasonable and customary. This means a fee that:

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

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

b. Our payment is reduced by:

i. the Copayment and/or Coinsurance for Emergency Services and X-ray Special Procedures performed in the emergency room. The emergency room and X-ray Special Procedures Copayment, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. Coordination of benefits; and
iv. any other payments you would have had to make if you received the same Services from our Plan Providers; and
v. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
vi. amounts you or your legal representative recovers from motor vehicle insurance or because of third party liability.

Note: The procedure for receiving reimbursement for out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care Services is described in the "Internal Claims and Appeals Procedure and External Review" section, below.

K. Family Planning Services

We cover the following:

1. Family planning counseling. This includes pre-abortion and post-abortion counseling and information on birth control.
2. Tubal ligations.
3. Vasectomies.
4. Voluntary termination of pregnancy.

This plan may exclude voluntary, elective abortions and any related Services. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory and X-ray Special Procedures"; contraceptive drugs and devices, see the "Drugs, Supplies and Supplements" section.

L. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

M. Hearing Services

1. Persons Under the Age of 18 Years

   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:

   a. Initial hearing aids and replacement hearing aids not more frequently than every 5 years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Persons Age 18 Years and Older

   a. Coverage

      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions:

      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

N. Home Health Care

1. Coverage

   We cover skilled nursing care, home health aide Services and medical social Services:

   a. only on a Part-Time Care or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Physician and administered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Physician and the approved Plan Provider; and
   d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Additional time up to 35 hours per week but less than eight (8) hours per day may be approved by Health Plan on a case-by-case basis.

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

2. Home Health Care Exclusions:

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

3. Special Services Program

   If you have been diagnosed with a terminal illness with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   This Program gives you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

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

O. Hospice Care

We cover hospice care for terminally ill Members inside our Service Area. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

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

We cover the following Services and other benefits when: (1) prescribed by a Plan Physician and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Kaiser Permanente:

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

P. Infertility Services

Infertility Services are **not** covered unless your Group has purchased additional supplemental coverage.

NOTE: To determine if your Group has the infertility benefit, see the "Schedule of Benefits (Who Pays What)."

Q. Mental Health Services

1. Coverage

We cover mental health Services as shown below. Coverage includes evaluation and Services for conditions which, in the judgment of a Plan Physician, would respond to therapeutic management. Mental health includes but is not limited to biologically based illnesses or disorders.

a. Outpatient Therapy

We cover: diagnostic evaluation; individual therapy; psychiatric treatment; and psychiatrically oriented child and teenage guidance counseling.

Visits for the purpose of monitoring drug therapy are covered.

Psychological testing as part of diagnostic evaluation is covered.

b. Inpatient Services

We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

c. Partial Hospitalization

We cover partial hospitalization in a Plan Hospital-based program.

We cover mental health services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary as determined by a Plan Physician and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions:

a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Plan Physician determines such evaluation to be Medically Necessary.

b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, including but not limited to attention deficit disorder.

c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary.

d. Court-ordered testing and testing for ability, aptitude, intelligence or interest.

e. Services which are custodial or residential in nature.

R. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage

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

We cover physical, occupational and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility and Home Health Care benefit.

b. Outpatient Care
We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility to improve or develop skills or functioning due to medical deficits, illness or injury. See the "Schedule of Benefits (Who Pays What)."

c. Multidisciplinary Rehabilitation Services
We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. We also cover multidisciplinary rehabilitation Services without Charge while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

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

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

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

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

f. Therapies for the Treatment of Autism Spectrum Disorders
For children under the age of 19, we cover the following therapies for the treatment of Autism Spectrum Disorders:
   i. Outpatient physical, occupational and speech therapy in a Plan Medical Office when prescribed by a Plan Physician as Medically Necessary. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers, up to the maximum benefit permitted by State law. See the "Schedule of Benefits (Who Pays What)."

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

3. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions:
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Copayment and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when a Plan Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

2. Reconstructive Surgery Exclusions:
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required. We cover the following Services:
   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

   Note: The following are covered, but not under this section: drugs, see “Drugs, Supplies and Supplements”; DME and prosthetics and orthotics, see “Durable Medical Equipment and Prosthetics and Orthotics”; X-ray, laboratory and X-ray special procedures, see “X-ray, Laboratory and X-ray Special Procedures”.

2. Skilled Nursing Facility Care Exclusion:
   Custodial Care, as defined in “Exclusions” under the “Limitations/Exclusions (What is Not Covered)”section.

V. Transplant Services

1. Coverage
   Transplants are covered on a **LIMITED** basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

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

   c. If all medical criteria developed by Medical Group are met, we cover: stem cell rescue; and transplants of organs, tissue or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance shown in the “Schedule of Benefits (Who Pays What).”

3. Terms and Conditions
   a. Health Plan, Medical Group and Plan Physicians do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accord with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Physician identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

   b. Plan Physicians must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Physician must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Physician or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations:
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Getting a Referral" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

W. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the Schedule of Benefits (Who Pays What). We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.

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

Your Group may have purchased additional optical coverage. See "Additional Provisions."

X. X-ray, Laboratory and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray and laboratory tests, Services and materials, which includes, but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms and ultrasounds.
      ii. Therapeutic X-ray Services and materials.
      iii. X-ray Special Procedures such as MRI, CT, PET and nuclear medicine. **Note:** Members will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. The Member is responsible for any applicable Copayment or Coinsurance for X-ray Special Procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, non-emergency, non-routine care, and outpatient surgery.
   b. Inpatient
      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET and nuclear medicine are covered without Charge.

2. X-ray, Laboratory and X-ray Special Procedures Exclusions:
   a. Testing of a Member for a non-Member's use and/or benefit.

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

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services See the "Schedule of Benefits (Who Pays What) to determine if you group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Spinal Manipulation Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Certain Exams and Services.** Physical examinations and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for:
   a. Employment;
   b. Participation in employee programs;
   c. Insurance;
   d. Disability;
   e. Licensing; or on court order or for parole or probation.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in major improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Custodial Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting and taking medicine.

5. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract; or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Physician for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma and, unless otherwise specified herein, (a) and (b) are received at a Plan Hospital, Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if a Plan Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.

6. **Directed Blood Donations.**

7. **Disposable Supplies.** Disposable supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;
   e. Dressings;
   f. Ace-type bandages; and
   g. Any other supplies, dressings, appliances or devices, not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

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

9. **Experimental or Investigational Services:**
   a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
      i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or

ii. Is the subject of a current new drug or new device application on file with the FDA; or
iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity or efficacy of the Service; or
iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; or
v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity or efficacy of Services; or
vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity or efficacy; or
viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity or efficacy of the Service.

b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
i. The Member's medical records; and
ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

10. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.

11. **Intermediate Care.** Care in an intermediate care facility.

12. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

13. **Services for Members in the Custody of Law Enforcement Officers.** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of- Plan Emergency Services or out-of-Plan non-emergency, non-routine care.

14. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

15. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

16. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accord with our internal travel and lodging guidelines in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services as described under "Getting a Referral" in the "How to Access Your Services and Obtain Approval of Benefits" section. Travel and lodging expenses are not covered for Members who are referred to a non-Plan Facility for non-transplant medical care. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

17. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

18. **Weight Management Facilities.** Services received in a weight management facility.

19. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been 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.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

a. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
    i. "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans 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.
    ii. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

    Each contract for coverage under i. or ii. is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

b. "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this 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.

c. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits, so that all plan benefits do not exceed 100% of the total Allowable expense.

d. "Allowable expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person 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 examples of expenses that are not allowable expenses:

i. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
ii. If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
iii. If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the secondary plan to determine its benefits.
v. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. "Claim determination period" is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

f. "Closed panel plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. "Custodial parent" means a parent awarded primary 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 two or more plans pay benefits, the rules for determining the order of payment are as follows:

a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

b. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

i. There is an exception: Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

d. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

i. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is

secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

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

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

1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
2. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.

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

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
2. 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;
3. 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
4. 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 child are as follows:
   - The plan covering the custodial parent;
   - The plan covering the spouse of the custodial parent;
   - The plan covering the non-custodial parent; and then
   - The plan covering the spouse of the non-custodial parent.

C. For a dependent child covered under more than one Plan of individuals who are not 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.

iii. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary 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 retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order of benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order of benefits.

v. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the Secondary plan.

vi. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the secondary 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 its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the

total benefits paid or provided by all Plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. 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-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

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 plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT
A payment made under another plan may include an amount that should have been paid under this plan. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have 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.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must reimburse us 100% of Charges for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage or (e) any other liability coverage.

If you are involved in an automobile-related accident, please contact **Patient Financial Services** right away so that we can coordinate benefits with the automobile insurance carrier and determine whether we or the automobile insurance carrier has primary coverage.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant Services.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against any other party, regardless of whether the other party admits fault. The proceeds of any judgment or settlement that you, your attorney or your representative get shall first be applied to fully satisfy our lien, even if the total amount of your recovery from all sources is less than the actual or estimated losses and damages you incurred, and without regard of how the proceeds are characterized or itemized. We deny any application of the Made Whole doctrine.

We will not be responsible for any fees you incur to obtain any judgment or settlement. Costs we incur will be borne by us. Costs of your representation will be borne by you. We deny any application of the Common Fund doctrine. Proceeds of such judgment or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against any other party, you must send written notice of the claim or legal action to **Patient Financial Services**. For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

If your estate, parent, guardian or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian or conservator and any settlement or judgment recovered by the estate, parent, guardian or

conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

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

Note: For recoveries on or after August 11, 2010, reimbursement for benefits will be governed by state law.

3. Surrogacy
   In situations where you receive monetary compensation to act as a surrogate, Health Plan will seek reimbursement of Charges for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, up to the monetary amount you receive to act as a surrogate. 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.

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and Non-Emergency, Non-Routine Care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from non–Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by non-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado State law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Physicians have telephone access to interpreters in over 150 languages.
3. Plan Physicians can also request an onsite interpreter for an appointment, procedure or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Binding Arbitration

Except for: (1) claims filed in Small Claims Court; (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) Benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan Providers or Affiliated Physicians ("Respondent(s)"), which arise from any alleged failure or violation of, including but not limited to any duty relating to or incident to the Evidence of Coverage or the Medical and Hospital Services Agreement, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

You must use Health Plan procedures to request arbitration. You can get a copy of these procedures from our **Quality, Risk, and Patient Safety** department**.** The arbitration hearing will be held in accord with Health Plan procedures, the Colorado Uniform Arbitration Act and the Federal Arbitration Act.

K. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

L. Contracts with Plan Providers

Your Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you

receive from that provider, in excess of any applicable Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

M. Governing Law

Except as preempted by federal law, this EOC will be governed in accord with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

N. Group and Members not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

O. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

P. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Q. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

R. Out-of-Pocket Maximum Takeover Credit

Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.)
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.)

A credit may be applied toward your Out-of-Pocket Maximum with Health Plan for certain eligible expenses accumulated toward your out-of-pocket maximum under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call **Claims Customer Service.**

S. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

T. Privacy Practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we may share your PHI with employers only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Member Services. You can also find the *Notice of Privacy Practices* on our website at *www.kp.org*.

U. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give the Member more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you only need to:

1. Show your Health Plan ID card; and
2. Pay the fee, if any; to the company that provides the value-added service.

Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as deductible or out-of-pocket maximum.

To learn about value-added services and which ones are available to you, please check our:

1. Quarterly member magazine*;* or
2. Website, *www.kp.org*.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Dues.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

V. Women's Health and Cancer Rights Act

In accord with the "Women's Health and Cancer Rights Act of 1998," and as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in Section I, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Dues, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts:

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Physician has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

A. Performed an act, practice, or omission that constitutes fraud; or
B. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Dues, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)
   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law
   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Dues to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the "Eligibility" section.

To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Dues, no later than 30 days after the date on which your Group coverage would otherwise terminate.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Dues to your Group and terminates on the earlier of:

a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
b. The date you become covered under another group medical plan; or
c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group, but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this Plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Dues, Copayments and Coinsurance may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of premiums (also called rescission or cancellation retroactively), or
   c. uphold our previous adverse benefit determination when you appeal.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, then such evidence establishes that the denial is subject to the appeals process.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described below in this "Appeals and Complaints" section.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures
There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission).

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals
   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized or pre-certified in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim
      Tell Health Plan in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal thereof, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within the initial 15 day decision period, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

We will send written notice of our decision to you and, if applicable to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal

Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 you are requesting; or (c)

your attending provider requests that your appeal be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 extending your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your claim, we will make our decision but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 day decision period ends and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal
Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal
Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 continuing your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals
Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim
Within 180 days from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after 180 days from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the end of the initial 30 day decision period ends, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the

requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal
Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)
We may terminate your membership retroactively (see Rescission of Membership under Section VIII. Termination/Nonrenewal/Continuation). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call the **Member Services Call Center** at **1-866-846-2650**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level Appeal
A Voluntary Second Level Appeal is another review by us that occurs after the mandatory internal appeal decision is communicated to you if you remain dissatisfied with our decision. This in-person review permits you to present evidence to the Second Level Appeal Panel and to ask questions. Choosing a Voluntary Second Level Appeal will not affect your right, if you have one, to request an independent external review.

Here is the procedure for a Voluntary Second Level of Appeal:

Within 30 days from the date of your receipt of our notice regarding your internal appeal. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination (mandatory internal appeal decision), and (5) all supporting documents. Your request and the supporting documents constitute your request for a Voluntary Second Level of Appeal. You must mail your request to the **Appeals Program**.

Within sixty (60) calendar days following receipt of your request, Health Plan will hold a Second Level Appeal meeting. Health Plan shall notify you of the date on which the Second Level Appeal Panel will meet at least 20 days prior to the date of this in-person meeting. You may request to postpone this date, and your request cannot be unreasonably denied by Health Plan.

You may present your appeal in person before the Second Level Appeal Panel, or request a file review. If you would like to present your appeal in person, but an in-person meeting is not practical, you may present your appeal by telephone. Please indicate in your appeal request how you want to present your appeal. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review.

You may request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least five (5) days prior to the date of the Second Level Appeal meeting.

You may submit additional information with your appeal request, or afterwards but no later than five (5) days prior to the date of your Second Level Appeal meeting. Any additional new material developed after this deadline shall be provided to us as soon as practicable. You may present your case to the Second Level Appeal Panel and ask questions of the Panel. You may be assisted or represented by an appointed representative of your choice including an attorney (at your own expense), other advocate or health care professional. If you decide to have an attorney present at the Second Level Appeal meeting, then you must let us know that at

least seven (7) days prior to that meeting. You must appoint this attorney as your representative in accordance with our procedures.

We will issue a written decision within seven (7) days of the completion of the Voluntary Second Level Appeal meeting.

If you would like further information about the Voluntary Second Level Appeal process, to assist you in making an informed decision about pursuing a Voluntary Second Level Appeal, please call the **Appeals Program**. Your decision to pursue a Voluntary Second Level Appeal will have no effect on your rights to any other Health Plan benefits, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review. However, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have an existing disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify

that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this 5 working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Dues, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

Charge(s):
1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment: The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Dues: Periodic membership charges paid by Group.

Emergency Medical Condition: A medical 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:
1. Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: All of the following with respect to an Emergency Medical Condition:
1. A medical screening examination (as required under the *Emergency Medical Treatment and Active Labor Act*) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the *Emergency Medical Treatment and Active Labor Act* requires to Stabilize the patient.

Family Unit: A Subscriber and all of his or her Dependents.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: Health Plan and Medical Group.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

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

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Dues. This EOC sometimes refers to a Member as "you" or "your."

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A Plan Medical Office or Plan Hospital.

Plan Hospital: Any hospital listed as a Plan Hospital in our provider directory. Plan Hospitals are subject to change at any time without notice.

Plan Medical Office: Any medical office listed in our provider directory. Plan Medical Offices are subject to change at any time without notice.

Plan Optometrist: Any licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to

provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies are subject to change at any time without notice.

Plan Physician: Any licensed physician who is an employee of Medical Group, an Affiliated Physician or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician or other health care provider that we designate as Plan Provider, except that Plan Providers are subject to change at any time without notice.

Service Area:
The ***Denver/Boulder*** Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park, Teller and Weld counties within the following zip codes: 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80252, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80437, 80439, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80623, 80640, 80642, 80643.

The ***Mountain Colorado*** Service Area is that portion of Eagle, Garfield, Grand, Routt and Summit counties within the following zip codes: 80423. 80424, 80426, 80435, 80443, 80463, 80497, 80498, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658.

The ***Northern Colorado*** Service Area is that portion of Adams, Boulder, Larimer, Morgan, and Weld counties within the following zip codes: 69128, 69145, 80511, 80512, 80513, 80515, 80517, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80532, 80534, 80535, 80536, 80537, 80538, 80539, 80541, 80542, 80543, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80610, 80611, 80612, 80615, 80620, 80622, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82082.

The ***Southern Colorado*** Service Area is that portion of Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132, 80133, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80943, 80944, 80945, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spinal Manipulation: Adjustment and manipulation of the vertebral column.

Spouse: Your partner in marriage or a civil union as determined by State law.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber For Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-gender domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this Evidence of Coverage; and

(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

DOMP0AA (01-15)

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

You must live or work in Health Plan's Service Area at the time of enrollment.

WOR0AA (01-10)

SPINAL MANIPULATION SERVICES

1. Coverage
   Spinal Manipulation Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by contracted providers. Coverage includes:
   a. Evaluation;
   b. Lab Services and X-rays required for such Services; and
   c. Manual and manipulative therapy.

   You may self-refer for visits to contracted providers.

2. Exclusions:
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services not related to the treatment of the musculoskeletal system.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Physical or massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

CHIR0AA (01-15) CMPL0AA

ACUPUNCTURE SERVICES

1. Coverage
   Acupuncture Services are covered as shown on the "Schedule of Benefits (Who Pays What)" when provided by contracted acupuncturists and if clinically appropriate.

   Coverage includes treatment for:
   a. Neuromusculoskeletal pain due to an injury or illness; or
   b. Allergy, asthma, nausea or vomiting.

   Services include:
   a. Acupuncture by manual stimulation.
   b. Electro-acupuncture applied to inserted needles and acupressure.

Cupping or moxibustion are only covered in lieu of electrical stimulation.

You may self-refer for visits to contracted acupuncturists.

2. Acupuncture Services Exclusions:
   a. Rental or purchase of durable medical equipment (DME);
   b. Air purifiers, therapeutic mattresses, supplies or similar devices, appliances, or equipment. Their use or installation does not have to be for therapy or easy access;
   c. Radiology and lab tests;
   d. Prescription drugs, vitamins, herbs or food supplements. It does not matter if they are prescribed or recommended by a contracted acupuncturist;
   e. Massage or soft tissue techniques, except acupressure;
   f. Treatment mainly for obesity or weight control;
   g. Vocational, stroke or long term rehabilitation;
   h. Hypnotherapy;
   i. Behavior training;
   j. Sleep therapy or biofeedback;
   k. Acupuncture Services provided for maintenance or preventive care Services;
   l. Addiction. This includes quitting smoking;
   m. Expenses for acupuncture Services provided during visits that exceed the member's visit limit;
   n. Expenses for any Services provided before coverage begins or after coverage ends for this benefit;
   o. Any Services provided by an acupuncturist who is not contracted. It does not matter if the Services are obtained in or out of Health Plan's Service Area;
   p. Acupuncture Services that Kaiser Permanente determines are not clinically appropriate in its utilization review. (Members may not be surcharged for such Services);
   q. Services not authorized by Kaiser Permanente. This exclusion does not apply to the initial evaluation;
   r. Any techniques or procedures not generally accepted in a majority of state acupuncture licensing boards; and
   s. Benefits, items or Services that are limited or excluded in the Evidence of Coverage, unless changed by this benefit.

CMPL0AA (01-15)
DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device or orthotic device that adequately meets a Member's medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage:
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Physician, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.
   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.
   c. Durable Medical Equipment Exclusions:
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.

iv. Exercise or hygiene equipment.
v. Comfort, convenience, or luxury equipment or features.
vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
vii. Replacement of lost equipment.
viii. Repairs, adjustments or replacements necessitated by misuse.
ix. More than one piece of DME serving essentially the same function, except for replacements.
x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
   Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and when obtained from sources designated by Health Plan.
   b. Prosthetic Devices Exclusions:
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate, as described above.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.
      iv. Spare devices or alternate use devices.
      v. Replacement of lost prosthetic devices.
      vi. Repairs, adjustments or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
   Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions:
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accord with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost orthotic devices.
      vii. Repairs, adjustments or replacements necessitated by misuse.

DMES0AB (01-16)
INFT0AA

INFERTILITY BENEFIT

1. **Coverage:**

   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (includes lab and X-ray); and.
   b. Office administered drugs; and
   c. Artificial insemination.

2. **Infertility Exclusions**:

   These exclusions apply to fertile as well as infertile individuals or couples.
   a. Services to reverse voluntary, surgically induced infertility.
   b. Donor semen.
   c. All Services and supplies related to procurement or storage of donor semen for artificial insemination.
   d. Prescription drugs received from the pharmacy for artificial insemination.

e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to conception by artificial means (in vitro fertilization; ovum transplants; gamete intra fallopian transfer; and zygote intra fallopian transfer)

INFT0AA (01-16)

PREVENTIVE SERVICES RIDER

Preventive care services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the " Schedule of Benefits (Who Pays What)" when prescribed by a Plan Physician. Please contact Member Services for a complete list of covered Preventive Services.

Coverage includes, but not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your Primary Care Plan Physician.
3. Cervical cancer screening.
4. Breast cancer screening.
5. Cholesterol screening.
6. Colorectal cancer screening.
7. Immunizations pursuant to the schedule established by the ACIP.
8. Tobacco use screening of adults and tobacco cessation interventions by your Primary Care Plan Physician.
9. Type 2 diabetes screening for adults with high blood pressure.
10. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
11. Prostate Cancer screening.
12. Cervical cancer vaccines.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. www.cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.

PV0AA (01-14)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan Drug Formularies. The term "non-preferred" refers to drugs that are not included in the Health Plan Drug Formularies.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible and supply limits that apply to the covered prescription drugs described below.

1. Coverage:
   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; specialty drugs, including self-administered injectable drugs; and a tier for prescribed non-preferred drugs authorized through the non-preferred drug process.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.
   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs:
   a. Available in the United States only from a single manufacturer; and
   b. Not listed as generic in the then-current commercially available drug database(s) Health Plan subscribes to;
   are provided at the brand-name Copayment. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Physician and are obtained at Plan Pharmacies; or
   b. Physician to whom a Member has been referred by a Plan Physician and are obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions); and are obtained at Plan Pharmacies.

   Covered drugs include:

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

   b. Insulin

   c. For Denver/Boulder and Northern Colorado Service Areas, compounded medications as long as they are on the compounding formulary.

2. Limitations for Southern Colorado Service Area:
   a. Some drugs may require prior authorization.
   b. Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.
   c. Plan Physicians may apply for formulary exceptions in cases where it is Medically Necessary.

3. Drugs, Supplies and Supplements Exclusions:
   a. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   b. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   c. Any drugs listed as not covered in the Schedule of Benefits
   d. Drugs to shorten the length of the common cold.
   e. Drugs to enhance athletic performance.
   f. Drugs available over the counter and by prescription for the same strength.
   g. Individual drugs and/or Drug classes determined excluded by our Pharmacy and Therapeutics Committee.
   h. Drugs for the treatment of weight control.
   i. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   j. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
   k. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.

RX0BL (01-16)

Kaiser Foundation Health Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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DARLENE K STEVENS
5972 S LITTLE RIVER CT
AURORA, CO 80016-2501

Important plan information

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TITLE PAGE (Cover Page)

Important Benefit Information Enclosed Evidence of Coverage

About this Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. This EOC is for your Group's 2016 contract year.

In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as “Health Plan,” “we,” or “us.” Members are sometimes referred to as “you.” Out-of-Health Plan is sometimes referred to as “Out-of-Plan.” Some capitalized terms have special meaning in this EOC; please see the “Definitions” section for terms you should know.

The health care coverage described in this EOC has been designed to be a High Deductible Health Plan (HDHP) compatible for use with a Health Savings Account (HSA). An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, you must be enrolled in a qualified High Deductible Health Plan.

Please note that the tax references contained in this document relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state’s income tax laws may differ from the federal tax treatment, and differs from state to state. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

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KAISER PERMANENTE®

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

Benefits for CITY OF LOUISVILLE

5920 - 002

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

V. DEPENDENT STUDENT LIMITING AGE

IMPORTANT INFORMATION PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC. Here is some ***important information*** to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. A Plan Physician ***must*** determine that the Service is ***Medically Necessary*** to prevent, diagnose or treat your medical condition. A Service is Medically Necessary ***only*** if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health; ***and***
   b. The Service ***must be*** provided, prescribed, authorized or directed by a Plan Physician; ***and***
   c. The Service ***must be*** a ***covered*** Service described in this EOC.
2. The Charges for your Services are ***not*** always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
6. You may be charged separate Deductibles, Copayments or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
7. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
8. For items ordered in advance, you pay the Deductibles, Copayments or Coinsurance in effect on the order date.
9. You, as the Subscriber, are responsible for any Deductibles, Copayments and/or Coinsurance, incurred by your Dependents enrolled in the Plan.
10. Dollar, day and visit limits, Deductibles and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

I. DEDUCTIBLES

The following medical Deductibles apply under your plan:

This plan has an:
AGGREGATE Medical Deductible

$2,500/Individual per Accumulation Period

$5,000/Family per Accumulation Period

(Applies to Out-of-Pocket Maximum)

(see "C. Definitions of Aggregate and Embedded Individual and Family Medical Deductibles")

The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies.

For covered Services that are subject to the medical Deductible, any amounts over usual, reasonable and customary charges will not apply toward the medical Deductible.

A. For covered Services that **ARE** subject to the medical Deductible:

1. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.
2. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").
3. Your applicable Copayment and Coinsurance may apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

B. For covered Services that **ARE NOT** subject to the medical Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance."

C. **Definitions of Aggregate and Embedded Individual and Family Medical Deductibles:**

1. **Aggregate Medical Deductible:**
   a. For plans with self only coverage (e.g., no dependents covered on the plan):
      i. The individual medical Deductible amount applies.
      ii. After the individual medical Deductible is met, the Member will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.
   b. For plans with two or more Members:
      i. There is no individual medical Deductible.
      ii. The family medical Deductible amount applies to the entire family as a whole (e.g. it is a cumulative family medical Deductible, which the entire family must collectively meet).
      iii. After the family medical Deductible is met, all covered family Members will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.
2. **Embedded Medical Deductible:**
   a. Each individual family Member has his or her own medical Deductible.
   b. If a family Member reaches his or her individual medical Deductible before the family medical Deductible is met, he or she will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.
   c. The entire family as a whole has a cumulative family medical Deductible. After the family medical Deductible is met, all covered family Members will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period. This is true even for family Members who have not met their individual medical Deductible.

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The following Out-of-Pocket Maximum (OPM) amounts apply under your plan:

This plan has an:

AGGREGATE OPM

$2,500/Individual per Accumulation Period

$5,000/Family per Accumulation Period

(see "D. Definitions of Aggregate and Embedded Individual and Family OPM")

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts over usual, reasonable and customary charges will not apply toward the OPM.

A. Your medical Deductible applies to the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** to the OPM.

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** to the OPM.

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

D. **Definitions of Aggregate and Embedded Individual and Family OPM**

1. **Aggregate OPM:**
   a. For plans with self only coverage (e.g., no dependents covered on the plan):
      i. The individual OPM amount applies.
      ii. After the individual OPM is met, the Member will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.
   b. For plans with two or more Members:
      i. There is no individual OPM.
      ii. The family OPM amount applies to the entire family as a whole (e.g. it is a cumulative family OPM, which the entire family must collectively meet).
      iii. After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for covered Services that apply to the OPM for the rest of the Accumulation Period.
2. **Embedded OPM:**
   a. Each individual family Member has his or her own OPM.
   b. If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.
   c. The entire family as a whole has a cumulative family OPM. After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.

Tracking Deductible and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will send you an

Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your medical Deductible and/or OPM amounts.

For more information about your medical Deductible or OPM amounts, please call **Member Services.**

III. COPAYMENTS AND COINSURANCE

Medical Deductible	
(Applies to Out-of-Pocket Maximum)	This plan has an: AGGREGATE Medical Deductible $2,500/Individual per Accumulation Period $5,000/Family per Accumulation Period

Out-of-Pocket Maximum	
	This plan has an: AGGREGATE OPM $2,500/Individual per Accumulation Period $5,000/Family per Accumulation Period

Outpatient Care	You Pay
Primary care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Specialty care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Consultations with clinical pharmacists *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Allergy injections *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Allergy evaluation and testing *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Gynecology care visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Routine prenatal and postpartum visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	0% Coinsurance
Outpatient surgery at designated outpatient facilities *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Hospital Inpatient Care	You Pay
(See III. "Benefits/Coverage (What Is Covered)", B. "Hospital Inpatient Care", in this EOC for the list of covered Services) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Inpatient professional Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	No Charge

Ambulance Services	You Pay
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	No Charge

Bariatric Surgery	You Pay
(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)	Not Covered Includes inpatient and outpatient covered Services

Chemical Dependency Services	You Pay
Inpatient medical detoxification *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Inpatient professional Services for medical detoxification *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Outpatient individual therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Outpatient group therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Residential rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge per inpatient admission

Complementary and Alternative Medicine	You Pay
Spinal manipluation Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Acupuncture Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Dialysis Care	You Pay
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	No Charge

Drugs, Supplies and Supplements	You Pay
Office-administered drugs (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	20% Coinsurance
• Travel immunizations	Not Covered
Outpatient prescription drugs Copayment/Coinsurance (except as listed below): *(Prescriptions are subject to the medical Deductible and apply to the Out-of-Pocket Maximum except as otherwise listed in this "Drugs, Supplies and Supplements" section.)*	No Charge Tobacco cessation and contraceptive drugs at No Charge; Not subject to Deductible
• Pharmacy Deductible	Not Applicable
• Infertility drugs	Not Covered
• Over the counter items (OTC): *(Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not Subject to medical Deductible)*	No Charge
• Prescribed supplies	No Charge
• Sexual dysfunction drugs	Not Covered
• Specialty drugs	No Charge
	Supply Limit
Day supply limit	60 days
Mail-order supply limit	60 days @ No Charge See Additional Provisions

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
	Annual Maximum Benefit
Annual maximum benefit paid by Health Plan	Not Applicable
	You Pay
Durable medical equipment *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Breast pumps *(**If covered**, must be obtained within 6 months (180 days) following delivery)* *(Not Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Prosthetic devices	
• Internally implanted prosthetic devices *(See "Hospital Inpatient Care" and "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)*	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment(s) and/or Coinsurance
• Prosthetic arm or leg *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• All other prosthetic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Orthotic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Oxygen *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Emergency Services and Non-Emergency, Non-Routine Care	You Pay
Plan and non-plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Non-emergency, non-routine visits at Plan Facilities after regular office hours *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Covered Services received during after-hour visits to Plan Facilities *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Family Planning Services	You Pay
Family planning counseling *(See "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance
Associated outpatient surgery procedures *(See "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance

Health Education Services	You Pay
Training in self-care and preventive care *(See "Outpatient Care" for mdical Deductible and Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Hearing aids for persons under the age of 18 *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Hearing aids for persons age 18 and over *(**If covered:** Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Not Covered

Home Health Care	You Pay
Health Services provided in your home and prescribed by a Plan Physician *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Special Services program For hospice-eligible Members who have not yet elected hospice care *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Hospice care for terminally ill patients *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Infertility Services	You Pay
All covered Services related to the diagnosis and treatment of infertility *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Artificial insemination, including associated X-ray and laboratory Services *(Not subject to Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Inpatient day limit	No inpatient day limit
Inpatient professional Services for psychiatric hospitalization (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	No inpatient day limit
Outpatient individual therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge including partial hospitalization
Outpatient group therapy *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Out-Of-Area Student	You Pay
• Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and chemical dependency, gynecology care, prevention visit and a visit with the administration of allergy injections. Does not include: allergy evaluation, routine prenatal and postpartum visits, spinal manipulations, acupuncture services, hearing exams, home health visits, hospice services, physical, occupational, and speech therapy, and applied behavioral analysis (ABA).)* *Visit: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other Services: (Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Visit: No Charge Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period
• Diagnostic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
• Outpatient prescription drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	See “Drugs, Supplies and Supplements” for applicable Copayment or Coinsurance Limited to 5 prescription drug fills per Accumulation Period

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	No Charge Up to 60 days per condition per Accumulation Period
Inpatient professional physical, occupational and speech therapy Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Short-term outpatient physical, occupational and speech therapy visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge Up to 20 visits per therapy per Accumulation Period
Pulmonary rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Therapies for the treatment of Autism Spectrum Disorders	
Outpatient physical, occupational and speech therapy visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Applied Behavioral Analysis (ABA) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Annual benefit maximum for children ages 0 through 8	Minimum of 550 visits/year *
• Annual benefit maximum for children ages 9 up to 19 *Per Colorado law, we will provide the equivalent of what was required prior to May 13, 2013: total visits equivalent to a benefit of $34,000 annually in ABA therapy benefits for children from birth through age 8, and $12,000 annually in ABA therapy benefits for children age 9 to 19.	Minimum of 185 visits/year *

Preventive Care Services	You Pay
• Preventive care visits *(Not Subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Adult preventive care exams • Well-woman care exams • Immunizations	No Charge
• Colorectal cancer screenings *(Not Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge Additional charges may apply for pathology Services. For example lab Services performed on a removed polyp (see Diagnostic Laboratory Services under "X-ray, Laboratory and Special Procedures" section for applicable Copayment or Coinsurance)
• Adult preventive care screenings *(Not Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Well-woman care screenings *(Not Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Well-child care *(Not Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge for children through age 17

Reconstructive Surgery	You Pay
(See "Hospital Inpatient Care" and "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment or Coinsurance

Skilled Nursing Facility Care	You Pay
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	No Charge Up to 100 days per Accumulation Period

Transplant Services	You Pay
(See "Hospital Inpatient Care" and "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	You Pay
Eye refraction test when performed by an Optometrist *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Eye refraction test when performed by an Ophthalmologist *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Optical hardware *(Not subject to Deductible;* Does not apply to Out-of-Pocket Maximum)	Not Covered

X-ray, Laboratory and Special Procedures	You Pay
Diagnostic laboratory Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic X-ray Services (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	No Charge
Therapeutic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine (*Subject to medical Deductible; Applies to Out-of-Pocket Maximum*)	No Charge

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the “Eligibility” section in the EOC.

V. DEPENDENT STUDENT LIMITING AGE

The Dependent student limiting age as described under Dependents in the "Eligibility" section is the end of the month in which age 26 is reached.

Additional Provisions

Please see “Additional Provisions” for any supplemental information that applies to your coverage.

CONTACT US

Advice Nurses

CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members**:** **970-207-7171** or call toll-free **1-800-218-1059** ***Mountain Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

After-Hours Medical Needs

CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059** ***Mountain Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Appeals Program

CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Binding Arbitration

CALL	**Quality, Risk, and Patient Safety 303-344-7298**

Claims Department

CALL	***Denver/Boulder*** Members: **303-338-3600** or toll-free **1-800-382-4661** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-382-4661** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE	***Denver/Boulder*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Southern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 372910** **Denver, CO 80237-6910** ***Northern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Mountain Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Member Services

CALL	***Denver/Boulder*** Members: **303-338-3800** or toll-free **1-800-632-9700** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-632-9700** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**www.kp.org**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Patient Financial Services

CALL	***Denver/Boulder*** Members: **303-743-5900** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-632-9700** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Personal Physician Selection Services	
CALL	***Denver/Boulder*** Members: **303-338-4477** ***Southern Colorado*** Members: **1-855-208-7221** ***Northern Colorado*** Members**:** **1-855-208-7221** ***Mountain Colorado*** Members: **1-855-208-7221**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**www.kp.org/chooseyourdoctor**

Transplant Administrative Offices	
CALL	**303-636-3226**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS (WHO PAYS WHAT
TITLE PAGE (COVER PAGE)
CONTACT US
TABLE OF CONTENTS
I. ELIGIBILITY 1
A. Who Is Eligible 1
1. General 1
2. Subscribers 1
3. Dependents 1
4. Medicare Eligibility 1
5. Health Savings Account Eligibility 1
B. Enrollment and Effective Date of Coverage 1
1. New Employees and their Dependents 2
2. Members Who are Inpatient on Effective Date of Coverage 2
3. Special Enrollment Due to Newly Acquired Dependents 2
4. Special Enrollment 2
5. Open Enrollment 3
6. Persons Barred From Enrolling 3
II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS 3
A. Your Primary Care Plan Physician 3
1. Choosing Your Primary Care Plan Physician 3
2. Changing Your Primary Care Plan Physician 4
B. Getting a Referral 4
1. Referrals 4
2. Specialty Self-Referrals 5
3. Second Opinions 5
C. Plan Facilities 5
1. Denver/Boulder Service Area 5
2. Southern, Northern and Mountain Colorado Service Areas 5
D. Getting the Care You Need 5
E. Out-of-Area Student Benefit 6
F. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area 6
G. Using Your Health Plan Identification Card 6
H. Cross Market Access 7
1. Denver/Boulder Members: 7
2. Southern, Northern and Mountain Colorado Members: 7
III. BENEFITS/COVERAGE (WHAT IS COVERED) 7
A. Outpatient Care 7
B. Hospital Inpatient Care 8
1. Inpatient Services in a Plan Hospital 8
2. Hospital Inpatient Care Exclusions: 8
C. Ambulance Services 8
1. Coverage 8
2. Ambulance Services Exclusion: 8
D. Chemical Dependency Services 8
1. Inpatient Medical and Hospital Services 8
2. Residential Rehabilitation 8
3. Outpatient Services 9
4. Chemical Dependency Services Exclusion: 9
E. Clinical Trials (applies to non-grandfathered health plans only) 9
F. Dialysis Care 9
G. Drugs, Supplies and Supplements 10

1. Coverage 10
2. Limitations: 11
3. Drugs, Supplies and Supplements Exclusions: 11

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics 11
1. Durable Medical Equipment (DME) 11
2. Prosthetic Devices 12
3. Orthotic Devices 12

I. Early Childhood Intervention Services 12
1. Coverage 12
2. Limitations 12
3. Early Childhood Intervention Services Exclusions: 12

J. Emergency Services and Non-Emergency, Non-Routine Care 12
1. Emergency Services 12
2. Non-Emergency, Non-Routine Care 13
3. Payment 14

K. Family Planning Services 14

L. Health Education Services 15

M. Hearing Services 15

N. Home Health Care 15
1. Coverage 15
2. Home Health Care Exclusions: 15
3. Special Services Program 15

O. Hospice Care 15

P. Infertility Services 16

Q. Mental Health Services 16
1. Coverage 16
2. Mental Health Services Exclusions 16

R. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services 16
1. Coverage 16
2. Limitations 17
3. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions 17

S. Preventive Care Services 17

T. Reconstructive Surgery 18
1. Coverage 18
2. Reconstructive Surgery Exclusions 18

U. Skilled Nursing Facility Care 18

V. Transplant Services 18
1. Coverage 18
2. Related Prescription Drugs 18
3. Terms and Conditions 18
4. Transplant Services Exclusions and Limitations 19

W. Vision Services 19
1. Coverage 19
2. Vision Services Exclusions 19

X. X-ray, Laboratory and X-ray Special Procedures 19
1. Coverage 19
2. X-ray, Laboratory and X-ray Special Procedures Exclusions 19

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED) 20

A. Exclusions 20

B. Limitations 22

C. Reductions 22
2. Injuries or Illnesses Alleged to be Caused by Other Parties 25
3. Surrogacy 26

V. MEMBER PAYMENT RESPONSIBILITY 26

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM) 26

VII. GENERAL POLICY PROVISIONS **26**
- **A.** Access Plan 26
- **B.** Access to Services for Foreign Language Speakers 26
- **C.** Administration of Agreement 27
- **D.** Advance Directives 27
- **E.** Agreement Binding on Members 27
- **F.** Amendment of Agreement 27
- **G.** Applications and Statements 27
- **H.** Assignment 27
- **I.** Attorney Fees and Expenses 27
- **J.** Binding Arbitration 27
- **K.** Claims Review Authority 27
- **L.** Contracts with Plan Providers 28
- **M.** Deductible/Out-of-Pocket Maximum Takeover Credit 28
- **N.** Governing Law 28
- **O.** Group and Members not Health Plan's Agents 28
- **P.** No Waiver 28
- **Q.** Nondiscrimination 28
- **R.** Notices 28
- **S.** Overpayment Recovery 28
- **T.** Privacy Practices 29
- **U.** Value-Added Services 29
- **V.** Women's Health and Cancer Rights Act 29

VIII. TERMINATION/NONRENEWAL/CONTINUATION **29**
- **A.** Termination Due to Loss of Eligibility 30
- **B.** Termination of Group Agreement 30
- **C.** Termination for Cause 30
- **D.** Termination for Nonpayment 30
- **E.** Termination of a Product or all Products (applies to non-grandfathered health plans only) 30
- **F.** Rescission of Membership 30
- **G.** Continuation of Group Coverage Under Federal Law, State Law or USERRA 30
  1. Federal Law (COBRA) 30
  2. State Law 30
  3. USERRA 31
- **H.** Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area 31

IX. APPEALS AND COMPLAINTS **31**

X. INFORMATION ON POLICY AND RATE CHANGES **39**

XI. DEFINITIONS **39**

ADDITIONAL PROVISIONS

I. ELIGIBILITY

A. Who Is Eligible

1. General
   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. On the first day of membership, the Subscriber must live in our Service Area. Our Service Area is described in the "Definitions" section. You cannot live in another Kaiser Foundation Health Plan or allied plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia and Washington. For more information, please call **Member Services**.

2. Subscribers
   You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents
   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

   a. Your Spouse. (Spouse includes a partner in a valid civil union under State law.)
   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."
   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court appointed permanent legal guardian (or was before the person reached age 18).
   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.
   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

   Students on Medical Leave of Absence. Dependent children over the dependent limiting age but under the dependent student limiting age as specified in the "Schedule of Benefits (Who Pays What)" who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

   If your plan has different eligibility requirements, please see "Additional Provisions."

4. Medicare Eligibility
   This health plan is not intended for Members entitled to benefits under Medicare. If you are or become eligible for Medicare during the term of your Group's Agreement, and you enroll in Medicare Part A, Part B or Part D with Health Plan, or another Medicare Advantage health plan, you no longer qualify as an eligible individual for an HSA-qualifying High Deductible Health Plan.

5. Health Savings Account Eligibility
   Enrollment in a High Deductible Health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Other requirements include that you must not be: (a) covered by another health coverage plan (for example, through your spouse's employer) that is not also an HSA-compatible health plan, with certain exceptions; (b) enrolled in Medicare; or (c) able to be claimed as a Dependent on another person's tax return. Consult your tax advisor for more information about your eligibility for an HSA.

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date.

1. New Employees and their Dependents
   If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage
   If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. A newborn child is covered for the first 31 days.
      For existing Subscribers:
      i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
      ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

   b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
      For existing Subscribers:
      i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
      ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

   c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment" below.

4. Special Enrollment
   If you have certain life events ("qualifying events), you can enroll in or change your health insurance plan outside of the open enrollment period. You may apply for enrollment as a Subscriber, and existing Subscribers may apply to enroll eligible Dependents, by submitting an enrollment form to Health Plan within 30 days after one of the following events happens to one of the people applying:

   a. You involuntarily lose existing minimum essential or creditable coverage due to the death of a covered employee; termination of employment or reduction in number of hours of the employment; covered employee becoming eligible for Medicare; divorce or legal separation from the covered employee's spouse or partner in a civil union; your Dependent child has a birthday and no longer qualifies as a Dependent on his/her parent's plan; your retiree coverage is terminated or substantially eliminated when your employer declares bankruptcy; termination of eligibility for coverage; involuntary termination of coverage; reduction or elimination of the employer's contributions toward coverage.

   b. You gain a Dependent or become a Dependent through marriage; civil union; birth, adoption or placement for adoption; by entering into a designated beneficiary agreement pursuant to the Colorado Designated Beneficiary Agreement Act, if your carrier offers coverage for designated beneficiaries; or pursuant to a court or administrative order mandating coverage.

c. A parent or legal guardian dis-enrolls a Dependent from, or a Dependent becomes ineligible for the Children's Basic Health Plan, and the parent or legal guardian requests enrollment of the Dependent in a health plan within 60 days of the disenrollment or determination of ineligibility.

d. You lose coverage under the Colorado Medical Assistance Act and then request coverage under an employer's group health plan within 60 days of the loss of coverage.

e. You or a Dependent become eligible for premium assistance under the Colorado Medical Assistance Act or the Children's Basic Health Plan for which you will have a 60 day special enrollment period.

Additionally, if you are aware of a future qualifying event, you may apply for new coverage up to 30 days in advance of that event.

If Health Plan accepts your enrollment form, your membership effective date will be one of the following:

a. For birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption.

b. For other qualifying events, the first day of the following month after Health Plan receives a completed enrollment form.

5. Open Enrollment
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred From Enrolling
You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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

- "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)," in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.
- "Getting a Referral," in this section.
- "Cross Market Access" in this section.

Your home Service Area is printed on your Health Plan Identification (ID) card. For more information about your ID card, please refer to the "Using Your Health Plan Identification Card" section, below.

A. Your Primary Care Plan Physician

Your primary care Plan Physician (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Plan Physician
You may select a PCP from family medicine, pediatrics, or internal medicine within your home service area. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the "Second Opinions" section, below.

a. ***Denver/Boulder*** Service Area
You may choose your PCP from our provider directory. To review a list of Plan Physicians and their biographies, visit our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations." You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a Plan Physician, accepting new patients, based on your health care needs.

b. ***Southern, Northern and Mountain Colorado*** Service Areas
You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

Medical Group contracts with a panel of Affiliated Physicians, specialists, and other health care professionals to provide medical Services in the ***Southern, Northern and Mountain Colorado*** Service Areas. You may choose your PCP from our panel of ***Southern, Northern and Mountain Colorado*** Plan Physicians.

You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can review a list of ***Southern, Northern and Mountain Colorado*** Plan Physicians by visiting our website. Go to www.kp.org, click on "Locate our services" then "Find doctors & locations." You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a Plan Physician, accepting new patients, based on your health care needs.

If you are seeking routine or specialty care in any ***Denver/Boulder*** Plan Hospital, you must have a referral from your local PCP. If you do not get a referral, you will be billed for the full amount of the office visit Charges. If you are visiting in the ***Denver/Boulder*** Service Area and need after-hours or emergency care, you can visit a ***Denver/Boulder*** Plan Facility without a referral. For care in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below.

2. Changing Your Primary Care Plan Physician
   a. ***Denver/Boulder*** Service Area
   Please call **Personal Physician Selection Services** to change your PCP. You may also change your physician when visiting a Plan Facility. You may change your PCP at any time.

   b. ***Southern, Northern and Mountain Colorado*** Service Areas
   Please call **Personal Physician Selection Services** to change your PCP. Notify us of your new PCP choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

B. Getting a Referral

1. Referrals
   a. ***Denver/Boulder*** Service Area
   Medical Group physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your Medical Group physician decides that you need covered Services not available from us, he or she will refer you to a non-Medical Group physician inside or outside our Service Area. You must have a written referral to the non-Medical Group physician in order for us to cover the Services.

   A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a non-Medical Group physician. A written or verbal recommendation by a Medical Group physician or an Affiliated Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered.

   For Services in Kaiser Permanente Plan Medical Offices in the ***Southern, Northern and Mountain Colorado*** Service Areas, please see "Cross Market Access," below. In order to receive Services from a Plan Facility, you must have a written referral. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Medical Group physician.

   A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved in advance according to Medical Group procedures. We will not pay for any care rendered or recommended by a non-Medical Group physician beyond the limits of the original referral unless the care is: (i) specifically authorized by your Medical Group physician; and (ii) approved in advance in accord with Medical Group procedures.

   b. ***Southern, Northern and Mountain Colorado*** Service Areas
   Plan Physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery and dermatology. If your Plan Physician decides that you need covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have a written referral to the non-Plan Provider in order for us to cover the Services.

   A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a designated non-Plan Provider. A written or verbal recommendation by a Plan Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Plan Provider.

   Health Plan authorization is required for Services provided by: (i) non-Plan Providers or non-Plan Facilities; (ii) Services provided by any provider outside the ***Southern, Northern and Mountain Colorado*** Service Areas; and (iii) Services performed in any facility other than the physician's office. For Services in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below. A referral for these Services will be submitted to Health Plan by the Plan Physician. Health Plan will make a determination regarding authorization for coverage.

   The provider to whom you are referred will receive a notice of Health Plan's authorization by fax. You will receive a written notice of Health Plan's 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.

2. Specialty Self-Referrals
   a. ***Denver/Boulder*** Service Area
   You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will still be required to get a written referral for laboratory or radiology Services and for specialty procedures such as a CT scan, MRI, or surgery. A written referral is also required for specialty-care visits to non-Medical Group physicians.

   b. ***Southern, Northern and Mountain Colorado*** Service Areas
   You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will find the specialty-care providers eligible to receive direct referrals in the Kaiser Permanente Provider Directory for your specific home Service Area. It is available on our website, *www.kp.org*, by clicking on "Locate our services" then "Find doctors & locations." You can get help choosing a specialty-care provider by calling **Personal Physician Selection Services**..

   A self-referral provides coverage for routine visits only. Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to Plan Physician specialty-care providers not eligible to receive direct referrals; and (iii) non-Plan Physicians. ***Southern, Northern and Mountain Colorado*** Members may be able to self-refer to Kaiser Permanente Plan Medical Offices in the ***Denver/Boulder*** Service Area (see "Cross Market Access," below). Services other than routine office visits with a Plan Physician specialty-care provider eligible to receive self-referrals will not be covered unless authorized by Kaiser Permanente before Services are rendered.

   The request for these Services can be generated by either your PCP or by a specialty-care provider. The physician or facility to whom you are referred will receive a notice of the authorization. You will receive a written notice of 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 that the authorization is valid and the Services authorized.

3. Second Opinions
   Upon request and subject to payment of any applicable Deductible, Copayments and/or Coinsurance, you may get a second opinion from a Plan Physician about any proposed covered Services.

C. Plan Facilities

Plan Facilities are Plan Medical Offices or Plan Hospitals in our Service Area that we contract with to provide covered Services to our Members.

1. ***Denver/Boulder*** Service Area
   We offer health care at Plan Medical Offices conveniently located throughout the ***Denver/Boulder*** Service Area. At most of our Plan Facilities, you can usually receive all the covered Services you need. This includes specialized care. You are not restricted to a certain Plan Facility. We encourage you to use the Plan Facility in your home service area that will be most convenient for you.

   Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations."

2. ***Southern, Northern and Mountain Colorado*** Service Areas
   When you select your PCP, you will receive your Services at that physician's office. You can find ***Southern, Northern and Mountain Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list from our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations."

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a life or limb threatening emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen, are covered at Plan Facilities during regular office hours. Your office visit Charge, as defined in the "Schedule of Benefits (Who Pays What)," will apply. If you need non-emergency, non-routine care after hours, you may use one of the designated after-hours Plan Facilities. The Charge for non-

emergency, non-routine care received in Plan Facilities after regular office hours listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about non-emergency, non-routine care, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.

Non-emergency, non-routine care received at a non-Plan Facility inside our Service Areas is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside our Service Areas, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized non-emergency, non-routine care outside our Service Areas. Please see "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about out-of-Plan non-emergency, non-routine care Services.

E. Out-of-Area Student Benefit

A limited benefit is available to students attending school outside any Kaiser Foundation Health Plan service area.

The Out-of-Area Student Benefit coverage is limited to certain office visits, diagnostic X-rays, and prescription drug fills as covered under this EOC:

1. Office visit exam charge limited to:
   a. Primary care visit.
   b. Specialty care visit.
   c. Preventive care visit.
   d. Gynecology care visit.
   e. Mental health visit.
   f. Chemical dependency visit.
   g. Visits with the administration of allergy injections.
2. Diagnostic X-rays.
3. Prescription drug fills

To qualify for the out-of-area student benefit, the student must provide verification of their student status. Students are covered up to the age of 26. For more information, please call **Member Services**.

See the "Schedule of Benefits (Who Pays What)" for more details.

Exclusions and Limitations:

This does not include, and is not limited to, the following Services:

1. Other Services provided during a covered office visit such as, but **not limited** to: lab, procedures, and office administered drugs and devices except for allergy injections.
2. Services received outside the United States.
3. Transplant Services.
4. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services, Non-emergency, Non-Routine Care).
5. Allergy evaluation, routine prenatal and postpartum visits, spinal manipulations, acupuncture services, hearing exams, home health visits, hospice services, physical, occupational and speech therapy and applied behavioral analysis (ABA).

To qualify for the out-of-area student benefit, the student must provide verification of student status. For more information, please call **Member Services.**

Visiting member care will continue to apply to students attending school in other Kaiser Foundation Health Plan or allied plan service areas.

F. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to an area not within any Kaiser Foundation Health Plan or allied plan service area, you can keep your membership with Health Plan, if you continue to meet all other eligibility requirements. However, you must go to a Plan Facility in a Kaiser Foundation Health Plan or allied plan service area in order to receive covered Services (except out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care).

G. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, claims for Emergency

or non-emergency care Services from non-Plan Providers will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership upon 30 days written notice that will include the reason for termination.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

H. Cross Market Access

Members may access certain Services at Kaiser Permanente Plan Medical Offices outside of their home Service Area.

1. ***Denver/Boulder*** Members***:***
   Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the ***Southern, Northern and Mountain Colorado*** Service Areas. ***Denver/Boulder*** Members do not have access to Affiliated Providers in ***Southern*** or ***Northern Colorado*** unless authorized by Health Plan.

2. ***Southern, Northern and Mountain Colorado*** Members***:***
   Southern, Northern and Mountain Colorado Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the ***Denver/Boulder*** Service Area.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; after-hours care; pharmacy; laboratory; X-ray; vision; and hearing Services. These Services may not be available at all Plan Medical Offices and are subject to change. For more information on what Services you may access outside your designated home Service Area and at which designated Kaiser Permanente Plan Medical Offices, if applicable, you may receive Services at, please call **Member Services**.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- A Plan Physician determines that the Services are Medically Necessary to prevent, diagnose or treat your medical condition. A Service is Medically Necessary only if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health.
- The Services are provided, prescribed, authorized or directed by a Plan Physician. This does not apply where specifically noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and (b) "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care".
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Getting a Referral" and "Specialty Self-Referrals"; and (b) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care".
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)."

A. Outpatient Care

Outpatient Care for Preventive Care, Diagnosis and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following outpatient care for preventive care, diagnosis and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility or at home:

1. Primary care visits: Services from family medicine, internal medicine and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists (***Denver/Boulder*** Members only).

5. Outpatient surgery.
6. Blood, blood products and their administration.
7. Second opinion.
8. House calls when care can best be provided in your home as determined by a Plan Physician.
9. Medical social Services.
10. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
11. Telemedicine visits (not including telephone conversations and electronic mail messages) are considered office visits and the applicable office visit copayment, coinsurance and/or deductible applies.

B. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital
   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Areas:
   a. Room and board, such as semiprivate accommodations or, when a Plan Physician determines it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for child birth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn after your discharge are subject to all Health Plan provisions. This includes his/her own Copayments and/or Deductibles requirements.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

2. Hospital Inpatient Care Exclusions***:***
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by State law.
   b. Bariatric surgery and cosmetic surgery related to bariatric surgery.

C. Ambulance Services

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide.

2. Ambulance Services Exclusion***:***
   Transportation by other than a licensed ambulance. This includes transportation by car, taxi, bus, gurney van, minivan and any other type of transportation, even if it is the only way to travel to a Plan Provider.

D. Chemical Dependency Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Medical Services for alcohol and drug detoxification are covered in the same way as for other medical conditions. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for services of a residential rehabilitation program and referral to such a facility or program, is made by or under the supervision of a Plan Physician.

   We cover inpatient services and partial hospitalization in a residential rehabilitation program approved by Kaiser Permanente for the treatment of alcoholism, drug abuse or drug addiction.

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

   We cover chemical dependency services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary as determined by a Plan Physician and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

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

4. Chemical Dependency Services Exclusion:
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

E. Clinical Trials (applies to non-grandfathered health plans only)

We cover Services you receive in connection with a clinical trial if all of the following conditions are met:

1. We would have covered the Services if they were not related to a clinical trial.
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination.
   b. You provide us with medical and scientific information establishing this determination.
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
4. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   c. The study or investigation is approved or funded by at least one of the following:
      i. The National Institutes of Health.
      ii. The Centers for Disease Control and Prevention.
      iii. The Agency for Health Care Research and Quality.
      iv. The Centers for Medicare & Medicaid Services.
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
      vii. 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 U.S. Secretary of Health and Human Services determines meets all of the following requirements:
         1. It is comparable to the National Institutes of Health system of peer review of studies and investigations.
         2. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, you will pay the applicable cost share shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the cost share that applies to hospital inpatient care.

Clinical trials exclusions:
1. The investigational Service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet all medical criteria developed by Medical Group and by the facility providing the dialysis; and
3. The facility is certified by Medicare and contracts with Medical Group; and
4. A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover: equipment; training; and medical supplies required for home dialysis. See the "Schedule of Benefits (Who Pays What)."

G. Drugs, Supplies and Supplements

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

In any Accumulation Period, you must pay full Charges for all drugs until you meet your Deductible. After you meet your Deductible, you pay the applicable Copayment or Coinsurance for these drugs for the rest of the Accumulation Period, subject to the annual Out-of-Pocket Maximum limits.

1. Coverage

a. Limited Drug Coverage Under Your Basic Drug Benefit

If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Physician and obtained at Plan Pharmacies, or in the ***Southern, Northern and Mountain Colorado*** Service Areas, at pharmacies designated by Health Plan. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

If your coverage includes supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance applies for these types of drugs. For more information, please refer to the prescription drug benefit description following your "Schedule of Benefits (Who Pays What)."

Note: Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your group has limited or supplemental prescription drug coverage.

b. Outpatient Prescription Drugs

Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." If your prescription drug Copayment shown on the "Schedule of Benefits (Who Pays What)" exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

i. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. Refills of maintenance drugs prescribed by Plan Physicians or Affiliated Physicians may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs have a significant potential for waste and diversion. Those drugs are not available by mail-order service. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please call **Member Services**.

ii. Specialty Drugs

Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

c. Administered Drugs

If the following are administered (1) during a covered stay in a Plan Hospital or Skilled Nursing Facility, or (2) in a Plan Medical Office or during home visits if administration or observation by medical personnel is required, they are covered at the applicable Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What):"

Drugs and injectables; radioactive materials used for therapeutic purposes; vaccines and immunizations approved for use by the U. S. Food and Drug Administration (FDA); and allergy test and treatment materials.

d. Food Supplements

Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism, elemental enteral nutrition and parenteral nutrition are provided under your hospital inpatient care benefit. Such

products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

e. Prescribed Supplies and Accessories
Prescribed supplies and accessories, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
i. home glucose monitoring supplies.
ii. disposable syringes for the administration of insulin.
iii. glucose test strips.
iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)," and, if your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations***:***
a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
b. ***Denver/Boulder, Northern and Mountain Colorado*** Service Areas: Compound medications are covered as long as they are on the compounding formulary.
c. ***Southern Colorado*** Service Area: Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.

3. Drugs, Supplies and Supplements Exclusions***:***
a. Drugs for which a prescription is not required by law.
b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
d. Any packaging except the dispensing pharmacy's standard packaging.
e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
g. Drugs to shorten the length of the common cold.
h. Drugs to enhance athletic performance.
i. Drugs for the treatment of weight control.
j. Drugs available over the counter and by prescription for the same strength.
k. Individual drugs and/or Drug classes determined excluded by our Pharmacy and Therapeutics Committee.
l. Unless approved by Health Plan, drugs:
i. Not approved by the FDA; and
ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. (***Denver/Boulder*** Members only).
n. Prescription drugs necessary for Services excluded under this Evidence of Coverage.

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Physician as described below; when prescribed by a Plan Physician during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
a. Coverage
DME, with the exception of the following is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.

iii. Infant apnea monitors are provided.

b. Durable Medical Equipment Exclusions:
   i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
   ii. Replacement of lost equipment.
   iii. Repair, adjustments or replacements necessitated by misuse.
   iv. More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
   We cover the following prosthetic devices, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accord with this EOC. Including repairs and replacements, of such prosthetic devices.
      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions:
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Physician can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
   Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

I. Early Childhood Intervention Services

1. Coverage
   Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law, are covered for the number of Early Intervention Services (EIS) visits as required by State law. EIS are subject to the Deductible and apply toward the Out-of-Pocket Maximum. EIS are not subject to any Copayments or Coinsurance.

   Note: You may be billed for any EIS received after the number of visits required by State law is satisfied.

2. Limitations
   The number of visits as required by State law does not apply to:
   a. Rehabilitation or therapeutic Services that are necessary as a result of an acute medical condition; or
   b. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal "Individuals with Disabilities Act"; or
   c. Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended.

3. Early Childhood Intervention Services Exclusions**:**
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination, as defined by State or federal law; and
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this Evidence of Coverage.

J. Emergency Services and Non-Emergency, Non-Routine Care

1. Emergency Services
   Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition, call 911 or go to the nearest hospital emergency department. You do not need prior authorization for

Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and non-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them from Plan Providers.

You are also covered for medical emergencies anywhere in the world. For information about emergency benefits away from home, please call **Member Services**.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

a. **Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)**

"Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Physician. There may be times when you or a family member may receive Emergency Services from non-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Medical Offices or the emergency room of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

Please refer to "ii. Emergency Services Limitation for non-Plan Providers," below, if you are hospitalized for Emergency Services.

i. We cover out-of-Plan Emergency Services as follows:

A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis or premature delivery.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

ii. Emergency Services Limitation for non-Plan Providers
If you are admitted to a non-Plan Hospital, non-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** and/or **Quality Resource Coordinator**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible.

b. Emergency Services Exclusions:

Continuing or follow-up treatment. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a Plan Facility we designate either inside or outside our Service Area. When approved by Health Plan or by a Plan Physician in this Service Area or in another Kaiser Foundation Health Plan or allied plan service area, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

2. Non-Emergency, Non-Routine Care

a. Non-Emergency, Non-Routine Care Provided by Plan Providers

i. ***Denver/Boulder*** Service Area
Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities **during** regular office hours. If you need non-emergency, non-routine care during office hours and you are a Member in the ***Denver/Boulder*** Service Area, you can visit one of our Plan Facilities.

Non-emergency, non-routine care needed **after hours** that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services**.

During regular office hours, please call **Advice Nurse** and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

After office hours, please call **After-Hours Medical Needs** for a recorded message about your options and/or to speak with the answering service who will redirect your call, 24 hours a day, 7 days a week.

ii. ***Southern, Northern and Mountain Colorado*** Service Areas
Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities during regular office hours. If you are a ***Southern*** or ***Northern Colorado*** Member and need non-emergency, non-routine care during regular office hours, please call your Plan Physician's office.

Non-emergency, non-routine care needed **after hours** that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, *www.kp.org,* for information on designated after-hours facilities.

After office hours, please call your Plan Physician or go to the provider directory or to our website, *www.kp.org,* for information on our designated after-hours facilities. You may also call the nurse advice line at the telephone number listed in your provider directory or our website, *www.kp.org*.

b. **Out-of-Plan Non-Emergency, Non-Routine Care**

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

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

3. Payment

a. Health Plan's payment for covered out-of-Plan non-emergency, non-routine care Services is based upon fees that we determine to be usual, reasonable and customary. This means a fee that:

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

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

b. Our payment is reduced by:

i. the Copayment and/or Coinsurance for Emergency Services and X-ray Special Procedures performed in the emergency room. The emergency room and X-ray Special Procedures Copayment, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Copayment or Coinsurance for ambulance Services, if any; and
iii. Coordination of benefits; and
iv. any other payments you would have had to make if you received the same Services from our Plan Providers; and
v. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
vi. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

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

K. Family Planning Services

We cover the following:

1. Family planning counseling. This includes pre-abortion and post-abortion counseling and information on birth control.
2. Tubal ligations.
3. Vasectomies.
4. Voluntary termination of pregnancy.

This plan may exclude voluntary, elective abortions and any related Services. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory and X-ray Special Procedures"; contraceptive drugs and devices, see the "Drugs, Supplies and Supplements" section.

L. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

M. Hearing Services

1. Persons Under the Age of 18 Years

   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every 5 years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Persons Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."
   b. Hearing Services Exclusions:
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

N. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services and medical social Services:
   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Physician and administered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Physician and the approved Plan Provider; and
   d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Additional time up to 35 hours per week but less than eight (8) hours per day may be approved by Health Plan on a case-by-case basis.

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

2. Home Health Care Exclusions:
   a. Custodial care.
   b. Homemaker Services.
   c. Care that Medical Group determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.
3. Special Services Program
   If you have been diagnosed with a terminal illness with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   This Program gives you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

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

O. Hospice Care

We cover hospice care for terminally ill Members inside our Service Area. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

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

We cover the following Services and other Benefits when: (1) prescribed by a Plan Physician and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Kaiser Permanente:

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

P. Infertility Services

Infertility Services are **not** covered unless your Group has purchased additional supplemental coverage.

NOTE: To determine if your Group has the infertility benefit, see the "Schedule of Benefits (Who Pays What)."

Q. Mental Health Services

1. Coverage

We cover mental health Services as shown below. Coverage includes evaluation and Services for conditions which, in the judgment of a Plan Physician, would respond to therapeutic management. Mental health includes but is not limited to biologically based illnesses or disorders.

a. **Outpatient Therapy**

We cover: diagnostic evaluation; individual therapy; psychiatric treatment; and psychiatrically oriented child and teenage guidance counseling.

Visits for the purpose of monitoring drug therapy are covered.

Psychological testing as part of diagnostic evaluation is covered.

b. **Inpatient Services**

We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

Separate Coinsurance applies to Services of Plan Physicians and mental health professionals.

c. **Partial Hospitalization**

We cover partial hospitalization in a Plan Hospital-based program.

We cover mental health services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary as determined by a Plan Physician and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions:

a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Plan Physician determines such evaluation to be Medically Necessary.
b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, including but not limited to attention deficit disorder.
c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary.
d. Court-ordered testing and testing for ability, aptitude, intelligence or interest.
e. Services which are custodial or residential in nature.

R. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage

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

We cover physical, occupational and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility and Home Health Care benefit.

b. Outpatient Care
We cover three (3) types of outpatient therapy (i.e., physical, occupational and speech therapy) in a Plan Facility to improve or develop skills or functioning due to medical deficits, illness or injury. See the "Schedule of Benefits (Who Pays What)."

c. Multidisciplinary Rehabilitation Services
We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. After your Deductible has been met, we also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

d. Pulmonary Rehabilitation
We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities. After your Deductible has been met, you pay the applicable physical, occupational and speech therapy Coinsurance. Clinical criteria are used to determine appropriate candidacy for the program, which consists of: an initial evaluation; up to six (6) education sessions; up to twelve exercise sessions; and a final evaluation to be completed within a two to three-month period. See the "Schedule of Benefits (Who Pays What)."

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

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

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

f. Therapies for the Treatment of Autism Spectrum Disorders
For children under the age of 19, we cover the following therapies for the treatment of Autism Spectrum Disorders:
   i. Outpatient physical, occupational and speech therapy in a Plan Medical Office when prescribed by a Plan Physician as Medically Necessary. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers, up to the maximum benefit permitted by State law. See the "Schedule of Benefits (Who Pays What)."

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

3. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions:
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Copayment and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when a Plan Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

2. Reconstructive Surgery Exclusions: Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required. We cover the following Services:

   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

   Note: The following are covered, but not under this section: drugs, see “Drugs, Supplies and Supplements”; DME and prosthetics and orthotics, see “Durable Medical Equipment and Prosthetics and Orthotics”; X-ray, laboratory and X-ray special procedures, see “X-ray, Laboratory and X-ray Special Procedures”.

2. Skilled Nursing Facility Care Exclusion: Custodial Care, as defined in “Exclusions” under the “Limitations/Exclusions (What is Not Covered)”section.

V. Transplant Services

1. Coverage
   Transplants are covered on a **LIMITED** basis as follows:

   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

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

   c. If all medical criteria developed by Medical Group are met, we cover: stem cell rescue; and transplants of organs, tissue or bone marrow.

2. Related Prescription Drugs
   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance shown in the “Schedule of Benefits (Who Pays What).”

3. Terms and Conditions
   a. Health Plan, Medical Group and Plan Physicians do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accord with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

   b. Plan Physicians must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

c. A Plan Physician must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Physician or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations:
   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Getting a Referral" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

W. Vision Services

1. Coverage
   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the Schedule of Benefits (Who Pays What). We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.

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

Your Group may have purchased additional optical coverage. See "Additional Provisions."

X. X-ray, Laboratory and X-ray Special Procedures

1. Coverage
   a. Outpatient
      We cover the following Services:
      i. Diagnostic X-ray and laboratory tests, Services and materials, which includes but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms and ultrasounds.
      ii. Therapeutic X-ray Services and materials.
      iii. X-ray Special Procedures such as MRI, CT, PET and nuclear medicine. Note: Members will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. The Member is responsible for any applicable Copayment or Coinsurance for X-ray Special Procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, non-emergency, non-routine care, and outpatient surgery.

   b. Inpatient
      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory and X-ray Special Procedures Exclusions:
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What) to determine if you group has purchased additional coverage.

   a. Acupuncture Services;
   b. Naturopathy Services;
   c. Massage therapy;
   d. Spinal Manipulation Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Bariatric Surgery and Cosmetic Surgery Related to Bariatric Surgery.**

3. **Certain Exams and Services.** Physical exams and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for:

   a. Employment;
   b. Participation in employee programs;
   c. Insurance;
   d. Disability;
   e. Licensing; or
   f. On court order or for parole or probation.

4. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

5. **Custodial Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting and taking medicine.

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Physician for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma and, unless otherwise specified herein, (a) and (b) are received at a Plan Hospital, Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if a Plan Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** Disposable supplies for home use such as:

   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;
   e. Dressings;
   f. Ace-type bandages; and
   g. Any other supplies, dressings, appliances or devices, not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

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

10. **Experimental or Investigational Services:**

a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:

   i. Has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
   ii. Is the subject of a current new drug or new device application on file with the FDA; or
   iii. Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity or efficacy of the Service; or
   iv. Is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; or
   v. Is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity or efficacy of Services; or
   vi. The Service has not been recommended for coverage by the Regional New Technology and Benefit Interpretation Committee, the Interregional New Technology Committee or the Medical Technology Assessment Unit based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
   vii. Is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity or efficacy; or
   viii. Is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity or efficacy of the Service.

b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:

   i. The Member's medical records; and
   ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
   iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
   iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
   v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
   vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

11. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.

12. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased supplemental coverage.

13. **Intermediate Care.** Care in an intermediate care facility.

14. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

15. **Services for Members in the Custody of Law Enforcement Officers.** Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or out-of-Plan non-emergency, non-routine care.

16. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

17. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

18. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accord with our internal travel and lodging guidelines in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services as described under "Getting a Referral" in the "How to Access Your Services and Obtain Approval of Benefits" section. Travel and lodging expenses are not covered for Members who are referred to a non-Plan Facility for non-transplant medical care. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

19. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

20. **Weight Management Facilities.** Services received in a weight management facility.

21. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:

    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been 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.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot, civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

   The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

   This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

   The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

   DEFINITIONS

   a. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

      i. "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans 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.
      ii. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

      Each contract for coverage under i. or ii. is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

b. "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this 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.

c. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits, so that all plan benefits do not exceed 100% of the total Allowable expense.

d. "Allowable expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person 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 examples of expenses that are not allowable expenses:

i. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
ii. If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
iii. If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.
iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the secondary plan to determine its benefits.
v. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. "Claim determination period" is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

f. "Closed panel plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. "Custodial parent" means a parent awarded primary 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 two or more plans pay benefits, the rules for determining the order of payment are as follows:

a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

b. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

i. There is an exception: Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

d. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

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

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

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

1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
2. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.

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

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
2. 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;
3. 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
4. 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 child are as follows:
   - The plan covering the custodial parent;
   - The plan covering the spouse of the custodial parent;
   - The plan covering the non-custodial parent; and then
   - The plan covering the spouse of the non-custodial parent.

C. For a dependent child covered under more than one Plan of individuals who are not 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.

iii. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary 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 retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order of benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order of benefits.

v. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the Secondary plan.

vi. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the secondary 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 its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. 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-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

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 plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Health Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Health Plan is more than it should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have 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.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties

You must reimburse us 100% of Charges for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers’ compensation coverage or (e) any other liability coverage.

If you are involved in an automobile-related accident, please contact **Patient Financial Services** right away so that we can coordinate benefits with the automobile insurance carrier and determine whether we or the automobile insurance carrier has primary coverage.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant Services.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against any other party, regardless of whether the other party admits fault. The proceeds of any judgment or settlement that you, your attorney or your representative get shall first be applied to fully satisfy our lien, even if the total amount of your recovery from all sources is less than the actual or estimated losses and damages you incurred, and without regard of how the proceeds are characterized or itemized. We deny any application of the Made Whole doctrine.

We will not be responsible for any fees you incur to obtain any judgment or settlement. Costs we incur will be borne by us. Costs of your representation will be borne by you. We deny any application of the Common Fund doctrine. Proceeds of such judgment or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against any other party, you must send written notice of the claim or legal action to **Patient Financial Services**. For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

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

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

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

Note: For recoveries on or after August 11, 2010, reimbursement for benefits will be governed by state law.

3. Surrogacy
   In situations where you receive monetary compensation to act as a surrogate, Health Plan will seek reimbursement of Charges for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, up to the monetary amount you receive to act as a surrogate. 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.

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and Non-Emergency, Non-Routine Care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from non–Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by non-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado State law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Physicians have telephone access to interpreters in over 150 languages.
3. Plan Physicians can also request an onsite interpreter for an appointment, procedure or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504).

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507).

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Binding Arbitration

Except for: (1) claims filed in Small Claims Court; (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) Benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan Providers or Affiliated Physicians ("Respondent(s)") must be submitted to binding arbitration before a single neutral arbiter. Claims are those that arise from any alleged failure or violation of, including but not limited to: any duty relating to or incident to the Evidence of Coverage or the Medical and Hospital Services Agreement; claims for contract benefits; premises liability; or claims related to the delivery of Services or items, regardless of the basis for the duty or of the legal theories upon which the claim is asserted. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

You must use Health Plan procedures to request arbitration. You can get a copy of these procedures from our **Quality, Risk, and Patient Safety** department**.** The arbitration hearing will be held in accord with Health Plan procedures, the Colorado Uniform Arbitration Act and the Federal Arbitration Act.

K. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this

EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

L. Contracts with Plan Providers

Your Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments and Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

M. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit will be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be eligible for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department**. To get a copy of the Prior Carrier Information Cover Form, please call **Claims Customer Service.**

N. Governing Law

Except as preempted by federal law, this EOC will be governed in accord with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

O. Group and Members not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

P. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Q. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

R. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

S. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

T. Privacy Practices

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Member Services. You can also find the notice at your local Plan Facility or on our website, *www.kp.org***.**

U. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give the Member more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you only need to:

1. Show your Health Plan ID card; and
2. Pay the fee, if any; to the company that provides the value-added service.

Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as deductible or out-of-pocket maximum.

To learn about value-added services and which ones are available to you, please check our:

1. Quarterly member magazine*;* or
2. Website, *www.kp.org*.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Dues.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

V. Women's Health and Cancer Rights Act

In accord with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination of Membership" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in Section I, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Dues, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts:

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan or a Plan Provider 's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Physician has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

A. Performed an act, practice, or omission that constitutes fraud; or
B. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Dues, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)
   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law
   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six

(6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Dues to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

a. Your coverage is through a Subscriber who dies, divorces or legally separates or becomes entitled to Medicare or Medicaid benefits; or
b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the "Eligibility" section.

To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Dues, no later than 30 days after the date on which your Group coverage would otherwise terminate.

Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Dues to your Group and terminates on the earlier of:
a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
b. The date you become covered under another group medical plan; or
c. The date Health Plan terminates its contract with the Group.

We may terminate your continuation coverage if payment is not received when due.

If you have chosen an alternate health care plan offered through your Group, but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA
If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Dues, Copayments and Coinsurance may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of premiums (also called rescission or cancellation retroactively), or
   c. uphold our previous adverse benefit determination when you appeal.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, then such evidence establishes that the denial is subject to the appeals process.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described below in this "Appeals and Complaints" section.

Language and Translation Assistance
You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim
If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect
If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures
There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission).

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized or pre-certified in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

a. Pre-Service Claim
Tell Health Plan in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal thereof, to permit you to pursue an expedited external review.

We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within the initial 15 day decision period, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

We will send written notice of our decision to you and, if applicable to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal
Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal
Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 you are requesting; or (c) your attending provider requests that your appeal be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 extending your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your claim, we will make our decision but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 day decision period ends and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all

the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal
Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal
Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see “External Review” in this “Appeals and Complaints” section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 continuing your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals
Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim
Within 180 days from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received

them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after 180 days from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the end of the initial 30 day decision period ends, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal
Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)
We may terminate your membership retroactively (see Rescission of Membership under Section VIII. Termination/Nonrenewal/Continuation). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call the **Member Services Call Center** at **1-866-846-2650**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level Appeal
A Voluntary Second Level Appeal is another review by us that occurs after the mandatory internal appeal decision is communicated to you if you remain dissatisfied with our decision. This in-person review permits you to present evidence to the Second Level Appeal Panel and to ask questions. Choosing a Voluntary Second Level Appeal will not affect your right, if you have one, to request an independent external review.

Here is the procedure for a Voluntary Second Level of Appeal:

Within 30 days from the date of your receipt of our notice regarding your internal appeal. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination (mandatory internal appeal decision), and (5) all supporting documents. Your request and the supporting documents constitute your request for a Voluntary Second Level of Appeal. You must mail your request to the **Appeals Program**.

Within sixty (60) calendar days following receipt of your request, Health Plan will hold a Second Level Appeal meeting. Health Plan shall notify you of the date on which the Second Level Appeal Panel will meet at least 20 days prior to the date of this in-person meeting. You may request to postpone this date, and your request cannot be unreasonably denied by Health Plan.

You may present your appeal in person before the Second Level Appeal Panel, or request a file review. If you would like to present your appeal in person, but an in-person meeting is not practical, you may present your appeal by telephone. Please indicate in your appeal request how you want to present your appeal. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review.

You may request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least five (5) days prior to the date of the Second Level Appeal meeting.

You may submit additional information with your appeal request, or afterwards but no later than five (5) days prior to the date of your Second Level Appeal meeting. Any additional new material developed after this deadline shall be provided to us as soon as practicable. You may present your case to the Second Level Appeal Panel and ask questions of the Panel. You may be assisted or represented by an appointed representative of your choice including an attorney (at your own expense), other advocate or health care professional. If you decide to have an attorney present at the Second Level Appeal meeting, then you must let us know that at least seven (7) days prior to that meeting. You must appoint this attorney as your representative in accordance with our procedures.

We will issue a written decision within seven (7) days of the completion of the Voluntary Second Level Appeal meeting.

If you would like further information about the Voluntary Second Level Appeal process, to assist you in making an informed decision about pursuing a Voluntary Second Level Appeal, please call the **Appeals Program**. Your decision to pursue a Voluntary Second Level Appeal will have no effect on your rights to any other Health Plan benefits, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

Following receipt of an adverse decision letter regarding you First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision, if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review. However, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have an existing disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this 5 working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Dues, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

Charge(s):
1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment: The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Dues: Periodic membership charges paid by Group.

Emergency Medical Condition: A medical 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:
1. Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services: All of the following with respect to an Emergency Medical Condition:
1. A medical screening examination (as required under the *Emergency Medical Treatment and Active Labor Act*) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the *Emergency Medical Treatment and Active Labor Act* requires to Stabilize the patient.

Family Unit: A Subscriber and all of his or her Dependents.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a

qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

High Deductible Health Plan (HDHP): A health benefit plan that meets the requirements of Section 223 (c)(2) of the Internal Revenue Code. The health care coverage under this EOC has been designed to be a High Deductible Health Plan compatible for use with a Health Savings Account.

Kaiser Permanente: Health Plan and Medical Group

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

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

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Dues. This EOC sometimes refers to a Member as "you" or "your."

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A Plan Medical Office or Plan Hospital.

Plan Hospital: Any hospital listed as a Plan Hospital in our provider directory. Plan Hospitals are subject to change at any time without notice.

Plan Medical Office: Any medical office listed in our provider directory. Plan Medical Offices are subject to change at any time without notice.

Plan Optometrist: Any licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies are subject to change at any time without notice.

Plan Physician: Any licensed physician who is an employee of Medical Group, an Affiliated Physician or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician or other health care provider that we designate as Plan Provider, except that Plan Providers are subject to change at any time without notice.

Service Area:
The ***Denver/Boulder*** Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park, Teller and Weld counties within the following zip codes: 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231, 80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80252, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80437, 80439, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80623, 80640, 80642, 80643.

The ***Mountain Colorado*** Service Area is that portion of Eagle, Garfield, Grand, Routt and Summit counties within the following zip codes: 80423. 80424, 80426, 80435, 80443, 80463, 80497, 80498, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658.

The ***Northern Colorado*** Service Area is that portion of Adams, Boulder, Larimer, Morgan, and Weld counties within the following zip codes: 69128, 69145, 80511, 80512, 80513, 80515, 80517, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80532, 80534, 80535, 80536, 80537, 80538, 80539, 80541, 80542, 80543, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80610, 80611, 80612, 80615, 80620, 80622, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82082.

The ***Southern Colorado*** Service Area is that portion of Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132, 80133, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80943, 80944, 80945, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spinal Manipulation: Adjustment and manipulation of the vertebral column.

Spouse: Your partner in marriage or a civil union as determined by State law.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-gender domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this Evidence of Coverage; and

(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

DOMP0AA (01-15)

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

You must live or work in Health Plan's Service Area at the time of enrollment.

WOR0AA (01-10)DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device or orthotic device that adequately meets a Member's medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage:
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Physician, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.
   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.
   c. Durable Medical Equipment Exclusions:
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.
      iv. Exercise or hygiene equipment.
      v. Comfort, convenience, or luxury equipment or features.
      vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
      vii. Replacement of lost equipment.
      viii. Repairs, adjustments or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.
x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and when obtained from sources designated by Health Plan.
   b. Prosthetic Devices Exclusions:
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate, as described above.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.
      iv. Spare devices or alternate use devices.
      v. Replacement of lost prosthetic devices.
      vi. Repairs, adjustments or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
      Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions:
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accord with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost orthotic devices.
      vii. Repairs, adjustments or replacements necessitated by misuse.

DMES0AB (01-16)

PREVENTIVE SERVICES RIDER

Preventive care services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the " Schedule of Benefits (Who Pays What)" when prescribed by a Plan Physician. Please contact Member Services for a complete list of covered Preventive Services.

Coverage includes, but not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your Primary Care Plan Physician.
3. Cervical cancer screening.
4. Breast cancer screening.
5. Cholesterol screening.
6. Colorectal cancer screening.
7. Immunizations pursuant to the schedule established by the ACIP.
8. Tobacco use screening of adults and tobacco cessation interventions by your Primary Care Plan Physician.
9. Type 2 diabetes screening for adults with high blood pressure.
10. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
11. Prostate Cancer screening.
12. Cervical cancer vaccines.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. www.cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.

PV0AA (01-14)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan Drug Formularies. The term "non-preferred" refers to drugs that are not included in the Health Plan Drug Formularies.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible and supply limits that apply to the covered prescription drugs described below.

1. Coverage:
   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; specialty drugs, including self-administered injectable drugs; and a tier for prescribed non-preferred drugs authorized through the non-preferred drug process.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.
   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs:
   a. Available in the United States only from a single manufacturer; and
   b. Not listed as generic in the then-current commercially available drug database(s) Health Plan subscribes to;
   are provided at the brand-name Copayment. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Physician and are obtained at Plan Pharmacies; or
   b. Physician to whom a Member has been referred by a Plan Physician and are obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions); and are obtained at Plan Pharmacies.

   Covered drugs include:

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

   b. Insulin

   c. For Denver/Boulder and Northern Colorado Service Areas, compounded medications as long as they are on the compounding formulary.

2. Limitations for Southern Colorado Service Area:
   a. Some drugs may require prior authorization.
   b. Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.
   c. Plan Physicians may apply for formulary exceptions in cases where it is Medically Necessary.

3. Drugs, Supplies and Supplements Exclusions:
   a. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   b. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   c. Any drugs listed as not covered in the Schedule of Benefits
   d. Drugs to shorten the length of the common cold.
   e. Drugs to enhance athletic performance.
   f. Drugs available over the counter and by prescription for the same strength.
   g. Individual drugs and/or Drug classes determined excluded by our Pharmacy and Therapeutics Committee.
   h. Drugs for the treatment of weight control.
   i. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   j. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
   k. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.

RX0BL (01-16)

NOTES

Kaiser Foundation Health Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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AMANDA B PERERA
3088 RED DEER TRL
LAFAYETTE, CO 80026-9322

Important plan information

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TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Health Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2016 contract year.

Important Information

The below section is changed as follows (changes are underlined)

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

H. Cross Market Access

Members may access certain Services at Kaiser Permanente Plan Medical Offices outside of their home Service Area.

1. ***Denver/Boulder*** Members***:***
   Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the ***Southern, Northern and Mountain Colorado*** Service Areas. ***Denver/Boulder*** Members do not have access to Affiliated Providers in ***Southern, Northern or Mountain Colorado*** unless authorized by Health Plan.

2. ***Southern, Northern and Mountain Colorado*** Members***:***
   Southern, Northern and Mountain Colorado Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the ***Denver/Boulder*** Service Area.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; after-hours care; pharmacy; laboratory; X-ray; vision; and hearing Services. These Services may not be available at all Plan Medical Offices and are subject to change. For more information on what Services you may access outside your designated home Service Area and at which designated Kaiser Permanente Plan Medical Offices, if applicable, you may receive Services at, please call **Member Services**.

CMDBMTAP (02-16)

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

Benefits for CITY OF LOUISVILLE

5920 - 008

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS

III. COPAYMENTS AND COINSURANCE

IV. DEPENDENT LIMITING AGE

V. DEPENDENT STUDENT LIMITING AGE

IMPORTANT INFORMATION PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the identical heading in the "Benefits/Coverage (What Is Covered)" section and to the "Limitations/Exclusions (What Is Not Covered)" section of this EOC. Here is some ***important information*** to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. A Plan Physician ***must*** determine that the Service is ***Medically Necessary*** to prevent, diagnose or treat your medical condition. A Service is Medically Necessary ***only*** if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health; ***and***
   b. The Service ***must be*** provided, prescribed, authorized or directed by a Plan Physician; ***and***
   c. The Service ***must be*** a ***covered*** Service described in this EOC.
2. The Charges for your Services are ***not*** always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. In addition to any Copayment or Coinsurance, you may be responsible for any amounts over usual, reasonable and customary charges.
6. You may be charged separate Deductibles, Copayments or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
7. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
8. For items ordered in advance, you pay the Deductibles, Copayments or Coinsurance in effect on the order date.
9. You, as the Subscriber, are responsible for any Deductibles, Copayments and/or Coinsurance, incurred by your Dependents enrolled in the Plan.
10. Dollar, day and visit limits, Deductibles and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

I. DEDUCTIBLES

A. The following medical Deductibles apply under your plan:

This plan has an:

EMBEDDED Medical Deductible

$1,000/Individual per Accumulation Period

$2,000/Family per Accumulation Period

(Applies to Out-of-Pocket Maximum)

(see "3. Definitions of Aggregate and Embedded Individual and Family Medical Deductibles")

The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies. Covered Services may or may not be subject to the medical Deductible. It depends on the plan your Group has purchased.

For covered Services that are subject to the medical Deductible, any amounts over usual, reasonable and customary charges will not apply toward the medical Deductible.

1. For covered Services that **ARE** subject to the medical Deductible:
   a. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.
   b. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").
   c. If your Group purchased a plan with a pharmacy Deductible, payments made for prescription drugs will be applied *only* to the pharmacy Deductible. Your applicable Copayment, Coinsurance, and medical Deductible may apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").
2. For covered Services that **ARE NOT** subject to the medical Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance."
3. **Definitions of Aggregate and Embedded Individual and Family Medical Deductibles:**
   a. **Aggregate Medical Deductible:**
      i. For plans with self only coverage (e.g., no dependents covered on the plan):
         - The individual medical Deductible amount applies.
         - After the individual medical Deductible is met, the Member will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.
      ii. For plans with two or more Members:
         - There is no individual medical Deductible.
         - The family medical Deductible amount applies to the entire family as a whole (e.g. it is a cumulative family medical Deductible, which the entire family must collectively meet).
         - After the family medical Deductible is met, all covered family Members will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.
   b. Embedded Medical Deductible:
      i. Each individual family Member has his or her own medical Deductible.
      ii. If a family Member reaches his or her individual medical Deductible before the family medical Deductible is met, he or she will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period.
      iii. The entire family as a whole has a cumulative family medical Deductible. After the family medical Deductible is met, all covered family Members will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period. This is true even for family Members who have not met their individual medical Deductible.

B. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

1. For prescription drugs that **ARE** subject to the pharmacy Deductible:

   a. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Drugs, Supplies and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.

   b. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Drugs, Supplies and Supplements").

   c. If your Group purchased a plan with a pharmacy Deductible, payments made for prescription drugs will be applied *only* to the pharmacy Deductible. Your pharmacy Deductible does not apply to the medical Deductible and accumulates separately from the medical Deductible.

   d. Your applicable Copayment, Coinsurance, and/or pharmacy Deductible may not apply to your annual Out-of-Pocket Maximum (OPM) (see "II. Annual Out-of-Pocket Maximums").

2. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible: Your Copayment or Coinsurance will always apply, as listed in "III. Copayments and Coinsurance", "Drugs, Supplies and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The following Out-of-Pocket Maximum (OPM) amounts apply under your plan:

This plan has an:

EMBEDDED OPM
$3,000/Individual per Accumulation Period
$6,000/Family per Accumulation Period

(see "D. Definitions of Aggregate and Embedded Individual and Family OPM")

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply to the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply to the OPM, any amounts over usual, reasonable and customary charges will not apply toward the OPM.

A. Your Deductible(s) may apply to the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** to the OPM.

   1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** to the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** to the OPM.

   1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").

   2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** to the OPM for the rest of the Accumulation Period.

D. Definitions of Aggregate and Embedded Individual and Family OPM

1. **Aggregate OPM:**
   a. For plans with self only coverage (e.g., no dependents covered on the plan):
      i. The individual OPM amount applies.
      ii. After the individual OPM is met, the Member will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.
   b. For plans with two or more Members:
      i. There is no individual OPM.
      ii. The family OPM amount applies to the entire family as a whole (e.g. it is a cumulative family OPM, which the entire family must collectively meet).
      iii. After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for covered Services that apply to the OPM for the rest of the Accumulation Period.
2. **Embedded OPM:**
   a. Each individual family Member has his or her own OPM.
   b. If a family Member reaches his or her individual OPM before the family OPM is met, he or she will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period.
   c. The entire family as a whole has a cumulative family OPM. After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.

Tracking Deductible(s) and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will send you an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your Deductible(s) and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services**.

III. COPAYMENTS AND COINSURANCE

Medical Deductible	
(Applies to Out-of-Pocket Maximum)	This plan has an: EMBEDDED Medical Deductible $1,000/Individual per Accumulation Period $2,000/Family per Accumulation Period

Out-of-Pocket Maximum	
	This plan has an: EMBEDDED OPM $3,000/Individual per Accumulation Period $6,000/Family per Accumulation Period

Outpatient Care	You Pay
Primary care visits *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)
Specialty care visits *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)
Consultations with clinical pharmacists *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)
Allergy injections *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Covered Services including allergy serum received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits) Additional charges may apply for allergy serum (see Covered Services in this "Outpatient Care" section for applicable Copayment or Coinsurance)
Allergy evaluation and testing *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Gynecology care visits *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $30 Copayment each visit Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)
Routine prenatal and postpartum visits *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Outpatient surgery at designated outpatient facilities *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Hospital Inpatient Care	You Pay
(See III. "Benefits/Coverage (What Is Covered)", B. "Hospital Inpatient Care", in this EOC for the list of covered Services) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Inpatient professional Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Ambulance Services	You Pay
(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to $500 per trip

Bariatric Surgery	You Pay
(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)	50% Coinsurance Includes inpatient and outpatient covered Services

Chemical Dependency Services	You Pay
Inpatient medical detoxification *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Inpatient professional Services for medical detoxification *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Outpatient individual therapy *Visit:(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit $15 Copayment per partial hospitalization day Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)
Outpatient group therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	Visit: 50% of individual therapy Copayment Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)
Residential rehabilitation *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance per inpatient admission

Complementary and Alternative Medicine	You Pay
Spinal manipulation Services *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Acupuncture Services *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

Dialysis Care	You Pay
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance

Drugs, Supplies and Supplements	You Pay
Office administered drugs *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Travel immunizations	Not Covered
Outpatient prescription drugs Copayment/Coinsurance (except as listed below): *(Prescriptions are not subject to the medical Deductible. Prescriptions are subject to the pharmacy Deductible except as otherwise listed in this "Drugs, Supplies and Supplements" section. Prescriptions: Do apply to Out-of-Pocket Maximum)*	$15 Generic/$30 Brand name/50% Non-preferred Tobacco cessation and contraceptive drugs at No Charge
• Pharmacy Deductible *Do apply to Out-of-Pocket Maximum*	Not Applicable
• Infertility drugs	Not Covered
• Over the counter items (OTC): *(Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to pharmacy Deductible)*	No Charge
• Prescribed supplies *(Not subject to pharmacy Deductible)*	20% Coinsurance
• Sexual dysfunction drugs	Not Covered
• Specialty drugs	20% Coinsurance up to $250 per drug dispensed Insulin @ applicable Copayment/Coinsurance
	Supply Limit
Day supply limit	30 days
Mail-order supply limit	90 days @ 2 Copayments See Additional Provisions

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
	Annual Maximum Benefit
Annual maximum benefit paid by Health Plan	Not Applicable
	You Pay
Durable medical equipment *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Breast pumps *(**If covered**, must be obtained within 6 months (180 days) following delivery; Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Prosthetic devices	
• Internally implanted prosthetic device *(See "Hospital Inpatient Care" and "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)*	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment(s) and/or Coinsurance
• Prosthetic arm or leg *(Subject to medical Deductible;Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• All other prosthetic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Orthotic devices *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance See Additional Provisions
Oxygen *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Emergency Services and Non-Emergency, Non-Routine Care	You Pay
Plan and non-plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded above, see "X-ray, Laboratory and Special Procedures" "for applicable Copayment or Coinsurance.
Non-emergency, non-routine visits at Plan Facilities after regular office hours *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$50 Copayment each visit
Covered Services received during after hour visits to Plan Facilities *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Family Planning Services	You Pay
Family planning counseling *(See "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance
Associated outpatient surgery procedures *(See "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance

Health Education Services	You Pay
Training in self-care and preventive care *(See "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction *Exam: (Exam: Copayment does not apply to medical Deductible* *Hearing aids for minors: Coinsurance applies to medical Deductible; Exam: Copayment applies to Out-of-Pocket Maximum* *Hearing aids for minors: Coinsurance applies to Out-of-Pocket maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Exam: $15 Copayment each visit Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)
Hearing aids for persons under the age of 18 *(Exam: Copayment does not apply to medical Deductible* *Hearing aids for minors: Coinsurance applies to medical Deductible; Exam: Copayment applies to Out-of-Pocket Maximum* *Hearing aids for minors: Coinsurance applies to Out-of-Pocket maximum)*	20% Coinsurance
Hearing aids for persons age 18 and over *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

HMO Plus	You Pay
Preventive care visits with a non-Plan Provider *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Primary care and allergy injection visits, outpatient mental health and chemical dependency individual therapy and short-term outpatient physical, occupational and speech therapy visits with a non-Plan Provider *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Specialty and gynecology care visits and allergy testing and evaluations with a non-Plan Provider *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
Covered Services received during an office visit with a non-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services and X-ray special procedures *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered
	Maximum Visit Limit
Maximum visit limit per Accumulation Period	Not Applicable

Home Health Care	You Pay
Health Services provided in your home and prescribed by a Plan Physician *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Special Services program For hospice-eligible Members who have not yet elected hospice care *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge

Hospice Care	You Pay
Hospice care for terminally ill patients *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance

Infertility Services	You Pay
All covered Services related to the diagnosis and treatment of infertility *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions
Artificial insemination, including associated X-ray and laboratory Services *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	50% Coinsurance See Additional Provisions

Mental Health Services	You Pay
Inpatient psychiatric hospitalization *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Inpatient day limit	20% Coinsurance No inpatient day limit
Inpatient professional Services for psychiatric hospitalization *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance No inpatient day limit
Outpatient individual therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit $15 Copayment per partial hospitalization day Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)
Outpatient group therapy *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other covered Services: (Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	Visit: 50% of individual therapy Copayment Covered Services received during a visit: 20% Coinsurance (does not apply to any covered Service listed elsewhere in this Schedule of Benefits)

Out-Of-Area Student	You Pay
• Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health* and *chemical dependency, gynecology care, prevention visit and a visit with the administration of allergy injections. Does not include: allergy evaluation, routine prenatal and postpartum visits, spinal manipulations, acupuncture services, hearing exams, home health visits, hospice services, physical, occupational, and speech therapy, and applied behavioral analysis (ABA).)* *Visit: (Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* *Other Services: (Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Visit: $15 Copayment each visit Other Services received during an office visit: Not Covered Limited to 5 visits per Accumulation Period
• Diagnostic X-ray Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Limited to 5 diagnostic X-rays per Accumulation Period
• Outpatient prescription drugs *(Not subject to pharmacy Deductible; Prescriptions: Do apply to Out-of-Pocket Maximum)*	See “Drugs, Supplies and Supplements” for applicable Copayment or Coinsurance Limited to 5 prescription drug fills per Accumulation Period

Physical, Occupational, and Speech Therapy and Multidisciplinary Rehabilitation Services	You Pay
Inpatient treatment in a multidisciplinary rehabilitation program provided in a designated rehabilitation facility *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Up to 60 days per condition per Accumulation Period
Inpatient professional physical, occupational and speech therapy Services *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurace
Short-term outpatient physical, occupational and speech therapy visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$40 Copayment each visit Up to 20 visits per therapy per Accumulation Period
Pulmonary rehabilitation *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$5 Copayment each visit
Therapies for the treatment of Autism Spectrum Disorders	
• Outpatient physical, occupational and speech therapy visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$40 Copayment each visit
• Applied Behavioral Analysis (ABA) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
• Annual benefit maximum for children ages 0 through 8	Minimum of 550 visits/year *
• Annual benefit maximum for children ages 9 up to 19	Minimum of 185 visits/year *
*Per Colorado law, we will provide the equivalent of what was required prior to May 13, 2013: total visits equivalent to a benefit of $34,000 annually in ABA therapy benefits for children from birth through age 8, and $12,000 annually in ABA therapy benefits for children age 9 to 19.	

Preventive Care Services	You Pay
• Preventive care visits *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)* • Adult preventive care exams • Well-woman care exams • Immunizations	No Charge
• Colorectal cancer screenings (*Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge Additional charges may apply for pathology Services. For example lab Services performed on a removed polyp (see Diagnostic Laboratory Services under "X-ray, Laboratory and Special Procedures" section for applicable Copayment or Coinsurance)
• Adult preventive care screenings *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Well-woman care screenings *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
• Well-child care *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge for children through age 17

Reconstructive Surgery	You Pay
(See "Hospital Inpatient Care" and "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment or Coinsurance

Skilled Nursing Facility Care	You Pay
(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)	20% Coinsurance Up to 100 days per Accumulation Period

Transplant Services	You Pay
(See "Hospital Inpatient Care" and "Outpatient Care" for medical Deductible and Out-of-Pocket Maximum information)	See "Hospital Inpatient Care" and "Outpatient Care" for applicable Copayment or Coinsurance

Vision Services and Optical	You Pay
Eye refraction test when performed by an Optometrist *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$15 Copayment each visit
Eye refraction test when performed by an Ophthalmologist *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	$30 Copayment each visit
Optical hardware *(Not subject to medical Deductible; Does not apply to Out-of-Pocket Maximum)*	Not Covered

X-ray, Laboratory and Special Procedures	You Pay
Diagnostic laboratory Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals) *(Not subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	No Charge
Diagnostic laboratory Services received in the outpatient department of a Plan Hospital *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Diagnostic X-ray Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals); *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Diagnostic X-ray Services received in the outpatient department of a Plan Hospital *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
Therapeutic X-ray Services received during an office visit, in a Plan Medical Office, in a contracted free-standing facility, or a Plan Hospital *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance
X-ray special procedures including but not limited to CT, PET, MRI, nuclear medicine *(Subject to medical Deductible; Applies to Out-of-Pocket Maximum)*	20% Coinsurance Copayment waived if X-ray special procedure is performed during an Emergency Room visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

IV. DEPENDENT LIMITING AGE

The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. A Dependent child will continue to be eligible until the Dependent child reaches this age, if he or she continues to meet all other eligibility requirements. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the “Eligibility” section in the EOC.

V. DEPENDENT STUDENT LIMITING AGE

The Dependent student limiting age as described under Dependents in the "Eligibility" section is the end of the month in which age 26 is reached.

Additional Provisions

Please see “Additional Provisions” for any supplemental information that applies to your coverage.

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AMENDMENT TO
EVIDENCE OF COVERAGE

POINT-OF- SERVICE (POS) PLANS

Your "Kaiser Permanente POS Plan" coverage gives you the ability to choose between two different health care options each time you seek care. You can receive Services through Kaiser Foundation Health Plan (Health Plan) or through your separate indemnity coverage provided by the Kaiser Permanente Insurance Company (KPIC).

This Evidence of Coverage (EOC) describes the Services covered by Health Plan that you receive from Kaiser Permanente Plan Providers at Plan Facilities. The KPIC *Certificate of Insurance* and *Schedule of Coverage* describe the Services covered by KPIC that you receive from participating providers and/or non-participating providers. KPIC coverage is not described in this EOC. To obtain a copy of your KPIC *Certificate of Insurance* and *Schedule of Coverage*, please call KPIC weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. ***Denver/Boulder*** Members, please call **Member Services** at **303-338-3800** or toll free **1-800-632-9700**. ***Southern Colorado*** Members, please call toll-free **1-888-681-7878**. ***Northern Colorado*** Members, please call toll-free **1-800-632-9700**. ***Mountain Colorado*** Members, please call toll-free **1-844-837-6884**.

The benefits, Deductibles, Copayments, and/or Coinsurance for Health Plan and KPIC are not the same. Some Services may be covered by one health care option, but not the other. A covered Service will be provided by one of the plans, but never by both. Neither Health Plan nor KPIC is responsible for a Member's decision to receive care under this EOC or the KPIC *Certificate of Insurance* and *Schedule of Coverage*.

The Deductibles and Out-of-Pocket Maximums in each tier or benefit level under your "Kaiser Permanente POS Plan" accumulate separately. That is, amounts paid toward the Deductibles and Out-of-Pocket Maximum for Services received from Health Plan cannot be used to satisfy the Deductible and Out-of-Pocket Maximum for Services received in KPIC's participating provider or non-participating provider tier or benefit level. Likewise, amounts paid toward the Deductibles and Out-of-Pocket Maximum for Services received from KPIC's participating provider or non-participating provider tier or benefit level generally cannot be used to satisfy the Deductible and Out-of-Pocket Maximum for Services received from Health Plan. Any exceptions will be noted in your KPIC *Certificate of Insurance* and *Schedule of Coverage.*

Please note prescriptions obtained from KPIC providers may be filled at Health Plan Pharmacies at the applicable Health Plan charge for medications on the Kaiser Permanente formulary; and routine lab and diagnostic X-ray orders obtained from KPIC providers may be brought to Health Plan Facilities and will be charged at the applicable Health Plan benefit level.

When you choose to use your Health Plan benefits covered under this EOC, you are selecting Kaiser Permanente's medical care program to provide your health care.

The Following Sections of your EOC are Amended, as Follows:

I. **Section II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS is amended by deleting, in its entirety, the Subsection titled "Out-of-Area Student Benefit."** Any references to "Out-of-Area Student Benefit" in the "Schedule of Benefits (Who Pays What), or anywhere else in this Evidence of Coverage, are also deleted in their entirety.

II. **Section IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED), Subsection "A. Exclusions," is amended to read as follows:**

A. Exclusions

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What Is Covered)" section. If a Service is not covered under this EOC, check your KPIC *Certificate of Insurance* and *Schedule of Coverage* to determine if it is covered by KPIC.

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AMENDMENT TO
EVIDENCE OF COVERAGE

POINT-OF- SERVICE (POS) PLANS

III. Section IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED), Subsection "C. Reductions, (1) Coordination of Benefits (COB)" is amended by *adding* the following paragraph to this subsection:

Note: The benefits administered by Health Plan as described in this *EOC* and the benefits administered by KPIC as described in your KPIC *Certificate of Insurance* and *Schedule of Coverage* are considered one plan for the purposes of coordination of benefits. Since a Service cannot be covered by both coverage options at the same time, there is no coordination of benefits between the two coverage options.

IV. The introductory paragraph of Section VIII. TERMINATION/NONRENEWAL/ CONTINUATION is amended by adding the following paragraph:

If for any reason, you lose your KPIC coverage administered by KPIC, your Health Plan coverage described in this *EOC* will terminate on the same date. Check with your Group to discuss alternative health plan options.

V. Section VII. GENERAL POLICY PROVISIONS is amended by *adding* the following provision:

POS Coverage

Health Plan is not responsible for the obligations of KPIC nor for its decisions regarding KPIC claims and benefits. KPIC is not responsible for the obligations of Health Plan nor for our decisions regarding claims and benefits. Health Plan is not responsible for your decision to receive Services from providers not contracting with us, the qualifications of these providers, or the Services they furnish. Furthermore, we are not liable for any act or omission of (1) such provider or the agents, officers, or employers of any of them, or (2) any other person or organization with which such providers have made or hereafter make arrangements for performance of Services.

VI. Section XI. DEFINITIONS is amended by *adding* the following definition:

Kaiser Permanente Insurance Company (KPIC): A for-profit California corporation which holds a certificate of authority to conduct business as a disability insurance company and underwrites the indemnity coverage of Kaiser Permanente's Point-of-Service (POS) plans. KPIC is a wholly owned subsidiary of Kaiser Foundation Health Plan, Inc. and the Permanente Medical Groups.

CONTACT US

Advice Nurses	
CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members**: 970-207-7171** or call toll-free **1-800-218-1059** ***Mountain Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

After-Hours Medical Needs	
CALL	***Denver/Boulder*** Members: **303-338-4545** or toll-free **1-800-218-1059** ***Southern Colorado*** Members: **1-800-218-1059** ***Northern Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059** ***Mountain Colorado*** Members: **970-207-7171** or call toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Appeals Program	
CALL	**303-344-7933** or toll free **1-888-370-9858**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Appeals Program** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Binding Arbitration	
CALL	**Quality, Risk, and Patient Safety 303-344-7298**

Claims Department	
CALL	***Denver/Boulder*** Members: **303-338-3600** or toll-free **1-800-382-4661** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-382-4661** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE	***Denver/Boulder*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Southern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 372910** **Denver, CO 80237-6910** ***Northern Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150** ***Mountain Colorado*** Members: **Claims Department** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Member Services

CALL	***Denver/Boulder*** Members: **303-338-3800** or toll-free **1-800-632-9700** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-632-9700** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**303-338-3444**
WRITE	**Member Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street** **Aurora, CO 80014-1622**
WEBSITE	**www.kp.org**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 203004** **Denver, CO 80220-9004**

Patient Financial Services

CALL	***Denver/Boulder*** Members: **303-743-5900** ***Southern Colorado*** Members: **1-888-681-7878** ***Northern Colorado*** Members: **1-800-632-9700** ***Mountain Colorado*** Members: **1-844-837-6884**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Personal Physician Selection Services

CALL	***Denver/Boulder*** Members: **303-338-4477** ***Southern Colorado*** Members: **1-855-208-7221** ***Northern Colorado*** Members**: 1-855-208-7221** ***Mountain Colorado*** Members: **1-855-208-7221**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**www.kp.org/chooseyourdoctor**

Transplant Administrative Offices

CALL	**303-636-3226**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS (WHO PAYS WHAT)
TITLE PAGE (COVER PAGE)
CONTACT US
TABLE OF CONTENTS
I. ELIGIBILITY 1
A. Who Is Eligible 1
1. General 1
2. Subscribers 1
3. Dependents 1
B. Enrollment and Effective Date of Coverage 1
1. New Employees and their Dependents 1
2. Members Who are Inpatient on Effective Date of Coverage 1
3. Special Enrollment Due to Newly Acquired Dependents 1
4. Special Enrollment 2
5. Open Enrollment 3
6. Persons Barred From Enrolling 3
II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS 3
A. Your Primary Care Plan Physician 3
1. Choosing Your Primary Care Plan Physician 3
2. Changing Your Primary Care Plan Physician 3
B. Getting a Referral 4
1. Referrals 4
2. Specialty Self-Referrals 4
3. Second Opinions 5
C. Plan Facilities 5
1. *Denver/Boulder* Service Area 5
2. *Southern, Northern and Mountain Colorado* Service Areas 5
D. Getting the Care You Need 5
E. Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas 5
F. Out-of-Area Student Benefit 6
G. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area 6
H. Using Your Health Plan Identification Card 6
I. Cross Market Access 6
1. *Denver/Boulder* Members: 6
2. *Southern, Northern and Mountain Colorado* Members: 7
III. BENEFITS/COVERAGE (WHAT IS COVERED) 7
A. Outpatient Care 7
Outpatient Care for Preventive Care, Diagnosis and Treatment 7
B. Hospital Inpatient Care 8
1. Inpatient Services in a Plan Hospital 8
2. Hospital Inpatient Care Exclusions: 8
C. Ambulance Services 8
1. Coverage 8
2. Ambulance Services Exclusion: 8
D. Chemical Dependency Services 8
1. Inpatient Medical and Hospital Services 8
2. Residential Rehabilitation 8
3. Outpatient Services 8
4. Chemical Dependency Services Exclusion: 9
E. Clinical Trials (applies to non-grandfathered health plans only) 9
F. Dialysis Care 9
G. Drugs, Supplies and Supplements 9

1. Coverage 10
2. Limitations: 11
3. Drugs, Supplies and Supplements Exclusions: 11

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics 11
1. Durable Medical Equipment (DME) 11
2. Prosthetic Devices 12
3. Orthotic Devices 12

I. Early Childhood Intervention Services 12
1. Coverage 12
2. Limitations 12
3. Early Childhood Intervention Services Exclusions: 12

J. Emergency Services and Non-Emergency, Non-Routine Care 12
1. Emergency Services 12
2. Non-Emergency, Non-Routine Care 13
3. Payment 14

K. Family Planning Services 14

L. Health Education Services 14

M. Hearing Services 14
1. Persons Under the Age of 18 Years 14
2. Persons Age 18 Years and Older 15

N. Home Health Care 15
1. Coverage 15
2. Home Health Care Exclusions 15
3. Special Services Program 15

O. Hospice Care 15

P. Infertility Services 16

Q. Mental Health Services 16
1. Coverage 16
2. Mental Health Services Exclusions: 16

R. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services 16
1. Coverage 16
2. Limitations: 17
3. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions: 17

S. Preventive Care Services 17

T. Reconstructive Surgery 17
1. Coverage 17
2. Reconstructive Surgery Exclusions: 17

U. Skilled Nursing Facility Care 18
1. Coverage 18
2. Skilled Nursing Facility Care Exclusion: 18

V. Transplant Services 18
1. Coverage 18
2. Related Prescription Drugs 18
3. Terms and Conditions 18
4. Transplant Services Exclusions and Limitations: 18

W. Vision Services 19
1. Coverage 19
2. Vision Services Exclusions: 19

X. X-ray, Laboratory and X-ray Special Procedures 19
1. Coverage 19
2. X-ray, Laboratory and X-ray Special Procedures Exclusions: 19

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED) 19

A. Exclusions 19

B. Limitations 22

C. Reductions 22

1. Coordination of Benefits (COB) ... 22
2. Injuries or Illnesses Alleged to be Caused by Other Parties ... 25
3. Surrogacy ... 25

V. MEMBER PAYMENT RESPONSIBILITY ... 26

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM) ... 26

VII. GENERAL POLICY PROVISIONS ... 26

A. Access Plan ... 26
B. Access to Services for Foreign Language Speakers ... 26
C. Administration of Agreement ... 26
D. Advance Directives ... 26
E. Agreement Binding on Members ... 26
F. Amendment of Agreement ... 26
G. Applications and Statements ... 27
H. Assignment ... 27
I. Attorney Fees and Expenses ... 27
J. Binding Arbitration ... 27
K. Claims Review Authority ... 27
L. Contracts with Plan Providers ... 27
M. Deductible/Out-of-Pocket Maximum Takeover Credit ... 27
N. Governing Law ... 28
O. Group and Members not Health Plan's Agents ... 28
P. No Waiver ... 28
Q. Nondiscrimination ... 28
R. Notices ... 28
S. Overpayment Recovery ... 28
T. Privacy Practices ... 28
U. Value-Added Services ... 28
V. Women's Health and Cancer Rights Act ... 29

VIII. TERMINATION/NONRENEWAL/CONTINUATION ... 29

A. Termination Due to Loss of Eligibility ... 29
B. Termination of Group Agreement ... 29
C. Termination for Cause ... 29
D. Termination for Nonpayment ... 30
E. Termination of a Product or all Products (applies to non-grandfathered health plans only) ... 30
F. Rescission of Membership ... 30
G. Continuation of Group Coverage Under Federal Law, State Law or USERRA ... 30
1. Federal Law (COBRA) ... 30
2. State Law ... 30
3. USERRA ... 30
H. Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area ... 31

IX. APPEALS AND COMPLAINTS ... 31

X. INFORMATION ON POLICY AND RATE CHANGES ... 38

XI. DEFINITIONS ... 38

ADDITIONAL PROVISIONS

I. ELIGIBILITY

A. Who Is Eligible

1. General

   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. On the first day of membership, the Subscriber must live in our Service Area. Our Service Area is described in the "Definitions" section. You cannot live in another Kaiser Foundation Health Plan or allied plan service area. For the purposes of this eligibility rule these other service areas may change on January 1 of each year. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia and Washington. For more information, please call **Member Services**.

2. Subscribers

   You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

   a. Your Spouse. (Spouse includes a partner in a valid civil union under State law.)
   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."
   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).
   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.
   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

   Students on Medical Leave of Absence. Dependent children over the dependent limiting age but under the dependent student limiting age as specified in the "Schedule of Benefits (Who Pays What)" who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

   If your plan has different eligibility requirements, please see "Additional Provisions."

B. Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date:

1. New Employees and their Dependents

   If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

   If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. A newborn child is covered for the first 31 days.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment" below.

4. Special Enrollment

If you have certain life events ("qualifying events"), you can enroll in or change your health insurance plan outside of the open enrollment period. You may apply for enrollment as a Subscriber, and existing Subscribers may apply to enroll eligible Dependents, by submitting an enrollment form to Health Plan within 30 days after one of the following events happens to one of the people applying:

a. You involuntarily lose existing minimum essential or creditable coverage due to the death of a covered employee; termination of employment or reduction in number of hours of the employment; covered employee becoming eligible for Medicare; divorce or legal separation from the covered employee's spouse or partner in a civil union; your Dependent child has a birthday and no longer qualifies as a Dependent on his/her parent's plan; your retiree coverage is terminated or substantially eliminated when your employer declares bankruptcy; termination of eligibility for coverage; involuntary termination of coverage; reduction or elimination of the employer's contributions toward coverage.

b. You gain a Dependent or become a Dependent through marriage; civil union; birth, adoption or placement for adoption; by entering into a designated beneficiary agreement pursuant to the Colorado Designated Beneficiary Agreement Act, if your carrier offers coverage for designated beneficiaries; or pursuant to a court or administrative order mandating coverage.

c. A parent or legal guardian dis-enrolls a Dependent from, or a Dependent becomes ineligible for the Children's Basic Health Plan, and the parent or legal guardian requests enrollment of the Dependent in a health plan within 60 days of the disenrollment or determination of ineligibility.

d. You lose coverage under the Colorado Medical Assistance Act and then request coverage under an employer's group health plan within 60 days of the loss of coverage.

e. You or a Dependent become eligible for premium assistance under the Colorado Medical Assistance Act or the Children's Basic Health Plan for which you will have a 60 day special enrollment period.

Additionally, if you are aware of a future qualifying event, you may apply for new coverage up to 30 days in advance of that event.

If Health Plan accepts your enrollment form, your membership effective date will be one of the following:

a. For birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption.

b. For other qualifying events, the first day of the following month after Health Plan receives a completed enrollment form.

5. Open Enrollment
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

6. Persons Barred From Enrolling
   You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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

- "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)," in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.
- "Getting a Referral," in this section.
- "Cross Market Access" in this section.

Your home Service Area is printed on your Health Plan Identification (ID) card. For more information about your ID card, please refer to the "Using Your Health Plan Identification Card" section, below.

A. Your Primary Care Plan Physician

Your primary care Plan Physician (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have his or her own PCP.

1. Choosing Your Primary Care Plan Physician
   You may select a PCP from family medicine, pediatrics, or internal medicine within your home service area. You may also receive a second medical opinion from a Plan Physician upon request. Please refer to the "Second Opinions" section below.

   a. ***Denver/Boulder*** Service Area
      You may choose your PCP from our provider directory. To review a list of Plan Physicians and their biographies, visit our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations." You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Services**. This team will help you choose a Plan Physician, accepting new patients, based on your health care needs.

   b. ***Southern, Northern and Mountain Colorado*** Service Areas
      You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, we will assign you one near your home.

      Medical Group contracts with a panel of Affiliated Physicians, specialists, and other health care professionals to provide medical Services in the ***Southern, Northern and Mountain Colorado*** Service Areas. You may choose your PCP from our panel of ***Southern, Northern and Mountain Colorado*** Plan Physicians.

      You can find these physicians, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can review a list of ***Southern, Northern and Mountain Colorado*** Plan Physicians by visiting our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations." You can also get a copy of the directory by calling **Member Services**. To choose a PCP, call **Personal Physician Selection Service**s. This team will help you choose a Plan Physician, accepting new patients, based on your health care needs.

      If you are seeking routine or specialty care in any ***Denver/Boulder*** Plan Hospital, you must have a referral from your local PCP. If you do not get a referral, you will be billed for the full amount of the office visit Charges. If you are visiting in the ***Denver/Boulder*** Service Area and need after-hours or emergency care, you can visit a ***Denver/Boulder*** Plan Facility without a referral. For care in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access." below.

2. Changing Your Primary Care Plan Physician
   a. ***Denver/Boulder*** Service Area
      Please call **Personal Physician Selection Services** to change your PCP. You may also change your physician when visiting a Plan Facility. You may change your PCP at any time.

   b. ***Southern, Northern and Mountain Colorado*** Service Areas

Please call **Personal Physician Selection Services** to change your PCP. Notify us of your new PCP choice by the 15th day of the month. Your selection will be effective on the first day of the following month.

B. Getting a Referral

1. Referrals

a. ***Denver/Boulder*** Service Area

Medical Group physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery, and dermatology. If your Medical Group physician decides that you need covered Services not available from us, he or she will refer you to a non-Medical Group physician inside or outside our Service Area. You must have a written referral to the non-Medical Group physician in order for us to cover the Services.

A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a non-Medical Group physician. A written or verbal recommendation by a Medical Group physician or an Affiliated Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered.

For Services in Kaiser Permanente Plan Medical Offices in the ***Southern, Northern and Mountain Colorado*** Service Areas, please see "Cross Market Access," below. In order to receive Services from a Plan Facility, you must have a written referral. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Medical Group physician.

A referral is limited to a specific Service, treatment, series of treatments and period of time. All referral Services must be requested and approved in advance according to Medical Group procedures. We will not pay for any care rendered or recommended by a non-Medical Group physician beyond the limits of the original referral unless the care is: (i) specifically authorized by your Medical Group physician; and (ii) approved in advance in accord with Medical Group procedures.

b. ***Southern, Northern and Mountain Colorado*** Service Areas

Plan Physicians offer primary medical and pediatric care. They also offer specialty care in areas such as general surgery, orthopedic surgery and dermatology. If your Plan Physician decides that you need covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. You must have a written referral to the non-Plan Provider in order for us to cover the Services. A referral is a written authorization from Kaiser Permanente for you to receive a covered Service from a designated non-Plan Provider. A written or verbal recommendation by a Plan Physician that you get non-covered Services (whether Medically Necessary or not) is **not** considered a referral and is **not** covered. Copayments or Coinsurance for referral Services are the same as those required for Services provided by a Plan Provider.

Health Plan authorization is required for Services provided by: (i) non-Plan Providers or non-Plan Facilities; (ii) Services provided by any provider outside the ***Southern, Northern and Mountain Colorado*** Service Areas; and (iii) Services performed in any facility other than the physician's office. For Services in ***Denver/Boulder*** Plan Medical Offices, see "Cross Market Access," below. A referral for these Services will be submitted to Health Plan by the Plan Physician. Health Plan will make a determination regarding authorization for coverage.

The provider to whom you are referred will receive a notice of Health Plan's authorization by fax. You will receive a written notice of Health Plan's 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.

2. **Specialty Self-Referrals**

a. ***Denver/Boulder*** Service Area

You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will still be required to get a written referral for laboratory or radiology Services and for specialty procedures such as a CT scan, MRI, or surgery. A written referral is also required for specialty-care visits to non-Medical Group physicians.

b. ***Southern, Northern and Mountain Colorado*** Service Areas

You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals. Female members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology. You will find the specialty-care providers eligible to receive direct referrals in the Kaiser Permanente Provider Directory for your specific home Service Area. It is available on our website, *www.kp.org*, by clicking on "Locate our services" then "Find doctors & locations." You can get help choosing a specialty-care provider by calling **Personal Physician Selection Services**. A self-referral provides coverage for routine visits only. Authorization from Kaiser Permanente is required for: (i) Services in addition to those provided as part of the visit, such as surgery; and (ii) visits to Plan Physician specialty-care providers not eligible to receive direct referrals; and (iii) non-Plan Physicians.

Southern, Northern and Mountain Colorado Members may be able to self-refer to Kaiser Permanente Plan Medical Offices in the ***Denver/Boulder*** Service Area (see "Cross Market Access," below). Services other than routine office visits with a Plan Physician specialty-care provider eligible to receive self-referrals will not be covered unless authorized by-Kaiser Permanente before Services are rendered.

The request for these Services can be generated by either your PCP or by a specialty-care provider. The physician or facility to whom you are referred will receive a notice of the authorization. You will receive a written notice of 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 that the authorization is valid and the Services authorized.

3. Second Opinions
   Upon request and subject to payment of any applicable Deductible, Copayments or Coinsurance, you may get a second opinion from a Plan Physician about any proposed covered Services.

C. Plan Facilities

Plan Facilities are Plan Medical Offices or Plan Hospitals in our Service Area that we contract with to provide covered Services to our Members.

1. ***Denver/Boulder*** Service Area
   We offer health care at Plan Medical Offices conveniently located throughout the ***Denver/Boulder*** Service Area. At most of our Plan Facilities, you can usually receive all the covered Services you need. This includes specialized care. You are not restricted to a certain Plan Facility. We encourage you to use the Plan Facility in your home service area that will be most convenient for you.

   Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations."

2. ***Southern, Northern and Mountain Colorado*** Service Areas
   When you select your PCP, you will receive your Services at that physician's office. You can find ***Southern, Northern and Mountain Colorado*** Plan Physicians and their facilities, along with a list of affiliated specialists and ancillary providers, in the Kaiser Permanente Provider Directory for your specific home Service Area. You can get a copy of the directory by calling **Member Services**. You can also get a list from our website. Go to *www.kp.org*, click on "Locate our services" then "Find doctors & locations."

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a life or limb threatening emergency, call 911 or go to the nearest emergency room.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.

Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen, are covered at Plan Facilities during regular office hours. Your office visit Charge, as defined in the "Schedule of Benefits (Who Pays What)," will apply. If you need non-emergency, non-routine care after hours, you may use one of the designated after-hours Plan Facilities. The Charge for non-emergency, non-routine care received in Plan Facilities after regular office hours listed in the "Schedule of Benefits (Who Pays What)," will apply. For additional information about non-emergency, non-routine care, please refer to "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section.

Non-emergency, non-routine care received at a non-Plan Facility inside our Service Areas is **not covered**. If you receive care for minor medical problems at non-Plan Facilities inside our Service Areas, you will be responsible for payment for any treatment received.

There may be instances when you need to receive unauthorized non-emergency, non-routine care outside our Service Areas. Please see "Emergency Services and Non-Emergency, Non-Routine Care" in the "Benefits/Coverage (What is Covered)" section for coverage information about out-of-Plan non-emergency, non-routine care Services.

E. Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily, you can get visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services, Copayments, Coinsurance and Deductibles described in this EOC.

Please call **Member Services** to get more information about visiting member care, including facility locations in other service areas. Service areas and facilities where you may get visiting member care may change at any time.

You receive the same prescription drug benefit as your home service area benefit. This includes your Copayments or Coinsurance, exclusions and limitations.

F. Out-of-Area Student Benefit

A limited benefit is available to students attending school outside any Kaiser Foundation Health Plan service area.

The Out-of-Area Student Benefit coverage is limited to certain office visits, diagnostic X-rays, and prescription drug fills as covered under this EOC.

1. Office visits exam charge limited to:
   a. Primary care visit.
   b. Specialty care visit.
   c. Preventive care visit.
   d. Gynecology care visit.
   e. Mental health visit.
   f. Chemical dependency visit.
   g. Visits with the administration of allergy injections.
2. Diagnostic X-rays.
3. Prescription drug fills.

To qualify for the out-of-area student benefit, the student must provide verification of their student status. Students are covered up to the age of 26. For more information, please call **Member Services**.

See the "Schedule of Benefits (Who Pays What)" for more details.

Exclusions and Limitations:

This does not include and is not limited to, the following Services:

1. Other Services provided during a covered office visit such as, but **not limited** to: lab, procedures, and office administered drugs and devices except for allergy injections.
2. Services received outside the United States.
3. Transplant Services.
4. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services, Non-Emergency, Non-Routine Care).
5. Allergy evaluation, routine prenatal and postpartum visits, spinal manipulations, acupuncture services, hearing exams, home health visits, hospice services, physical, occupational and speech therapy and applied behavioral analysis (ABA).

To qualify for the out-of-area student benefit, the student must provide verification of student status. For more information, please call **Member Services.**

Visiting member care will continue to apply to students attending school in other Kaiser Foundation Health Plan or allied plan service areas.

G. Moving Outside of Any Kaiser Foundation Health Plan or Allied Plan Service Area

If you move to an area not within any Kaiser Foundation Health Plan or allied plan service area, you can keep your membership with Health Plan, if you continue to meet all other eligibility requirements. However, you must go to a Plan Facility in a Kaiser Foundation Health Plan or allied plan service area in order to receive covered Services (except out-of-Plan Emergency Services and out-of-Plan non-emergency, non-routine care). If you go to another Kaiser Foundation Health Plan or allied plan service area for care, covered Services, Copayments or Coinsurance will be as described under "Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas" above.

H. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Health Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Health Record Number is used to identify your medical records and membership information. You should always have the same Health Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Health Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, claims for Emergency or non-emergency care Services from non-Plan Providers will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership upon 30 days written notice that will include the reason for termination.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

I. Cross Market Access

Members may access certain Services at Kaiser Permanente Plan Medical Offices outside of their home Service Area.

1. ***Denver/Boulder*** Members**:**
   Denver/Boulder Members have access for certain Services at designated Kaiser Permanente Plan Medical Offices in the

Southern, Northern and Mountain Colorado Service Areas. ***Denver/Boulder*** Members do not have access to Affiliated Providers in ***Southern*** or ***Northern Colorado*** unless authorized by Health Plan.

2. ***Southern, Northern and Mountain Colorado*** Members:
   Southern, Northern and Mountain Colorado Members have access for certain Services at any Kaiser Permanente Plan Medical Office in the ***Denver/Boulder*** Service Area.

Services available to Members at Kaiser Permanente Plan Medical Offices outside of their home Service Area include: primary care; specialty care; after-hours care; pharmacy; laboratory; X-ray; vision; and hearing Services. These Services may not be available at all Kaiser Permanente Plan Medical Offices and are subject to change. For more information on what Services you may access outside your designated home Service Area and at which designated Kaiser Permanente Plan Medical Offices, if applicable, you may receive Services at, please call **Member Services**.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- A Plan Physician determines that the Services are Medically Necessary to prevent, diagnose or treat your medical condition. A Service is Medically Necessary only if a Plan Physician determines that it is medically appropriate for you and its omission would have an adverse effect on your health.
- The Services are provided, prescribed, authorized or directed by a Plan Physician. This does not apply where specifically noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and (b) "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care".
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Getting a Referral" and "Specialty Self-Referrals"; and (b) "Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)" and "Out-of-Plan Non-Emergency, Non-Routine Care" in "Emergency Services and Non-Emergency, Non-Routine Care").
- You have met any Deductible requirements described in the "Schedule of Benefits (Who Pays What)."

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)."

A. Outpatient Care

Outpatient Care for Preventive Care, Diagnosis and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following outpatient care for preventive care, diagnosis and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility or at home:

1. Primary care visits: Services from family medicine, internal medicine and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists (***Denver/Boulder*** Members only).
5. Outpatient surgery.
6. Blood, blood products and their administration.
7. Second opinion.
8. House calls when care can best be provided in your home as determined by a Plan Physician.
9. Medical social Services.
10. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" Section for more details).
11. Telemedicine visits (not including telephone conversations and electronic mail messages) are considered office visits and the applicable office visit copayment, coinsurance and/or deductible applies.

NOTE: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

B. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Areas:

   a. Room and board, such as semiprivate accommodations or, when a Plan Physician determines it is Medically Necessary, private accommodations or private duty nursing care.

   b. Intensive care and related hospital Services.

   c. Professional Services of physicians and other health care professionals during a hospital stay.

   d. General nursing care.

   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for child birth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. If your newborn remains in the hospital following your discharge, Charges incurred by the newborn after your discharge are subject to all Health Plan provisions. This includes his/her own Copayments and/or Deductible requirements.

   f. Meals and special diets.

   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   NOTE: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Medical Group's criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions:

   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by State law.

   b. Cosmetic surgery related to bariatric surgery.

C. Ambulance Services

1. Coverage

   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide.

2. Ambulance Services Exclusion:

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

D. Chemical Dependency Services

1. Inpatient Medical and Hospital Services

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

2. Residential Rehabilitation

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

   We cover inpatient services and partial hospitalization in a residential rehabilitation program approved by Kaiser Permanente for the treatment of alcoholism, drug abuse or drug addiction.

3. Outpatient Services

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

   We cover chemical dependency services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary as determined by a Plan Physician and

otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

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

4. Chemical Dependency Services Exclusion:
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Physician.

E. Clinical Trials (applies to non-grandfathered health plans only)

We cover Services you receive in connection with a clinical trial if all of the following conditions are met:

1. We would have covered the Services if they were not related to a clinical trial.
2. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
   a. A Plan Provider makes this determination.
   b. You provide us with medical and scientific information establishing this determination.
3. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
4. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
   b. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
   c. The study or investigation is approved or funded by at least one of the following:
      i. The National Institutes of Health.
      ii. The Centers for Disease Control and Prevention.
      iii. The Agency for Health Care Research and Quality.
      iv. The Centers for Medicare & Medicaid Services.
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
      vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
      vii. 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 U.S. Secretary of Health and Human Services determines meets all of the following requirements:
         1. It is comparable to the National Institutes of Health system of peer review of studies and investigations.
         2. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, you will pay the applicable cost share shown on the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the cost share that applies to hospital inpatient care.

Clinical trials exclusions:

1. The investigational Service.
2. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet all medical criteria developed by Medical Group and by the facility providing the dialysis; and
3. The facility is certified by Medicare and contracts with Medical Group; and
4. A Plan Physician provides a written referral for care at the facility.

After the referral to a dialysis facility, we cover: equipment; training; and medical supplies required for home dialysis. See the "Schedule of Benefits (Who Pays What)."

G. Drugs, Supplies and Supplements

We use drug formularies. A drug formulary includes the list of prescription drugs that have been approved by our formulary committees for our Members. Our committees are comprised of Plan Physicians, pharmacists and a nurse practitioner. The committees select prescription drugs for our drug formularies based on a number of factors, including safety and effectiveness as determined from a review of medical literature and research. The committees meet regularly to consider

adding and removing prescription drugs on the drug formularies. If you would like information about whether a particular drug is included in our drug formularies, please call **Member Services**.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
      If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Physician and obtained at Plan Pharmacies, or in the ***Southern, Northern and Mountain Colorado*** Service Areas, at pharmacies designated by Health Plan. You may obtain these drugs at the Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

      If your coverage includes supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance applies for these types of drugs. For more information, please refer to the prescription drug benefit description following your "Schedule of Benefits (Who Pays What)."

      Note: Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your group has limited or supplemental prescription drug coverage.

   b. Outpatient Prescription Drugs
      Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." If your prescription drug Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)" exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.
      i. Prescriptions by Mail
         If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. Refills of maintenance drugs prescribed by Plan Physicians or Affiliated Physicians may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs have a significant potential for waste and diversion. Those drugs are not available by mail-order service. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please call **Member Services**.

      ii. Specialty Drugs
         Prescribed specialty drugs, including self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown on the "Schedule of Benefits (Who Pays What)."

   c. Administered Drugs
      If the following are administered (1) during a covered stay in a Plan Hospital or Skilled Nursing Facility; or (2) in a Plan Medical Office or during home visits if administration or observation by medical personnel is required, they are covered at the applicable Copayment or Coinsurance shown on the "Schedule of Benefits (Who Pays What)."

      Drugs and injectables; radioactive materials used for therapeutic purposes; vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and allergy test and treatment materials.

   d. Food Supplements
      Prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism, elemental enteral nutrition and parenteral nutrition are provided under your hospital inpatient care benefit. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

   e. Prescribed Supplies and Accessories
      Prescribed supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
      i. home glucose monitoring supplies.
      ii. disposable syringes for the administration of insulin.
      iii. glucose test strips.
      iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)," and, if your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations:
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
   b. ***Denver/Boulder, Northern and Mountain Colorado*** Service Areas: Compound medications are covered as long as they are on the compounding formulary.
   c. ***Southern Colorado*** Service Area: Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.

3. Drugs, Supplies and Supplements Exclusions:
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Individual drugs and/or drug classes determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process. (***Denver/Boulder*** Members only)
   n. Prescription drugs necessary for Services excluded under this Evidence of Coverage.

H. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Physician as described below; when prescribed by a Plan Physician during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
   b. Durable Medical Equipment Exclusions:
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost equipment.
      iii. Repair, adjustments or replacements necessitated by misuse.
      iv. More than one piece of DME serving essentially the same function, except for replacements, spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments and replacements other than those necessitated by misuse or loss, when prescribed by a Plan Physician and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prostheses is no longer functional. Custom made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and provided in accord with this EOC. Including repairs and replacements, of such prosthetic devices.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

   b. Prosthetic Devices Exclusions:
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Physician can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
   Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

I. Early Childhood Intervention Services

1. Coverage
   Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by State law, are covered for the number of Early Intervention Services (EIS) visits as required by State law. EIS are not subject to any Deductibles, Copayments or Coinsurance; or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

   Note: You may be billed for any EIS received after the number of visits required by State law is satisfied.

2. Limitations
   The number of visits as required by State law does not apply to:
   a. Rehabilitation or therapeutic Services that are necessary as a result of an acute medical condition; or
   b. Services provided to a child that is not participating in the Early Intervention program for infants and toddlers under Part C of the federal "Individuals with Disabilities Act"; or
   c. Services that are not provided pursuant to an Individualized Family Service Plan developed pursuant to 20 U.S.C. Sec. 1436 and 34 C.F.R. 303.340, as amended.

3. Early Childhood Intervention Services Exclusions:
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination, as defined by State or federal law; and
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

J. Emergency Services and Non-Emergency, Non-Routine Care

1. Emergency Services
   Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition, call 911 or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and non-Plan Providers anywhere in the world, as long as the Services would have been covered under your plan if you had received them from Plan Providers.

   You are also covered for medical emergencies anywhere in the world. For information about emergency benefits away from home, please call **Member Services**.

   Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC.

a. Emergency Services Provided by non-Plan Providers (out-of-Plan Emergency Services)
"Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Physician. There may be times when you or a family member may receive Emergency Services from non-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Medical Offices or the emergency room of a Plan Hospital, or, the patient may need Emergency Services while traveling outside our Service Area.

Please refer to "ii. Emergency Services Limitation for non-Plan Providers," below, if you are hospitalized for Emergency Services.

i. We cover out-of-Plan Emergency Services as follows:

A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility. Covered benefits include Medically Necessary out-of-Plan Emergency Services for conditions that arise unexpectedly, including but not limited to myocardial infarction, appendicitis or premature delivery.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if you reasonably believed that your life or limb was threatened in such a manner that the delay in going to a Plan Hospital, a hospital where we have contracted for Emergency Services, or a Plan Facility for your treatment would result in death or serious impairment of health.

ii. Emergency Services Limitation for non-Plan Providers
If you are admitted to a non-Plan Hospital, non-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** and/or **Quality Resource Coordinator**.

We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible.

b. Emergency Services Exclusions:
Continuing or follow-up treatment. We cover only the out-of-Plan Emergency Services that are required before you could, without medically harmful results, have been moved to a Plan Facility we designate either inside or outside our Service Area. When approved by Health Plan or by a Plan Physician in this Service Area or in another Kaiser Foundation Health Plan or allied plan service area, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

2. Non-Emergency, Non-Routine Care
a. Non-Emergency, Non-Routine Care Provided by Plan Providers
i. ***Denver/Boulder*** Service Area
Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities **during** regular office hours. If you need non-emergency, non-routine care during office hours and you are a Member in the ***Denver/Boulder*** Service Area, you can visit one of our Plan Facilities.
Non-emergency, non-routine care needed **after hours** that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan Facilities, please call **Member Services**.

During regular office hours, please call **Advice Nurse** and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

After office hours, please call **After-Hours Medical Needs** for a recorded message about your options and/or to speak with the answering service who will redirect your call, 24 hours a day, 7 days a week.

ii. ***Southern, Northern and Mountain Colorado*** Service Areas
Non-emergency, non-routine care needed for medical problems such as an earache or sore throat with fever that do not meet the definition of an emergency because they are not sudden or unforeseen are covered at Plan Facilities during regular office hours. If you are a ***Southern*** or ***Northern Colorado*** Member and need non-emergency, non-routine care during regular office hours, please call your Plan Physician's office.

Non-emergency, non-routine care needed **after hours** that cannot wait for a routine visit, can be received at one of our designated after-hours Plan Facilities. For information regarding the designated after-hours Plan

Facilities, please call **Member Services** during normal business hours. You can also go to our website, www.kp.org, for information on designated after-hours facilities.

After office hours, please call your Plan Physician or go to the provider directory or to our website, www.kp.org, for information on our designated after-hours facilities. You may also call the nurse advice line at the telephone number listed in your provider directory or our website, www.kp.org.

b. Out-of-Plan Non-Emergency, Non-Routine Care
There may be situations when it is necessary for you to receive unauthorized non-emergency, non-routine care outside our Service Area. Non-emergency, non-routine care received from non-Plan Providers is covered only when obtained outside our Service Area, if all of the following requirements are met:
   i. The care is required to prevent serious deterioration of your health; and
   ii. The need for care results from an unforeseen illness or injury when you are temporarily away from our Service Area; and
   iii. The care cannot be delayed until you return to our Service Area.

3. Payment
   a. Health Plan's payment for covered out-of-Plan non-emergency, non-routine care Services is based upon fees that we determine to be usual, reasonable and customary. This means a fee that:
      i. does not exceed most Charges which providers in the same area charge for that Service; and
      ii. does not exceed the usual Charge made by the provider for that Service; and
      iii. is in accord with standard coding guidelines and consistent with accepted health care reimbursement payment practices.

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

   b. Our payment is reduced by:
      i. the Copayment and/or Coinsurance for Emergency Services and X-ray Special Procedures performed in the emergency room. The emergency room and X-ray Special Procedures Copayment, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
      ii. the Copayment or Coinsurance for ambulance Services, if any; and
      iii. Coordination of benefits; and
      iv. any other payments you would have had to make if you received the same Services from our Plan Providers; and
      v. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
      vi. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

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

K. Family Planning Services

We cover the following:
1. Family planning counseling. This includes pre-abortion and post-abortion counseling and information on birth control.
2. Tubal ligations.
3. Vasectomies.
4. Voluntary termination of pregnancy.

This plan may exclude voluntary, elective abortions and any related Services. See "Additional Provisions" for additional coverage or exclusions, if applicable to your Group.

Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory and X-ray Special Procedures"; contraceptive drugs and devices, see the "Drugs, Supplies and Supplements" section.

L. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

M. Hearing Services

1. Persons Under the Age of 18 Years
We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every 5 years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and

c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

2. Persons Age 18 Years and Older
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions:
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

N. Home Health Care

1. Coverage
   We cover skilled nursing care, home health aide Services and medical social Services:
   a. only on a Part-Time or Intermittent Care basis; and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Physician and administered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Physician and the approved Plan Provider; and
   d. only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

   Part-Time Care or Intermittent Care means part-time or intermittent skilled nursing and home health aide Services. Services must be clinically indicated; may not exceed 28 hours per week combined over any number of days per week; and must be for less than eight (8) hours per day. Additional time up to 35 hours per week but less than eight (8) hours per day may be approved by Health Plan on a case-by-case basis.

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

2. Home Health Care Exclusions:
   a. Custodial care.
   b. Homemaker Services.
   c. Care that Medical Group determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

3. Special Services Program
   If you have been diagnosed with a terminal illness with a life expectancy of one year or less, but are not yet ready to elect hospice care, you are eligible for the Special Services Program ("Program"). Coverage of hospice care is described below.

   This Program gives you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

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

O. Hospice Care

We cover hospice care for terminally ill Members inside our Service Area. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

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

We cover the following Services and other Benefits when: (1) prescribed by a Plan Physician and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Kaiser Permanente:

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

P. Infertility Services

Infertility Services are **not** covered unless your Group has purchased additional supplemental coverage.

NOTE: To determine if your Group has the infertility benefit, see the "Schedule of Benefits (Who Pays What)."

Q. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Coverage includes evaluation and Services for conditions which, in the judgment of a Plan Physician, would respond to therapeutic management. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy

      We cover: diagnostic evaluation; individual therapy; psychiatric treatment; and psychiatrically oriented child and teenage guidance counseling.

      Visits for the purpose of monitoring drug therapy are covered.

      Psychological testing as part of diagnostic evaluation is covered.

   b. Inpatient Services

      We cover psychiatric hospitalization in a facility designated by Medical Group or Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Physicians and mental health professionals and the following Services and supplies as prescribed by a Plan Physician while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

      Separate Coinsurance applies to Services of Plan Physicians and mental health professionals.

   c. Partial Hospitalization

      We cover partial hospitalization in a Plan Hospital-based program.

   We cover mental health services whether they are voluntary, or are court-ordered as a result of contact with the criminal justice or juvenile justice system, when they are Medically Necessary as determined by a Plan Physician and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

2. Mental Health Services Exclusions:

   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless a Plan Physician determines such evaluation to be Medically Necessary.

   b. Special education, counseling, therapy or care for learning deficiencies or behavioral problems, whether or not associated with a manifest mental disorder, retardation or other disturbance, including but not limited to attention deficit disorder.

   c. Mental health Services ordered by the court, to be used in a court proceeding, or as a condition of parole or probation, unless a Plan Physician determines such Services to be Medically Necessary.

   d. Court-ordered testing and testing for ability, aptitude, intelligence or interest.

   e. Services which are custodial or residential in nature.

R. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services

1. Coverage

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

      We cover physical, occupational and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility and Home Health Care benefit.

   b. Outpatient Care

      We cover three (3) types of outpatient therapy (i.e., physical, occupational and speech therapy) in a Plan Facility to improve or develop skills or functioning due to medical deficits, illness or injury. See the "Schedule of Benefits (Who Pays What)."

   c. Multidisciplinary Rehabilitation Services

      We will cover treatment in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility. We also cover multidisciplinary rehabilitation Services while you are an inpatient in a designated facility. See the "Schedule of Benefits (Who Pays What)."

   d. Pulmonary Rehabilitation

      Treatment in a pulmonary rehabilitation program is provided if prescribed or recommended by a Plan Physician and provided by therapists at designated facilities. Clinical criteria are used to determine appropriate candidacy for the

program, which consists of: an initial evaluation; up to six (6) education sessions; up to twelve exercise sessions; and a final evaluation to be completed within a two to three-month period. See the "Schedule of Benefits (Who Pays What)."

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

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

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

f. Therapies for the Treatment of Autism Spectrum Disorders
For children under the age of 19, we cover the following therapies for the treatment of Autism Spectrum Disorders:
   i. Outpatient physical, occupational and speech therapy in a Plan Medical Office when prescribed by a Plan Physician as Medically Necessary. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers, up to the maximum benefit permitted by State law. See the "Schedule of Benefits (Who Pays What)."

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

3. Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Services Exclusions:
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

S. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

If you receive any other covered Services during a preventive care visit, you may pay the applicable Copayment and Coinsurance for those Services.

T. Reconstructive Surgery

1. Coverage
We cover reconstructive surgery when a Plan Physician determines it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

2. Reconstructive Surgery Exclusions:
Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

U. Skilled Nursing Facility Care

1. Coverage

   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required. We cover the following Services:

   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Medical Group.

   Note: The following are covered, but not under this section: drugs, see "Drugs, Supplies and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment and Prosthetics and Orthotics"; X-ray laboratory and X-ray special procedures, see "X-ray, Laboratory and X-ray Special Procedures".

2. Skilled Nursing Facility Care Exclusion:

   Custodial Care, as defined in "Exclusions" under "Limitations/Exclusions (What is Not Covered)," below.

V. Transplant Services

1. Coverage

   Transplants are covered on a **LIMITED** basis as follows:

   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.

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

   c. If all medical criteria developed by Medical Group are met, we cover: stem cell rescue; and transplants of organs, tissue or bone marrow.

2. Related Prescription Drugs

   Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are provided at the applicable outpatient prescription drug Copayment or Coinsurance shown in the "Schedule of Benefits (Who Pays What)."

3. Terms and Conditions

   a. Health Plan, Medical Group and Plan Physicians do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Medical Group. In accord with our guidelines for living transplant donors, we provide certain donation-related Services for a donor, or a person Medical Group or a Plan Physician identifies as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

   b. Plan Physicians must determine that the Member satisfies Medical Group medical criteria before the Member receives Services.

   c. A Plan Physician must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Medical Group. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Medical Group selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

   d. After referral, if a Plan Physician or the medical staff of the referral facility determines the Member does not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations:

   a. Bone marrow transplants, associated with high dose chemotherapy for solid tissue tumors, (except bone marrow transplants covered under this EOC) are excluded.

   b. Non-human and artificial organs and their implantation are excluded.

   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.

d. Travel and lodging expenses are excluded, except that in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services, as described in "Getting a Referral" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. Travel and lodging expenses related to non-transplant Services are not covered. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices.**

W. Vision Services

1. Coverage

   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the Schedule of Benefits (Who Pays What). We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Physician or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Health Plan Medical Offices.

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

Your Group may have purchased additional optical coverage. See "Additional Provisions."

X. X-ray, Laboratory and X-ray Special Procedures

1. Coverage
   a. Outpatient

      We cover the following Services:
      i. Diagnostic X-ray and laboratory tests, Services and other materials, which includes but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms and ultrasounds.
      ii. Therapeutic X-ray Services and materials
      iii. X-ray Special Procedures such as MRI, CT, PET and nuclear medicine. **Note:** Members will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. The Member is responsible for any applicable Copayment or Coinsurance for X-ray Special Procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to Emergency Services, non-emergency, non-routine care, and outpatient surgery.

   b. Inpatient

      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including diagnostic and therapeutic X-rays and isotopes, electrocardiograms, electroencephalograms, MRI, CT, PET and nuclear medicine are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory and X-ray Special Procedures Exclusions:
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What) to determine if you group has purchased additional coverage.
   a. Acupuncture Services.
   b. Naturopathy Services.
   c. Massage therapy.
   d. Spinal Manipulation Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Certain Exams and Services.** Physical exams and other Services, and related reports and paperwork, in connection with third-party requests or requirements, such as those for:
   a. Employment;
   b. Participation in employee programs;
   c. Insurance;
   d. Disability;
   e. Licensing; or
   f. On court order or for parole or probation.

3. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in major improvement in physical function. This includes cosmetic surgery related to bariatric surgery. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

4. **Custodial Care.** Assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse. Assistance with activities of daily living include: walking; getting in and out of bed; bathing; dressing; feeding; toileting and taking medicine.

5. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Physician for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma and, unless otherwise specified herein, (a) and (b) are received at a Plan Hospital, Plan Facility or Skilled Nursing Facility.
   The following Services for TMJ may be covered if a Plan Physician determines they are Medically Necessary: diagnostic X-rays; lab testing; physical therapy; and surgery.

6. **Directed Blood Donations.**

7. **Disposable Supplies.** Disposable supplies for home use such as:
   a. Bandages;
   b. Gauze;
   c. Tape;
   d. Antiseptics;
   e. Dressings;
   f. Ace-type bandages; and
   g. Any other supplies, dressings, appliances or devices, not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

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

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

viii. is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity or efficacy of the Service.

b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
   i. The Member's medical records; and
   ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
   iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
   iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
   v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
   vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

d. Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

10. **Genetic Testing.** Genetic testing unless determined to be: Medically Necessary; and meets Medical Group criteria.

11. **Infertility Services.** All Services related to the diagnosis or treatment of infertility unless your Group has purchased additional supplemental coverage.

12. **Intermediate Care.** Care in an intermediate care facility.

13. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

14. **Services for Members in the Custody of Law Enforcement Officers.** Non-Plan provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out of Plan Emergency Services or out-of-Plan non-emergency, non-routine care.

15. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

16. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

17. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accord with our internal travel and lodging guidelines in some situations, when Medical Group or a Plan Physician refers you to a non-Plan Provider outside our Service Area for transplant Services as described under "Getting a Referral" in the "How to Access Your Services and Obtain Approval of Benefits" section. Travel and lodging expenses are not covered for Members who are referred to a non-Plan Facility for non-transplant medical care. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.

18. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not een classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

19. **Weight Management Facilities.** Services received in a weight management facility.

20. **Workers' Compensation or Employer's Liability.** Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Charges for any such Services from the following sources:
    a. Any source providing a Financial Benefit or from whom a Financial Benefit is due.
    b. You, to the extent that a Financial Benefit is provided or payable or would have been 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.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

a. A "plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   i. "Plan" includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans 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.
   ii. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

b. "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this 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.

c. The order of benefit determination rules determine whether this plan is a "primary plan" or "secondary plan" when compared to another plan covering the person.

   When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits. When this plan is secondary, its benefits are determined after those of another plan and may be reduced because of the primary plan's benefits, so that all plan benefits do not exceed 100% of the total Allowable expense.

d. "Allowable expense" is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person 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 examples of expenses that are not allowable expenses:
   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

ii. If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

iii. If a person is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

iv. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the secondary plan to determine its benefits.

v. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the Plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. "Claim determination period" is usually a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person is covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period. However, it does not include any part of a year during which a person has no coverage under this plan, or before the date this COB provision or a similar provision takes effect.

f. "Closed panel plan" is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. "Custodial parent" means a parent awarded primary 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 two or more plans pay benefits, the rules for determining the order of payment are as follows:

a. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

b. A plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both plans state that the complying plan is primary.

i. There is an exception: Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

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

d. The first of the following rules that describes which plan pays its benefits before another plan is the rule to use.

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

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

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

1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
2. If both parents have the same birthday, the Plan that has covered the parent the longest is the primary plan.

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

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
2. 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;
3. 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
4. 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 child are as follows:
   - The plan covering the custodial parent;
   - The plan covering the spouse of the custodial parent;
   - The plan covering the non-custodial parent; and then
   - The plan covering the spouse of the non-custodial parent.

C. For a dependent child covered under more than one Plan of individuals who are not 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.

iii. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary 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 retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order of benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order of benefits.

v. Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the Secondary plan.

vi. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the Plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the secondary 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 its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. 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-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

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 plan and other plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a

benefit paid under this plan. Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have 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.

2. Injuries or Illnesses Alleged to be Caused by Other Parties
You must reimburse us 100% of Charges for covered Services you receive for an injury or illness that is alleged to be caused by another party. You do not have to reimburse us more than you receive from or on behalf of any other party, insurance company or organization as a result of the injury or illness. Our right to reimbursement shall include all sources as allowed by law. This includes any recovery you receive from: (a) uninsured motorist coverage; or (b) underinsured motorist coverage; or (c) automobile medical payment coverage; or (d) workers' compensation coverage or (e) any other liability coverage.

If you are involved in an automobile-related accident, please contact **Patient Financial Services** right away so that we can coordinate benefits with the automobile insurance carrier and determine whether we or the automobile insurance carrier has primary coverage.

To the extent allowed by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant Services.

We shall have a first priority lien on the proceeds of any judgment or settlement, whether by compromise or otherwise, you obtain against any other party, regardless of whether the other party admits fault. The proceeds of any judgment or settlement that you, your attorney or your representative get shall first be applied to fully satisfy our lien, even if the total amount of your recovery from all sources is less than the actual or estimated losses and damages you incurred, and without regard of how the proceeds are characterized or itemized. We deny any application of the Made Whole doctrine.

We will not be responsible for any fees you incur to obtain any judgment or settlement. Costs we incur will be borne by us. Costs of your representation will be borne by you. We deny any application of the Common Fund doctrine. Proceeds of such judgment or settlement in your or your attorney's possession shall be held in trust for our benefit.

Within 30 days after submitting or filing a claim or legal action against any other party, you must send written notice of the claim or legal action to **Patient Financial Services**. For us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us: all consents; releases; authorizations; assignments; and other documents, including lien forms directing your attorney, any other party and any respective insurer to pay us or our legal representatives directly. You must cooperate to protect our interests under this "Injuries or Illnesses Alleged to be Caused by Other Parties" provision and must not take any action prejudicial to our rights.

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

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers normally charge to the general public ("General Fees"). However, these contracts may allow providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

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

Note: For recoveries on or after August 11, 2010, reimbursement for benefits will be governed by state law.

3. Surrogacy
In situations where you receive monetary compensation to act as a surrogate, Health Plan will seek reimbursement of Charges for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, up to the monetary amount you receive to act as a surrogate. 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.

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, is located in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and Non-Emergency, Non-Routine Care is located in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from non–Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by non-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims.

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado State law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Physicians have telephone access to interpreters in over 150 languages.
3. Plan Physicians can also request an onsite interpreter for an appointment, procedure or Service.
4. Any interpreter assistance we arrange or provide will be at no Charge to the Member.

C. Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote efficient administration of the Group Agreement and this EOC.

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting Benefits/Coverage (What is Covered) under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

J. Binding Arbitration

Except for: (1) claims filed in Small Claims Court; (2) Claims subject to the Colorado Health Care Availability Act, Section 13-64-403, C.R.S.; (3) claims subject to the provisions of Colorado Revised Statutes, Section 10-3-1116(1); (4) Benefit claims under Section 502(a)(1)(B) of ERISA, pursuant to a qualified benefit plan; and (5) Claims subject to Medicare Appeals procedures, Chapter 13 of the Medicare Managed Care Manual; your enrollment in this health benefit plan requires that all claims by you, your spouse, your heirs, or anyone acting on your or their behalf, against Kaiser Foundation Health Plan of Colorado, the Medical Group, the Permanente Federation, LLC, The Permanente Company, LLC, or any employees or shareholders of these entities, or Plan Providers or Affiliated Physicians ("Respondent(s)"), which arise from any alleged failure or violation of, including but not limited to any duty relating to or incident to the Evidence of Coverage or the Medical and Hospital Services Agreement, must be submitted to binding arbitration before a single neutral arbiter. By enrolling in this health benefit plan, you have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

You must use Health Plan procedures to request arbitration. You can get a copy of these procedures from our **Quality, Risk, and Patient Safety** department**.** The arbitration hearing will be held in accord with Health Plan procedures, the Colorado Uniform Arbitration Act and the Federal Arbitration Act.

K. Claims Review Authority

We are responsible for determining whether you are entitled to Benefits/Coverage (What is Covered) under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

L. Contracts with Plan Providers

Your Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non–Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

M. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit will be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be eligible for this credit, you must submit an Explanation of Benefits/Coverage (What is Covered) ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call **Claims Customer Service**.

N. Governing Law

Except as preempted by federal law, this EOC will be governed in accord with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

O. Group and Members not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

P. No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Q. Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care Services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

R. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

S. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

T. Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* explains our privacy practices in detail. To request a copy, please call Member Services. You can also find the notice at your local Plan Facility or on our website, *www.kp.org*.

U. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give the Member more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you only need to:

1. Show your Health Plan ID card; and
2. Pay the fee, if any; to the company that provides the value-added service.

Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as deductible or out-of-pocket maximum.

To learn about value-added services and which ones are available to you, please check our:

1. Quarterly member magazine; or
2. Website, *www.kp.org*.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Dues.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

V. Women's Health and Cancer Rights Act

In accord with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Breast prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to Benefits/Coverage (What is Covered) end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination/Nonrenewal/Continuation" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in Section I, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

If your Group's Agreement with us terminates for any reason, your membership ends on the same date.

If your Group's Agreement terminates for reasons other than nonpayment of Dues, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts:

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Physician has made reasonable efforts to promote such a relationship; or

2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or Benefits/Coverage (What is Covered).

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to Benefits/Coverage (What is Covered) cease on the date of termination. You will be billed as a non-Member for any

Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

You are entitled to coverage only for the period for which we have received the appropriate Dues from your Group. If your Group fails to pay us the appropriate Dues for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

A. Performed an act, practice, or omission that constitutes fraud; or
B. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Dues, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Dues to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a subscriber who dies, divorces or legally separates or becomes entitled to Medicare or Medicaid Benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the "Eligibility" section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Dues, no later than 30 days after the date on which your Group coverage would otherwise terminate.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Dues to your Group and terminates on the earlier of:

   a. 18-months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

   We may terminate your continuation coverage if payment is not received when due.

   If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA

   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied plan service area, you should contact your Group's Benefits administrator before you move to learn about your Group health care options. You will be terminated from Health Plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, Benefits, dues and Copayments or Coinsurance may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).
2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of premiums (also called rescission or cancellation retroactively), or
   c. uphold our previous adverse benefit determination when you appeal.
3. An **appeal** is a request for us to review our initial adverse benefit determination.

In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied benefit, then such evidence establishes that the denial is subject to the appeals process.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described below in this "Appeals and Complaints" section.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

Reviewing Information Regarding Your Claim

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling the **Appeals Program**.

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should contact **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal

When you appeal, you may send us additional information including comments, documents, and additional medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to the **Appeals Program**. To arrange to give testimony by telephone, you should contact the **Appeals Program**.

We will add the information that you provide through testimony or other means to your claim file and we will review it without regard to whether this information was submitted and/or considered in our initial decision regarding your claim.

Sharing Additional Information That We Collect

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next adverse benefit determination we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the new or additional information and/or reasons and inform you how you can respond to the information in the letter if you choose to do so. If you do not respond before we must make our next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission).

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will he/she be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized or pre-certified in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

      If you want us to consider your pre-service claim on an urgent basis, your request should tell us that. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 you are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal thereof, to permit you to pursue an expedited external review.

      We will review your claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial 15 day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within the initial 15 day decision period, and we will give you 45 days to send the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our

request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

We will send written notice of our decision to you and, if applicable to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) orally or in writing within a timeframe appropriate to your clinical condition but not later than 72 hours after we receive your claim. Within 24 hours after we receive your claim, we may ask you for more information. We will notify you of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify you of our decision within 48 hours after making our request. If we notify you of our decision orally, we will send you written confirmation within three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Pre-Service Appeal
Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our denial of your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. Urgent Pre-Service Appeal
Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 you are requesting; or (c) your attending provider requests that your appeal be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, if we either (a) deny your request to extend your current authorized ongoing care (your concurrent care claim) or (b) inform you that authorized care that you are currently receiving is going to end early and you then appeal our adverse benefit determination at least 24 hours before your ongoing course of covered treatment will end, then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and

your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

Here are the procedures for filing a concurrent care claim, a non-urgent concurrent care appeal, and an urgent concurrent care appeal:

a. Concurrent Care Claim
Tell us in writing that you want to make a concurrent care claim for an ongoing course of covered treatment. Inform us in detail of the reasons that your authorized ongoing care should be continued or extended. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Member Services**.

If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your care ends, you may request that we review your concurrent claim on an urgent basis. We will decide whether your claim is urgent or non-urgent unless your attending health care provider tells us your claim is urgent. If we determine that your claim is not urgent, we will treat your claim as non-urgent. Generally, a claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize your life, health or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 extending your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

We will review your claim, and if we have all the information we need we will make a decision within a reasonable period of time. If you submitted your claim 24 hours or more before your care is ending, we will make our decision before your authorized care actually ends. If your authorized care ended before you submitted your claim, we will make our decision but no later than 15 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we send you notice before the initial 15 day decision period ends and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if your care has not ended, or within 15 days after we first receive any information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request.

If we consider your concurrent claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but not later than 24 hours after we received your appeal. If we notify you of our decision orally, we will send you written confirmation within three (3) days after receiving your claim.

If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Non-Urgent Concurrent Care Appeal
Within 180 days after you receive our adverse benefit determination notice, you must tell us in writing that you want to appeal our adverse benefit determination. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and all supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal
Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally, by mail or by fax to the **Appeals Program**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you are already disabled, create an imminent and substantial limitation on your existing ability to live independently; 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 continuing your course of covered treatment; or (c) your attending provider requests that your claim be treated as urgent. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

We will review your appeal and notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 72 hours after we receive your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within 180 days from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after 180 days from the date of Services.

We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information before the end of the initial 30 day decision period ends, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. Post-Service Appeal

Within 180 days after you receive our adverse benefit determination, tell us in writing that you want to appeal our denial of your post-service claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the specific Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to the **Appeals Program**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see Rescission of Membership under Section VIII. Termination/Nonrenewal/Continuation). We will send you written notice at least 30 days prior to the termination. If you have

general questions about retroactive membership terminations or appeals, please call the **Member Services Call Center** at **1-866-846-2650**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Member Services**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level Appeal

A Voluntary Second Level Appeal is another review by us that occurs after the mandatory internal appeal decision is communicated to you if you remain dissatisfied with our decision. This in-person review permits you to present evidence to the Second Level Appeal Panel and to ask questions. Choosing a Voluntary Second Level Appeal will not affect your right, if you have one, to request an independent external review.

Here is the procedure for a Voluntary Second Level of Appeal:

Within 30 days from the date of your receipt of our notice regarding your internal appeal. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or relevant symptoms, (3) the specific Service that you are requesting, (4) all of the reasons why you disagree with our adverse benefit determination (mandatory internal appeal decision), and (5) all supporting documents. Your request and the supporting documents constitute your request for a Voluntary Second Level of Appeal. You must mail your request to the **Appeals Program**.

Within sixty (60) calendar days following receipt of your request, Health Plan will hold a Second Level Appeal meeting. Health Plan shall notify you of the date on which the Second Level Appeal Panel will meet at least 20 days prior to the date of this in-person meeting. You may request to postpone this date, and your request cannot be unreasonably denied by Health Plan.

You may present your appeal in person before the Second Level Appeal Panel, or request a file review. If you would like to present your appeal in person, but an in-person meeting is not practical, you may present your appeal by telephone. Please indicate in your appeal request how you want to present your appeal. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review.

You may request in writing that Health Plan transmit all material that will be presented to the Second Level Appeal Panel at least five (5) days prior to the date of the Second Level Appeal meeting.

You may submit additional information with your appeal request, or afterwards but no later than five (5) days prior to the date of your Second Level Appeal meeting. Any additional new material developed after this deadline shall be provided to us as soon as practicable. You may present your case to the Second Level Appeal Panel and ask questions of the Panel. You may be assisted or represented by an appointed representative of your choice including an attorney (at your own expense), other advocate or health care professional. If you decide to have an attorney present at the Second Level Appeal meeting, then you must let us know that at least seven (7) days prior to that meeting. You must appoint this attorney as your representative in accordance with our procedures.

We will issue a written decision within seven (7) days of the completion of the Voluntary Second Level Appeal meeting.

If you would like further information about the Voluntary Second Level Appeal process, to assist you in making an informed decision about pursuing a Voluntary Second Level Appeal, please call the **Appeals Program**. Your decision to pursue a Voluntary Second Level Appeal will have no effect on your rights to any other Health Plan benefits, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that is (1) a denial of a preauthorization for a Service; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; and/or (3) a denial of a request for Services on the ground that the Service is experimental or investigational. If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review. However, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call the **Appeals Program** to request a copy of this form) to the **Appeals Program** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Appeals Program** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have an existing disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this 5 working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

Except when external review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, you must exhaust our internal claims and appeals procedure (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Dues, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Physician: Any doctor of medicine contracting with Medical Group to provide covered Services to Members under this EOC.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment: The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period . The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. For Dependent eligibility requirements, see "Who Is Eligible" in the "Eligibility" section.

Dues: Periodic membership charges paid by Group.

Emergency Medical Condition: A medical 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:

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

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

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

Family Unit: A Subscriber and all of his or her Dependents.

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Kaiser Permanente: Health Plan and Medical Group.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

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

Member: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Dues. This EOC sometimes refers to a Member as "you" or "your."

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A Plan Medical Office or Plan Hospital.

Plan Hospital: Any hospital listed as a Plan Hospital in our provider directory. Plan Hospitals are subject to change at any time without notice.

Plan Medical Office: Any medical office listed in our provider directory. Plan Medical Offices are subject to change at any time without notice.

Plan Optometrist: Any licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies are subject to change at any time without notice.

Plan Physician: Any licensed physician who is an employee of Medical Group, an Affiliated Physician or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, Plan Physician or other health care provider that we designate as Plan Provider, except that Plan Providers are subject to change at any time without notice.

Service Area:
The ***Denver/Boulder*** Service Area is that portion of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Larimer, Park, Teller and Weld counties within the following zip codes: 80001, 80002, 80003, 80004, 80005, 80006, 80007, 80010, 80011, 80012, 80013, 80014, 80015, 80016, 80017, 80018, 80019, 80020, 80021, 80022, 80023, 80024, 80025, 80026, 80027, 80030, 80031, 80033, 80034, 80035, 80036, 80037, 80038, 80040, 80041, 80042, 80044, 80045, 80046, 80047, 80102, 80104, 80107, 80108, 80109, 80110, 80111, 80112, 80113, 80116, 80117, 80120, 80121, 80122, 80123, 80124, 80125, 80126, 80127, 80128, 80129, 80130, 80131, 80134, 80135, 80137, 80138, 80150, 80151, 80155, 80160, 80161, 80162, 80163, 80165, 80166, 80201, 80202, 80203, 80204, 80205, 80206, 80207, 80208, 80209, 80210, 80211, 80212, 80214, 80215, 80216, 80217, 80218, 80219, 80220, 80221, 80222, 80223, 80224, 80225, 80226, 80227, 80228, 80229, 80230, 80231,

80232, 80233, 80234, 80235, 80236, 80237, 80238, 80239, 80241, 80243, 80244, 80246, 80247, 80248, 80249, 80250, 80251, 80252, 80256, 80257, 80259, 80260, 80261, 80262, 80263, 80264, 80265, 80266, 80271, 80273, 80274, 80281, 80290, 80291, 80293, 80294, 80299, 80301, 80302, 80303, 80304, 80305, 80306, 80307, 80308, 80309, 80310, 80314, 80401, 80402, 80403, 80419, 80421, 80422, 80425, 80427, 80433, 80437, 80439, 80452, 80453, 80454, 80455, 80457, 80465, 80466, 80470, 80471, 80474, 80481, 80501, 80502, 80503, 80504, 80510, 80514, 80516, 80520, 80530, 80533, 80540, 80544, 80601, 80602, 80603, 80614, 80621, 80623, 80640, 80642, 80643.

The ***Mountain Colorado*** Service Area is that portion of Eagle, Garfield, Grand, Routt and Summit counties within the following zip codes: 80423. 80424, 80426, 80435, 80443, 80463, 80497, 80498, 81620, 81631, 81632, 81637, 81645, 81649, 81655, 81657, 81658.

The ***Northern Colorado*** Service Area is that portion of Adams, Boulder, Larimer, Morgan, and Weld counties within the following zip codes: 69128, 69145, 80511, 80512, 80513, 80515, 80517, 80521, 80522, 80523, 80524, 80525, 80526, 80527, 80528, 80532, 80534, 80535, 80536, 80537, 80538, 80539, 80541, 80542, 80543, 80545, 80546, 80547, 80549, 80550, 80551, 80553, 80610, 80611, 80612, 80615, 80620, 80622, 80624, 80631, 80632, 80633, 80634, 80638, 80639, 80644, 80645, 80646, 80648, 80649, 80650, 80651, 80652, 80654, 80729, 80732, 80742, 80754, 82063, 82082.

The ***Southern Colorado*** Service Area is that portion of Crowley, Custer, Douglas, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Otero, Park, Pueblo and Teller counties within the following zip codes: 80106, 80118, 80132, 80133, 80808, 80809, 80813, 80814, 80816, 80817, 80819, 80820, 80827, 80829, 80831, 80832, 80833, 80840, 80841, 80860, 80863, 80864, 80866, 80901, 80902, 80903, 80904, 80905, 80906, 80907, 80908, 80909, 80910, 80911, 80912, 80913, 80914, 80915, 80916, 80917, 80918, 80919, 80920, 80921, 80922, 80923, 80924, 80925, 80926, 80927, 80928, 80929, 80930, 80931, 80932, 80933, 80934, 80935, 80936, 80937, 80938, 80939, 80941, 80942, 80943, 80944, 80945, 80946, 80947, 80949, 80950, 80951, 80960, 80962, 80970, 80977, 80995, 80997, 81001, 81002, 81003, 81004, 81005, 81006, 81007, 81008, 81009, 81010, 81011, 81012, 81019, 81022, 81023, 81025, 81039, 81062, 81069, 81212, 81215, 81221, 81222, 81223, 81226, 81232, 81233, 81240, 81244, 81253, 81290.**Services:** Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spinal Manipulation: Adjustment and manipulation of the vertebral column.

Spouse: Your partner in marriage or a civil union as determined by State law.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see “Who Is Eligible” in the “Eligibility” section).

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ADDITIONAL PROVISIONS

Please refer to the Summary Chart in this booklet for specific charges and other limitations that may apply to the coverage(s) described below.

DOMESTIC PARTNER COVERAGE

Your Group coverage includes health benefits for same-gender domestic partners. To be covered they must meet:

(1) the eligibility requirements as described in the "Eligibility" section of this Evidence of Coverage; and

(2) the conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group's benefit administrator for details.

DOMP0AA (01-15)

ELIGIBILITY AND ENROLLMENT

(Does not apply to Kaiser Permanente Senior Advantage HMO Plan)

You must live or work in Health Plan's Service Area at the time of enrollment.

WOR0AA (01-10)DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Physician and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional Charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device or orthotic device that adequately meets a Member's medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage:
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Physician, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.
   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.
   c. Durable Medical Equipment Exclusions:
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.
      iv. Exercise or hygiene equipment.
      v. Comfort, convenience, or luxury equipment or features.
      vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
      vii. Replacement of lost equipment.
      viii. Repairs, adjustments or replacements necessitated by misuse.

ix. More than one piece of DME serving essentially the same function, except for replacements.
x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Medical Group or Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Physician and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Physician, as Medically Necessary and when obtained from sources designated by Health Plan.
   b. Prosthetic Devices Exclusions:
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment for treatment of cleft lip and cleft palate, as described above.
      ii. Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.
      iv. Spare devices or alternate use devices.
      v. Replacement of lost prosthetic devices.
      vi. Repairs, adjustments or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
      Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions:
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accord with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Physician, unless the Member is covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost orthotic devices.
      vii. Repairs, adjustments or replacements necessitated by misuse.

DMES0AB (01-16)
INFT0AA

INFERTILITY BENEFIT

1. **Coverage:**

   We cover the following Services as shown on the "Schedule of Benefits (Who Pays What)":

   a. Services for diagnosis and treatment of involuntary infertility (includes lab and X-ray); and.
   b. Office administered drugs; and
   c. Artificial insemination.

2. **Infertility Exclusions**:

   These exclusions apply to fertile as well as infertile individuals or couples.
   a. Services to reverse voluntary, surgically induced infertility.
   b. Donor semen.
   c. All Services and supplies related to procurement or storage of donor semen for artificial insemination.
   d. Prescription drugs received from the pharmacy for artificial insemination.
   e. Any and all Services, supplies, office administered drugs and prescription drugs received from the pharmacy that are related to conception by artificial means (in vitro fertilization; ovum transplants; gamete intra fallopian transfer; and zygote intra fallopian transfer)

PREVENTIVE SERVICES RIDER

Preventive care services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the " Schedule of Benefits (Who Pays What)" when prescribed by a Plan Physician. Please contact Member Services for a complete list of covered Preventive Services.

Coverage includes, but not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your Primary Care Plan Physician.
3. Cervical cancer screening.
4. Breast cancer screening.
5. Cholesterol screening.
6. Colorectal cancer screening.
7. Immunizations pursuant to the schedule established by the ACIP.
8. Tobacco use screening of adults and tobacco cessation interventions by your Primary Care Plan Physician.
9. Type 2 diabetes screening for adults with high blood pressure.
10. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
11. Prostate Cancer screening.
12. Cervical cancer vaccines.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. www.cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.

PV0AA (01-14)

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this Evidence of Coverage or Membership Agreement, the term "preferred" refers to drugs that are included in the Health Plan Drug Formularies. The term "non-preferred" refers to drugs that are not included in the Health Plan Drug Formularies.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible and supply limits that apply to the covered prescription drugs described below.

1. Coverage:
   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a preferred generic drug tier; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; specialty drugs, including self-administered injectable drugs; and a tier for prescribed non-preferred drugs authorized through the non-preferred drug process.

   Prescribed supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.
   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Kaiser Permanente may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs:
   a. Available in the United States only from a single manufacturer; and
   b. Not listed as generic in the then-current commercially available drug database(s) Health Plan subscribes to;
   are provided at the brand-name Copayment. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Physician and are obtained at Plan Pharmacies; or
   b. Physician to whom a Member has been referred by a Plan Physician and are obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions); and are obtained at Plan Pharmacies.

   Covered drugs include:

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

   b. Insulin

   c. For Denver/Boulder and Northern Colorado Service Areas, compounded medications as long as they are on the compounding formulary.

2. Limitations for Southern Colorado Service Area:
   a. Some drugs may require prior authorization.
   b. Plan Physicians may request compound medications through the medical exception process. Medical Necessity requirements must be met.
   c. Plan Physicians may apply for formulary exceptions in cases where it is Medically Necessary.

3. Drugs, Supplies and Supplements Exclusions:
   a. Prescription drugs necessary for Services excluded in the Evidence of Coverage or Membership Agreement.
   b. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   c. Any drugs listed as not covered in the Schedule of Benefits
   d. Drugs to shorten the length of the common cold.
   e. Drugs to enhance athletic performance.
   f. Drugs available over the counter and by prescription for the same strength.
   g. Individual drugs and/or Drug classes determined excluded by our Pharmacy and Therapeutics Committee.
   h. Drugs for the treatment of weight control.
   i. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   j. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged or stolen prescriptions.
   k. Unless approved by Health Plan, drugs:
      i. Not approved by the FDA; and
      ii. Not in general use as of March 1 of the year prior to your effective date or last renewal.

RX0BL (01-16)

Kaiser Foundation Health Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

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MARK A WOZNY
1216 ASPEN DR
BERTHOUD, CO 80513-1000

Important plan information

000005920 008 AC21 NC ID GP 59_16 [Jan 28 2016] OVC1UHOSPCBBLDKFMHOP1QSPVC1NOPT--CDOP0THEAR3NEMER2ZPV0TAFTR2E ACUMCLALG1DALGT9DAMB0QAUTB0RBLD2ZCDIPZ2CDRR 39CHIR--CMPL--COIN15CRCS0KDEDL0DENNADIAL2ZDMEBE2DMES1KDPP--DUMY01EMPH--EPOT--EXAB--FAMC4GRP0OGYN1LHC2ZHCSS0JHH2ZHLTHC0HOS250HRA--INFTX5LAB15LTMNAMHBI02MH BO01MHIP13OPMYROVC2E2OXYGE2RX03KFPNMT1OPP--REHB05REOP2USGOP71SNF2DSNKR--STUL--TABS2ZTRAN12TRGNCCTRVL--WLCH0JXPRO2ZXRAY1URX03KF DOMP01GREX01GRFD02OAD6 MOAS6MWORAEOCXIC

SUBJECT: **REJECT BIDS FOR RECREATION CENTER CAMPUS AND HERITAGE PARK A.D.A. RESTROOM IMPROVEMENTS PROJECTS**

DATE: **MARCH 8, 2016**

PRESENTED BY: **JOE STEVENS, PARKS AND RECREATION DIRECTOR**

SUMMARY:
Previously, the City of Louisville completed a Federally Mandated American's with Disability Audit and Transition Plan for the City of Louisville's Parks and Recreation Department. In 2015 the Recreation Center Campus Restroom Facility and the Heritage Park Restroom Facilities were included within the City Adopted Capital Improvements Plan (CIP). The City contracted with Allred and Associates to design and prepare construction documents to include the following:

- Construction of a new A.D.A. compliant restroom facility with plumbing and heating for year-round use at the Recreation Center Campus.
- Demolition and removal of the existing restroom facility at Heritage Park and construction of a new A.D.A. compliant restroom facility with plumbing and heating for year-round use.

After construction documents were completed and reviewed by the former Horticulture & Forestry Advisory Board, an Invitation to Bid was posted on the City website and published in the Daily Camera on January 17th and February 1st, and was advertised on Rocky Mountain Bid System. The bid opening occurred on February 18th with the following bids accepted for the Recreation Center Campus Facility:

Company	Address	Base Bid Amount
Vertix Builders	3762 Puritan Way, Unit 1 Frederick CO	$725,218
Anderson Construction	4963 Verbena St. Denver, CO	$481,684
Basset & Associates, Inc.	7076 S. Alton Way, Bldg. C Centennial, CO	$541,320
DS Constructors, LLC	3780 N. Garfield Ave. Ste. 101 Loveland, CO	$754,440
Rhinotrax Construction, Inc.	1035 Coffman St. Ste. 110 Longmont, CO	$583,808
Carwile Construction Co.	9745 East Hampden Ave. Ste. 303 Denver, CO	$543,948
Casey Construction, LLC	1418 Clermont St. Denver, CO	$566,988

The following bids were accepted for the Heritage Park Facility:

Company	Address	Base Bid Amount
Vertix Builders	3762 Puritan Way, Unit 1 Frederick CO	$510,418
Anderson Construction	4963 Verbena St. Denver, CO	$472,945
Basset & Associates, Inc.	7076 S. Alton Way, Bldg. C Centennial, CO	$505,705
DS Constructors, LLC	3780 N. Garfield Ave. Ste. 101 Loveland, CO	$713,908
Rhinotrax Construction, Inc.	1035 Coffman St. Ste. 110 Longmont, CO	$517,867
Carwile Construction Co.	9745 East Hampden Ave. Ste. 303 Denver, CO	$442,283
Casey Construction, LLC	1418 Clermont St. Denver, CO	$476,776

Details on bid alternates are shown below.

- Alternate #1: Replace manufactured stone with natural stone.
- Alternate #2: Replace the Corten steel roof with a different material to reduce cost.
- Alternate #3 & #4: Changes to the floor and ceiling finishes to reduce cost.

The Recreation Center Campus Facility was originally budgeted in the amount of $199,000 and the Heritage Park Facility was originally budget in the amount of $160,500. With all of the bids significantly exceeding the budgets and the Architects Estimate of probable costs, staff is recommending that all bids be rejected and other methods of acquiring A.D.A. Compliant Restroom Facilities is explored in hopes of finding an acceptable, cost effective alternative.

FISCAL IMPACT:
None

RECOMMENDATION:
Staff recommends City Council direct staff to reject all bids and explore options to acquire A.D.A. Compliant Restroom Facilities.

ATTACHMENT(S):
None

City of Louisville
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CITY COUNCIL COMMUNICATION
AGENDA ITEM 5E

SUBJECT: **APPROVAL OF INTERIM APPOINTMENTS TO THE CULTURAL COUNCIL**

DATE: **MARCH 8, 2016**

PRESENTED BY: **MEREDYTH MUTH, CITY MANAGER'S OFFICE**

SUMMARY:
The Cultural Council (LCC) currently has two vacant positions. The board has recruited two residents, Paul Ewing and Steve Spencer, who wish to serve on the LCC for the remainder of 2016. Each has submitted an application (attached) and the Mayor has interviewed each by phone. As these are mid-year appointments the terms expire at the end of 2016. Both are eligible to apply for full terms during the regular appointment process at the end of the year.

FISCAL IMPACT:
None

RECOMMENDATION:
Appoint Paul Ewing and Steve Spencer to the Cultural Council for the remainder of 2016.

ATTACHMENT(S):
1. Paul Ewing Application
2. Steve Spencer Application

City of Louisville
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Meredyth

2016 Cultural Council Vacancy Application for Appointment

The Cultural Council is recruiting for two members to fill vacancies on the board. These appointments to the LCC will be for the remainder of 2016 and anyone appointed will need to reapply to the Council for 2017 during the annual appointment process in November.

You MUST meet the following criteria to serve on ANY Louisville Board or Commission:

- You must reside in the City of Louisville
- You may not be an employee of the City of Louisville

Name of Applicant: ___Paul Ewing_____

Date of Birth: ___**Jan 26, 1945**_____

Home Address: _____638 West Pine Street_____Louisville CO 80027

Home Phone Number: __303-673-0606_____ **Cell Phone Number:**303-453-9250__

Email Address: _____p.ewing@comcast.net_____

Occupation: ____Retired_____

Employer: _____

Length of Time Living in Louisville: ____27 years_____

Education: _____BS Degree Business _____

STATEMENT OF INTEREST: THE LOVE FOR THE ARTS, COLLECTOR OF ALL TYPES OF MEDIA.

Briefly describe your interest in serving on this Board or Commission. Feel free to indicate any areas of expertise, background, concerns and/or general information may be applicable.

NOTE: *You may also attach a letter, resume, statement, or other information you feel may be relevant to your application.*

SCHEDULING CONFLICTS:

What times Monday through Thursday are you generally **unavailable** to attend meetings? (The meeting times of each board are available on the City's web site at www.LouisvilleCO.gov.)

_____

DISCLOSURES:

It is the policy of the City Council to make appointments to the citizen boards, commissions, committees, and task forces based on the needs of the City as well as the interests and qualifications of each applicant without discrimination based on race, color, national origin or ancestry, gender, religious convictions, disability, age, or sexual orientation.

City of Louisville
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Within the last ten years, have you ever been convicted of a crime or received a suspended sentence, deferred sentence or deferred prosecution, or forfeited bail, for any offense in criminal or military court, or do you have any criminal charges currently pending against you? Exclude minor traffic violations.
☐ YES **X NO** If yes, list for each case:
(1) date of offense; (2) charge; (3) jurisdiction; (4) court name and (5) disposition:

_____

_____

Within the last ten years, has your driver's license in any state ever been suspended or revoked, or have you ever been denied a driver's license in any state? ☐ YES **X NO**
If Yes, please explain below:

_____

_____

Have you ever been involved in an incident involving child/elder abuse or child/elder neglect for which a report was filed with or issued by any law enforcement agency or social services agency? ☐ YES **X NO** If Yes, please explain below:

_____

_____

Do you or a company you work for or own do business with the City of Louisville?
☐ YES **X NO** If Yes, please explain below:

_____

_____

- **All Board and Commission members serve without compensation.**
- **Anyone applying to a Board or Commission is subject to a background check.**
- **The City may reject an applicant for any lawful reason. An appointed Board or Commission member may be removed during his/her term of office for cause as defined in the City Charter and Resolution No. 16, Series 2009. Reasons for rejection or removal from office include, without limitation, where a background investigation reveals an arrest, conviction, or pending charges for a criminal offense (excluding minor traffic violations).**
- **All information on this application is public record and may be released for public review.**
- **Questions about a board/commission or the application process may be directed to Meredyth Muth (MeredythM@LouisvilleCO.gov or 303.335.4536).**

I certify that the information in this application is true and complete. I understand false statements, misrepresentations or omissions of information in this application may result in

City of Louisville
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rejection of this application. The City is expressly authorized to investigate all statements contained in this application and, in connection therewith, to request a criminal history. I consent to the release of information about my ability and fitness for volunteer assignment by employers, schools, criminal justice agencies, and other individuals and organizations to investigators, personnel staffing specialists, and other authorized employees of the City of Louisville, and release all parties for all liability for any damage that may result from furnishing such information.

In the event that I am selected to serve on a City of Louisville Board or Commission, I agree to comply with all of its ordinances, rules, and regulations. I fully understand and agree to provide my services to the City of Louisville as a volunteer in a voluntary capacity and that I will receive no compensation or benefits for services provided.

I understand that I am NOT insured by the City of Louisville Worker's Compensation Insurance and NOT covered by any Accident Medical Insurance Policy while I am a volunteer with the City of Louisville. I authorize that all necessary first aid steps may be taken as prescribed by qualified personnel.

I grant full permission to use any photographs, videotapes, recordings or any other record of my volunteer participation as a Board or Commission member.

The City will provide any applicant who is rejected as a result of a background investigation information on how to obtain the report and contact information for the reporting agency. Determinations to reject an applicant as a result of the criminal background investigation report are final.

BY SIGNING BELOW, I AGREE THAT I UNDERSTAND AND CONSENT TO THE ABOVE STATEMENT:

Paul W Ewing — **Feb 17, 2016**

Signature — Date

City of Louisville
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2016 Cultural Council Vacancy Application for Appointment

The Cultural Council is recruiting two members to fill vacancies for 2016. These appointments will be for the remainder of 2016 and anyone appointed will need to reapply to the Council for 2017 during the annual appointment process in November.

You MUST meet the following criteria to serve on ANY Louisville Board or Commission:

- You must reside in the City of Louisville
- You may not be an employee of the City of Louisville

Name of Applicant: Steven C Spencer

Date of Birth: 5/8/1949

Home Address: 931 Treece Street Louisville CO 80027

Home Phone Number: 303 284 2463 **Cell Phone Number:** 720 378 3105

Email Address: StevecSpencer@Comcast.net

Occupation: Real Estate Appraiser

Employer: Self

Length of Time Living in Louisville: 4 1/2 yrs

Education: B.A. Econ M.A. Econ

STATEMENT OF INTEREST:
Briefly describe your interest in serving on this Board or Commission. Feel free to indicate any areas of expertise, background, concerns and/or general information that may be applicable.

I have assisted with the cultural council's activities for several years and enjoy the experience.

NOTE: *You may also attach a letter, resume, statement, or other information you feel may be relevant to your application.*

It is the policy of the City Council to make appointments to the citizen boards, commissions, committees, and task forces based on the needs of the City as well as the interests and qualifications of each applicant without discrimination based on race, color, national origin or ancestry, gender, religious convictions, disability, age, or sexual orientation

City of Louisville
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SCHEDULING CONFLICTS:
What times Monday through Thursday are you generally **unavailable** to attend meetings? (The meeting times of each board are available on the City's web site at www.LouisvilleCO.gov.)

9 - 4

DISCLOSURES:

Within the last ten years, have you ever been convicted of a crime or received a suspended sentence, deferred sentence or deferred prosecution, or forfeited bail, for any offense in criminal or military court, or do you have any criminal charges currently pending against you? Exclude minor traffic violations.
☐ YES ☒ NO If yes, list for each case:
(1) date of offense; (2) charge; (3) jurisdiction; (4) court name and (5) disposition:

Within the last ten years, has your driver's license in any state ever been suspended or revoked, or have you ever been denied a driver's license in any state? ☐ YES ☒ NO
If Yes, please explain below:

Have you ever been involved in an incident involving child/elder abuse or child/elder neglect for which a report was filed with or issued by any law enforcement agency or social services agency? ☐ YES ☒ NO If Yes, please explain below:

Do you or a company you work for or own do business with the City of Louisville?
☐ YES ☒ NO If Yes, please explain below:

- **All Board and Commission members serve without compensation.**
- **Anyone applying to a Board or Commission is subject to a background check.**
- **The City may reject an applicant for any lawful reason. An appointed Board or Commission member may be removed during his/her term of office for cause as defined in the City Charter and Resolution No. 16, Series 2009. Reasons for rejection or removal from office include, without limitation, where a background investigation reveals an arrest, conviction, or pending charges for a criminal offense (excluding minor traffic violations).**

City of Louisville
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- **All information on this application is public record and may be released for public review.**
- **Questions about a board/commission or the application process may be directed to Meredyth Muth (MeredythM@LouisvilleCO.gov or 303.335.4536).**

I certify that the information in this application is true and complete. I understand false statements, misrepresentations or omissions of information in this application may result in rejection of this application. The City is expressly authorized to investigate all statements contained in this application and, in connection therewith, to request a criminal history. I consent to the release of information about my ability and fitness for volunteer assignment by employers, schools, criminal justice agencies, and other individuals and organizations to investigators, personnel staffing specialists, and other authorized employees of the City of Louisville, and release all parties for all liability for any damage that may result from furnishing such information.

In the event that I am selected to serve on a City of Louisville Board or Commission, I agree to comply with all of its ordinances, rules, and regulations. I fully understand and agree to provide my services to the City of Louisville as a volunteer in a voluntary capacity and that I will receive no compensation or benefits for services provided.

I understand that I am NOT insured by the City of Louisville Worker's Compensation Insurance and NOT covered by any Accident Medical Insurance Policy while I am a volunteer with the City of Louisville. I authorize that all necessary first aid steps may be taken as prescribed by qualified personnel.

I grant full permission to use any photographs, videotapes, recordings or any other record of my volunteer participation as a Board or Commission member.

The City will provide any applicant who is rejected as a result of a background investigation information on how to obtain the report and contact information for the reporting agency. Determinations to reject an applicant as a result of the criminal background investigation report are final.

BY SIGNING BELOW, I AGREE THAT I UNDERSTAND AND CONSENT TO THE ABOVE STATEMENT:

Steven C Spencer
Signature

2/18/2016
Date

CITY COUNCIL COMMUNICATION
AGENDA ITEM 5F

SUBJECT: **RESOLUTION NO. 11, SERIES 2016 – A RESOLUTION APPROVING AND ADOPTING THE 2016 BOULDER COUNTY, COLORADO MULTI-HAZARD MITIGATION PLAN**

DATE: **MARCH 8, 2016**

PRESENTED BY: **CHIEF DAVID D. HAYES, POLICE DEPARTMENT**

SUMMARY:
An adopted Multi-Hazard Mitigation Plan is required as a condition of future funding for mitigation projects under multiple FEMA pre- and post-disaster mitigation grant programs. Undertaking hazard mitigation actions will reduce the potential for harm to people and property from future hazard occurrences.

The Colorado Division of Emergency Management and Federal Emergency Management Agency, Region VIII officials have reviewed the Boulder County, Colorado Multi-Hazard Mitigation Plan and approved it, contingent upon this official adoption of the participating governing body (the City of Louisville); which resides within the county Planning Area, and fully participated in the mitigation planning process to prepare this Multi-Hazard Mitigation Plan.

As a participating governing body within Boulder County, the City of Louisville's portion of the Mitigation Plan is referenced in Annex F: Louisville.

FISCAL IMPACT:
N/A

RECOMMENDATION:
Approve the Boulder County Multi-Hazard Mitigation Plan, which includes Annex F: Louisville.

ATTACHMENT(S):
1. Resolution No. 11, Series 2016
2. Boulder County, Colorado Multi-Hazard Mitigation Plan 2016

RESOLUTION NO. 11
SERIES 2016

A RESOLUTION APPROVING AND ADOPTING THE 2016 BOULDER COUNTY, COLORADO MULTI-HAZARD MITIGATION PLAN

Whereas, the City of Louisville recognizes the threat that natural hazards pose to people and property within our community; and

Whereas, undertaking hazard mitigation actions will reduce the potential for harm to people and property from future hazard occurrences; and

Whereas, an adopted Multi-Hazard Mitigation Plan is required as a condition of future funding for mitigation projects under multiple FEMA pre- and post-disaster mitigation grant programs; and

Whereas, the Colorado Division of Emergency Management and Federal Emergency Management Agency, Region VIII have reviewed the 2016 Boulder County, Colorado Multi-Hazard Mitigation Plan and approved it contingent upon official adoption of the participating governing bodies; and

Whereas, the City of Louisville resides within the county Planning Area, and fully participated in the mitigation planning process to prepare the 2016 Boulder County Multi-Hazard Mitigation Plan; and

Whereas, the City Council desires approve and adopt such Plan so that the goals and objectives of the Plan can be pursued and accomplished.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF LOUISVILLE, COLORADO:

1. The City of Louisville hereby approves and adopts the 2016 Boulder County, Colorado, Multi-Hazard Mitigation Plan (the "Plan") as an official plan of the City of Louisville. A copy of the Plan accompanies this Resolution.

2. The City staff is hereby authorized and directed to submit this adopted Resolution to the Colorado Division of Emergency Management and Federal Emergency Management Agency, Region VIII to enable the Plan's final approval.

3. The Mayor, City Manager and City staff are hereby authorized and directed to take such other actions as are necessary to provide for the final approval and effectiveness of the Plan and to implement and carry out the goals and objectives of the Plan, subject to and consistent with budgetary and other measures adopted by the City Council.

PASSED AND ADOPTED this 8th day of March, 2016

By:_____
Robert P. Muckle, Mayor

Attest: _____
Carol Hanson, Acting City Clerk

Hazard Mitigation Plan

Boulder County

The Hazard Mitigation Plan identifies hazards in Boulder County and identifies values at risk and mitigation projects to reduce or eliminate impacts through community involvement.

Adopted March 8, 2016

Annex F: Louisville

F.1 Community Profile

The City of Louisville is a home rule municipality with 8 square miles within the municipal boundaries. The City lies in southeastern Boulder County roughly six miles east of the City of Boulder and 25 miles northwest of Denver. The Louisville area is characterized by generally flat lands and low hills with some gently rolling terrain trending toward Coal Creek and Rock Creek.

The City of Louisville's history is based on coal mines and the coal mining industry. Louisville is an area that was known as the Northern Coal Field, an extensive coal field in Boulder and Weld counties. In August 1877 the first coal mine was opened and Louis Nawatny, a land owner in the area, platted his farmland into the town and named it after himself. Coal miners from around the world moved to the new town to work in the new, safer mine. Because mining was seasonal, and strikes too often interrupted production, the economy was generally depressed. Family gardens and odd jobs were the way of life during summertime unemployment.

From 1890 to 1928, the Acme Mine operated directly beneath the original town of Louisville. Worked on two levels, the Acme produced nearly two million tons of coal and was one of 171 coal mines in Boulder County. There were 30 mines that opened in and around Louisville. During the peak years of 1907 to 1909, there were 12 mines in operation. The use of coal declined following World War II, and the last mines in and around Louisville closed in 1952.

The community has become a generally middle-class community where the workers leave for all manner of jobs in every direction. In recent years, a variety of advanced industries including bioscience, advanced engineering, software, and natural products have opened facilities and offices in Louisville providing employment opportunities and attracting new residents.

F.1.1 Population

The estimated 2014 population of the City of Louisville was 20,112. Select Census 2000 demographic and social characteristics for Louisville are shown in Table F.1.

Table F.1. Louisville's Demographic and Social Characteristics

Characteristic	
Gender/Age	
Male (%)	49.0%
Female (%)	51.0%
Under 5 Years (%)	5.8%
65 Years and Over (%)	9.9%
Race/Ethnicity (one race)	
White (%)	90.8%
Hispanic or Latino (Of Any Race) (%)	7.2%
Other	
Average Household Size	2.42%
High School Graduate or Higher (%)	98.7%

Source: U.S. Census Bureau, 2010, www.census.gov/

F.1.2 Economy

According to the 2009-2013 Census Bureau's Community Survey , the industries that employed most of Louisville's labor force were educational, health and social services (26.2%); professional, scientific, management, administrative and waste management services (21%); manufacturing (12.2%); and Arts, entertainment, and recreation, and accommodation and food services (7.8%). Select economic characteristics for Louisville from the 2009-2013 Census Bureau's Community Survey are shown in Table F.2.

Table F.2. Louisville's Economic Characteristics

Characteristic	
Families below Poverty Level, 2009-2013	6.2%
Individuals below Poverty Level, 2009-2013	6.8%
Median Home Value, 2009-2013	$370,800.00
Median Household Income, 2009-2013	$84,560.00
Per Capita Income, 2009-2013	$42,586.00
Population in Labor Force, 2009-2013	10,969

Source: U.S. Census Bureau (2009-2013) Community Survey, www.census.gov/

F.2 Hazard Summary

The most significant hazards for Louisville are floods, expansive soils, land subsidence, severe winter storm and wildfire. Refer to Section 4.3 Vulnerability Assessment for detailed vulnerability to the flood hazard. Due to the historical coal mining in the area subsidence of the land surface is a concern in Louisville. Other hazards that could impact Louisville include dam failure, drought, hailstorm, earthquake, extreme heat, lightning, tornado, windstorm, West Nile Virus and Pandemic Flu.

F.3 Asset Inventory

F.3.1 Property Inventory

Table F.3 represents an inventory of property in Louisville based on the Boulder County Assessor's data as of September, 2015.

Table F.3. Louisville's Property Inventory

Property Type	Parcel Count	Land Values ($)	Improved Parcel Count	Improved Values ($)	Total Values ($)
Residential	6,357	$1,235,283,600	6,355	$1,865,255,569	$3,100,539,169
Commercial	261	$140,463,892	261	$287,429,032	$427,892,924
Industrial	112	$42,389,131	65	$224,358,946	$266,748,077
Exempt	65	$43,578,078	112	$107,626,662	$151,204,740
Agricultural	4	$79,300	4	$1,414,000	$1,493,300
Vacant	282	$81,068,258	0	$0	$81,068,258
Minerals	28	$11,900	0	$0	$11,900
State Assessed	163	$44,209,510	0	$0	$44,209,510
Unknown	-	-	-	-	0
Total	**7,272**	**$1,587,083,669**	**6,797**	**$2,486,084,209**	**$4,073,167,878**

Source: Boulder County Assessor's Office

F.3.2 Other Assets

Table F.4 is a detailed inventory of assets identified by the City's planning team. This inventory includes critical facilities. For more information about how "critical facility" is defined in this plan, see Section 4.3 Vulnerability Assessment.

Table F.4. Louisville's Assets

Name of Asset	Type	Address	Replacement Value ($)	Occupancy /Capacity #	Hazard Specific Info
Avista Hospital	Essential	100 Health Park Dr.	$39,157,800	800	
Centennial Peaks Mental Hospital	Essential	2255 S. 88th St.	$3,429,000	300	
Louisville Fire Department 2	Essential	895 Via Appia Wy	$2,479,900	50	
Louisville Fire Department 1	Essential	1240 Main Street	$1,235,800	50	
Louisville Fire Department 3	Essential	489 S. 104th St.	$6,565,700	50	

Table F.4. Louisville's Assets (cont'd)

Louisville Police & Court Building	Essential	992 Via Appia	$5,165,000	100	
Schools- Boulder Valley School District	High potential loss	Various	$76,380,600	Various	
Balfour Nursing Home	High potential loss	1336 Hecla	$70,000,000	1200	
Wellspring Nursing Home	High potential loss	1078 S. 88th St.	$13,000,000	300	
Harper Lake Dam	High potential loss	1052 McCaslin	$4,000,000		
Louisville City Hall	High potential loss	749 Main St.	$10,000,000	200	
Louisville Public Works Shops	High potential loss	1501 Empire	$4,000,000	120	
Louisville Library	High potential loss	800 Front	$20,000,000	250	
Louisville Elementary School	High potential loss	400 Hutchinson	$6,000,000	500	
Coal Creek Elementary School	High potential loss	801 W Tamarisk	$6,000,000	500	
Monarch K-8 School	High potential loss	263 Campus	$20,000,000	600	
Fireside Elementary	High potential loss	845 W Dahlia	$6,000,000	500	
Louisville Middle School	High potential loss	1341 Main St.	$20,000,000	1200	
Monarch High School	High potential loss	329 Campus	$30,000,000	1800	
Saint Louis School	High potential loss	925 Grant	$6,000,000	400	
Balfour Senior Care Campus	High potential loss	1336 Hecla	$40,000,000	800	
La Petite Academy	High potential loss	380 S McCaslin	$2,500,000	80	
KinderCare 1	High potential loss	107 McCaslin	$2,500,000	80	
Goddard School	High potential loss	380 Centennial	$3,000,000	80	
Louisville Montessori	High potential loss	461 Tyler	$1,500,000	80	
Bright Horizons	High potential loss	1818 Centennial	$1,000,000	80	
CTC Industrial Park	High potential loss	Dillon Rd.	$700,000,000		

Table F.4. Louisville's Assets (cont'd)

Xcel Natural Gas Pumping Stations	High potential loss	95th / Highway	$30,000,000	42	
Louisville Water Storage-Marshall	Lifeline	7000 Marshall	$15,000,000	10	
Louisville Waste Water Pumping Stations	Lifeline	Various	$30,000,000		
Waste Water Treatment Plan	Lifeline	1601 Empire	$60,000,000	50	
Water Treatment Main	Lifeline	Empire Rd.	$25,000,000	50	
Water Treatment N.	Lifeline	1955 Washington	$25,000,000	50	
Burlington Northern RR	Transportation	Various	$50,000,000		
Highway 36	Transportation	Various	$6,000,0000		
RTD Park & Ride	Transportation	Dillon Rd.	$4,000,000		
Centennial Valley	Economic	Various	$800,000,000		
La Quinta Inn	Economic	902 Dillon	$20,000,000	325	
Hampton Inn	Economic	912 Dillon	$20,000,000	325	
Comfort Inn	Economic	1196 Dillon	$15,000,000	325	
Residence Inn by Marriot	Economic	845 Coal Creek	$20,000,000	325	
Courtyard by Marriott	Economic	948 Dillon	$25,000,000	325	
Coal Creek Golf Course	Economic		$10,000,000	60	
City Services Facility	High Potential Loss		$12,000,000	100	
Coal Creek Trail	Transportation	Various	$2,000,000		
Eldorado Intake Facility	Lifeline		$2,000,000	5	

Many of the facilities listed above are also in GIS databases provided by and Boulder County. Critical facility counts and types are shown in Table F.5 and in the map in Figure F.1. Shelters may be in facilities such as schools or recreation centers and are not indicated on the map.

Table F.5. Summary of Louisville's Critical Facilities in GIS

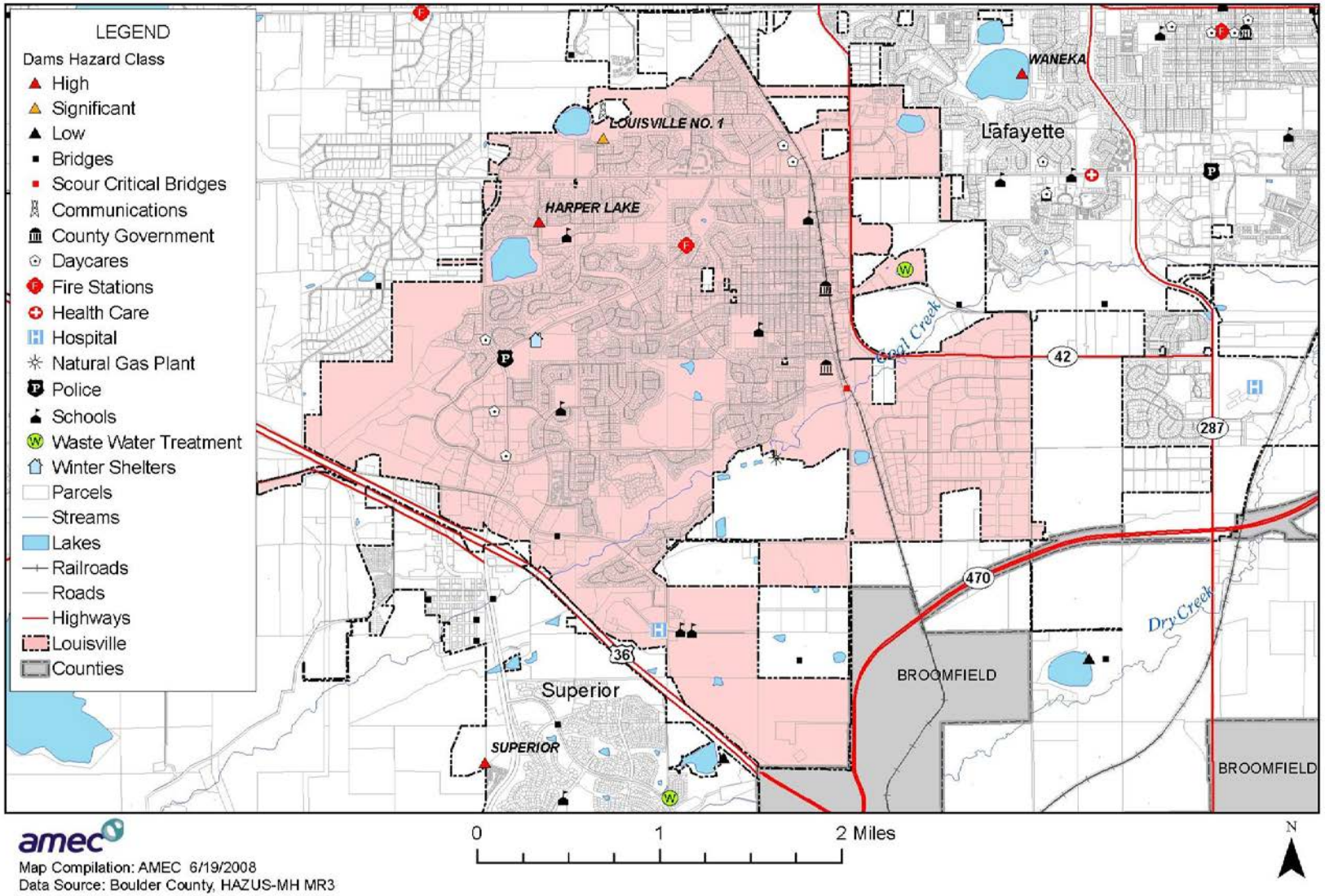
Critical Facility Type	Facility Count
Municipal Government Buildings	8
Bridges	3
County Government Buildings	0
Dams	1
Daycare Centers	7

Table F.5. Summary of Louisville's Critical Facilities in GIS (cont'd)

Fire Stations	3
Hospital	2
Police	1
Schools	6
Shelters	1
Water Treatment	3
Waste Water Treatment	1
Winter Shelters	1
Total	**37**

Source: Boulder County and City of Louisville

Figure F.1. Louisville's Base Map and Critical Facilities



F.3.3 Economic Assets

Economic assets at risk may include major employers or primary economic sectors, such as, agriculture, whose losses or inoperability would have severe impacts on the community and its ability to recover from disaster. After a disaster, economic vitality is the engine that drives recovery. Every community has a specific set of economic drivers, which are important to understand when planning ahead to reduce disaster impacts to the economy. When major employers are unable to return to normal operations, impacts ripple throughout the community.

According to the 2007 Louisville Community Profile from the Denver Regional Council of Governments, the following are Louisville's major employers. In addition, Conoco-Phillips is scheduled to begin construction in 2008 of a research center at the former Storage Technology site.

Conoco-Phillips Research Center
Kable Fulfillment Services Inc.
Avista Hospital
Boulder Valley School District
EDS Resource Management Corporation
City of Louisville
Home Depot
Lowes
Raindance Communications Inc.
Inovonics Corporation

F.3.4 Natural, Historic, and Cultural Resources

Assessing the vulnerability of Louisville to disaster also involves inventorying the natural, historical, and cultural assets of the area. This step is important for the following reasons:

The community may decide these types of resources warrant a greater degree of protection due to their unique and irreplaceable nature and contribution to the overall economy. If these resources are impacted by a disaster, knowing so ahead of time allows for more prudent care in the immediate aftermath, when the potential for additional impacts are higher. The rules for reconstruction, restoration, rehabilitation, and/or replacement are often different for these types of designated resources.

Natural resources can have beneficial functions that reduce the impacts of natural hazards, such as wetlands and riparian habitat, which help absorb and attenuate floodwaters.

Natural Resources

Floodplains along Coal and Rock creeks hold relatively intact riparian corridors that are critical for flood protection, wildlife movement, and the aquatic health of the streams. Most of Louisville's lands within the 100-year floodplain are in public ownership (parks and open space) or agriculture. Boulder County and the Colorado Natural Heritage Program have not identified any rare, endangered, threatened, imperiled plant and animal species or critical wildlife habitats within the City limits or on City open space. The Colorado Tallgrass Prairie Natural Area lies just to the west of the City. Prebles Meadow jumping mice are found along Coal Creek, but not in the segment through Louisville.

For information about natural resources in Boulder County, which includes Louisville, see Section 4.3 Vulnerability Assessment.

Historic and Cultural Resources

Table F.6 lists the properties in Louisville that are on the National Register of Historic Places and/or the Colorado State Register of Historic Properties (for more information about these registers, see Section 4.3 Vulnerability Assessment).

Table F.6. Louisville's Historic Properties/Districts in National and State Registers

Property	Address	Date Listed
Denver Elevator--Grain Elevator	Tract 712 near CO 42	2/14/1986
Ginacci House	1116 LaFarge Street	2/14/1986
Jacoe Store	1001 Main Street	2/14/1986
Lackner's Tavern	1006 Pine	2/14/1986
LaSalla House	1124 Main Street	2/14/1986
National Fuel Company Store	801 Main Street	2/14/1986
Petrelli--DelPizzo House	1016 Main Street	2/14/1986
Rhoades House	1024 Grant	2/14/1986
Robinson House	301 Spruce	2/14/1986
Stolmes House	616 Front Street	2/14/1986
Tego Brothers Drugstore--State National Bank of Louisville	700 Main Street	2/14/1986
Thomas House	700 Lincoln	2/14/1986

Sources: Directory of Colorado State Register Properties, www.coloradohistory-oahp.org/programareas/register/1503/; National Register Information System, www.nr.nps.gov/

Additionally, six properties have been designated as Louisville historic landmarks (Table F.7).

Table F.7. Louisville's Historic Landmarks

Property	Address	Year Designated
Austin-Niehoff House	717 Main Street	9/6/2005
Louisville Center for the Arts	801 Grant Avenue	9/6/2005
Jacoe Store	1001 Main Street	9/20/2005
Tomeo House	1001 Main Street	9/20/2005
Jordinelli House	1001 Main Street	9/20/2005
Jannucci House	1116 LaFarge Avenue	4/15/2008
Fabrizio House	557 Jefferson Avenue	2010
Ball House	1117 Jefferson Avenue	2010
Jacoe-Conarroe House	1131 Jefferson Avenue	2010
Zarini House	1109 LaFarge Avenue	2010
Adkins House	816 McKinley Avenue	201
Zarini-Ross House	501 South Street	2010
Rex Theater	817 Main Street	2011
Thomas House	700 Lincoln Avenue	2011
Sotelli Bouse	1021 Jefferson Avenue	2011
Caranci House	1145 Main Street	2011
Hibler House	612 Grant Avenue	2012
Allera House	1005 Lafarge Avenue	2012
Thomas-Decker House	733 Pine Street	2012
Guenzi House	1036 Walnut Street	2012
Butcher-Jones House	1013 Jefferson Avenue	2013
Restas-Morgan House	1131 Spruce Street	2013
James House	700 Pine Street	2013
Porta House	925 Lafarge Avenue	2013
Di Francia Saloon	740 Front Street	2014
Pearson Store	927 Main Street	2014
D'Agostino House	1245 Grant Avenue	2015
Atkin House	1101 Grant Avenue	2015
Louisville Grain Elevator	540 County Road	2015
Vaughn House	701 Lincoln Avenue	2015
Steinbaugh House	945 Front Street	2015

Source: City of Louisville Historic Preservation Commission, www..louisvilleco.gov

It should be noted that as defined by the National Environmental Policy Act (NEPA), any property over 50 years of age is considered a historic resource and is potentially eligible for the National Register. Thus, in the event that the property is to be altered, or has been altered, as the result of a major federal action, the property must be evaluated under the guidelines set forth by NEPA. Structural mitigation projects are considered alterations for the purpose of this regulation.

F.4 Growth and Development Trends

Table F.8 illustrates how Louisville has grown in terms of population and number of housing units between 2010 and 2014.

Table F.8. Louisville's Change in Population and Housing Units, 2000-2006

2010 Population	2014 Population Estimate	Estimated Percent Change 2000-2006	2010 # of Housing Units	2014 Estimated # of Housing Units	Estimated Percent Change 2010-2014
18,376	20,112	8.60	7,892	6,357	18%

Source: Colorado Division of Local Government State Demography Office, www.dola.colorado.gov/dlg/demog/

According to the City's 2013 Comprehensive Plan, growth in Louisville between 2010 and 2014 can be attributed to the fact the residential market improved and compensated for the lack of growth between 2000 and 2010 and residential supplies had completed the entitlement process. The plan also estimated that based on current zoning, the City would be built out at a population of 22,145 (assuming 2.4 people per household).

F.5 Capability Assessment

Capabilities are the programs and policies currently in use to reduce hazard impacts or that could be used to implement hazard mitigation activities. This capabilities assessment summarizes Louisville's regulatory mitigation capabilities, administrative and technical mitigation capabilities, and fiscal mitigation capabilities and then discusses these capabilities in further detail along with other mitigation efforts as they pertain to the National Flood Insurance Program's Community Rating System (CRS). Although the CRS is flood-focused, this discussion also incorporates activities related to other hazards into the categories established by the CRS.

F.5.1 Mitigation Capabilities Summary

Table F.9 lists planning and land management tools typically used by local jurisdictions to implement hazard mitigation activities and indicates those that are in place in Louisville.

Table F.9. Louisville's Regulatory Mitigation Capabilities

Regulatory Tool (ordinances, codes, plans)	Yes/No	Comments
Master plan	Yes	Louisville Comprehensive Plan, 2013
Zoning ordinance	Yes	Louisville Municipal Code
Subdivision ordinance	Yes	Louisville Municipal Code
Growth management ordinance	Yes	Louisville Comprehensive Plan, 2013
Site plan review requirements	Yes	Louisville Municipal Code
Floodplain ordinance	Yes	Louisville Municipal Code
Other special purpose ordinance (stormwater, steep slope, wildfire)	Yes	Louisville Municipal Code and Louisville Public Works
Building code	Yes	International Building Code, 2012
BCEGS Rating		
Fire department ISO rating	Yes	
Erosion or sediment control program	Yes	Louisville Land Municipal Code
Stormwater management program	Yes	Louisville Public Works
Capital improvements plan	Yes	Louisville Public Works
Economic development plan		Office of Louisville City Manager
Local emergency operations plan	Yes	Louisville Police Department
Other special plans	Yes	Drought Management Plan, Open Space Master Plan, Comprehensive Plan of Fire and Emergency Services 2005-2015
Flood insurance study or other engineering study for streams	Yes	FEMA Flood Insurance Study, October 4, 2002
Elevation certificates	Yes	7 in 2014 and 2 in 2015. Planning Department

Table F.10 identifies the personnel responsible for mitigation and loss prevention activities as well as related data and systems in Louisville.

Table F.10. Louisville's Administrative and Technical Mitigation Capabilities

Personnel Resources	Yes/No	Department/Position	Comments
Planner/engineer with knowledge of land development/land management practices	Yes	City of Louisville	
Engineer/professional trained in construction practices related to buildings and/or infrastructure	Yes	City of Louisville	Engineer/professional trained in construction practices related to buildings and/or infrastructure
Planner/engineer/scientist with an understanding of natural hazards	No		
Personnel skilled in GIS	Yes	City of Louisville	

Table F.10. Louisville's Administrative and Technical Mitigation Capabilities (cont'd)

Full-time building official	Yes	City of Louisville	
Floodplain manager	Yes	City of Louisville	
Emergency manager	No		
Grant writer	Yes	City of Louisville	
Other personnel	No	City of Louisville	Other personnel
GIS Data – Hazard areas	Yes	City of Louisville	
GIS Data – Critical facilities	Yes	City of Louisville	
GIS Data – Building footprints	Yes	City of Louisville	GIS Data – Building footprints
GIS Data – Land use	Yes	City of Louisville	GIS Data – Land use
GIS Data – Links to assessor's data	Yes	City of Louisville	
Warning systems/services	Warning systems/services	Warning systems/services	Warning systems/services
(Reverse 9-11, cable override, outdoor warning signals)	Yes	City of Louisville	

Table F.11 identifies financial tools or resources that Louisville could potentially use to help fund mitigation activities.

Table F.11. Louisville's Fiscal Mitigation Capabilities

Financial Resources	Accessible/Eligible to Use (Y/N)	Comments
Community Development Block Grants	Yes	
Capital improvements project funding	Yes	
Authority to levy taxes for specific purposes	No	
Fees for water, sewer, gas, or electric services	Yes	
Impact fees for new development	Yes	
Incur debt through general obligation bonds	Yes	
Incur debt through special tax bonds	No	
Incur debt through private activities	No	
Withhold spending in hazard-prone areas	No	

F.5.2 Community Rating System Activities (All Hazards)

National Flood Insurance Program

The City of Louisville joined the National Flood Insurance Program (NFIP) on May 4, 1973. The NFIP allows private property owners to purchase affordable flood insurance and enables the community to retain its eligibility to receive certain federally backed monies and disaster relief funds. Community Rating System (CRS) on The CRS is a voluntary program for NFIP-participating communities. It provides

flood insurance discounts to policyholders in communities that provide extra measures of flood above the minimum NFIP requirements. As of May 2015, Louisville had a CRS class rating of 7 (one a scale of 1-10, 1 being the best). This rating provides a 15 percent discount for policyholders within a special flood hazard area (SFHA) and a 5 percent discount for those outside of an SFHA.

NFIP insurance data indicates that as of February 29, 2008, there were 22 policies in force in Louisville, resulting in $7,752,000 of insurance in force. Of these, 16 were for residential properties (all but 2 were single-family homes), and 10 were in A zones (special flood hazard areas). In Louisville, there have not been any historical claims for flood losses, thus there were no repetitive or severe repetitive losses.

Community Rating System Categories

The Community Rating System (CRS) categorizes hazard mitigation activities into six categories. These categories, and applicable Louisville activities, are described below. Note: some of the activities are appropriate to multiple categories. For purposes of simplicity, they are only included in the category deemed most appropriate based on the definitions and examples provided in the CRS Coordinator's Manual.

Preventive

Preventive activities keep problems from getting worse. The use and development of hazard-prone areas is limited through planning, land acquisition, or regulation. They are usually administered by building, zoning, planning, and/or code enforcement offices.

City of Louisville Comprehensive Plan (2013)

The City's Comprehensive Plan gives general guidance, establishing a Vision Statement with 13 Core Community Values and a flexible Framework Plan with supporting community-based principles, policies, and implementation strategies recommended by the Planning Commission and adopted City Council to realize the community's vision for the City. The Vision Statement with its 13 Core Community Vales and the Framework plan with its supporting principles and policies cover a broad range of subject matter related to aspirations, services, and issues needing to be addressed within Louisville. Combined, these elements serve to direct future policy decisions to preserve vital community attributes and service levels and manage growth.

Louisville Municipal Code

Title 17 Zoning (Includes Floodplain Zoning) - The Ordinances codified in chapters 17.04 through 17.72 are enacted for the purpose of promoting the health, safety, morals, convenience, order, prosperity and welfare of the present and future inhabitants of the city, by lessening congestion in the streets and roads; by securing safety from fire and other dangers; by providing adequate light and air; by avoiding undue congestion of population and facilitating the adequate provision of transportation, water, schools, sewerage and other public requirements through the classification of land uses and the

distribution of land development and utilization; and by other means in accordance with a comprehensive development plan and the zoning map adopted in section 17.04.060.

Ordinance No. 1625, Series 2012 – An ordinance repealing and reenacting with amendments Chapter 17.56 of the Louisville Municipal Code concerning floodplain zoning was adopted November 20, 2012. This ordinance adopted the model floodplain zoning code developed by the Federal Emergency Management Agency (FEMA) the minimum standards for floodplain development codes developed by the State of Colorado. This adopted ordinance was reviewed by representatives from FEMA and the Colorado Water Conservation Board for compliance.

Ordinance No. 1652, Series 2013 – An ordinance adopting by reference the 2012 editions of the International Building Code, International Residential Code, International Mechanical Code, International Fuel Gas Code, International Energy Conservation Code, International Fire Code, and International Plumbing Code and the 2011 Edition of the National Electrical Code adopted by the state; enacting certain amendments to the foregoing international codes; amending, repealing and reenacting certain sections of Title 15 of the Louisville Municipal Code in connection with the adoption of the foregoing international codes; and establishing penalties for violations of such codes was adopted February 18, 2014 and became effective March 31, 2014.

Title 4 City Open Space—This title establishes a board of citizens to advise City staff and council on matters related to the acquisition, management, restoration, preservation, and use of open space lands and establishes standards for the acquisition, management, restoration, use, and preservation of such open space lands.

Title 13 Water and Sewers—This title includes provisions to construct, operate, and maintain stormwater facilities and to establish a methodology and requirement for the payment of reasonable stormwater utility fees for property owners to pay for a share of the costs of improvements and facilities reasonably necessary to manage stormwater. Furthermore, it promotes the general public health, safety, and welfare by reducing the potential for the movement of emergency vehicles to be impeded or inhibited during storm or flooding periods; by minimizing storm and flood losses, inconvenience, and damage resulting from runoff; and by promoting activities which improve the water quality of runoff in the City of Louisville.

Title 16 Subdivisions—Among the purposes of these regulations, as they relate to hazard mitigation, are the following:

- To promote the health, safety, convenience, order, prosperity and welfare of the present and future inhabitants of the City
- To promote orderly growth and to provide for the harmonious development of the City in accordance with its comprehensive plan
- To provide for adequate light, air, and privacy and to secure safety from fire, flood, and other danger
- To ensure that public facilities and services are available and will have sufficient capacity to serve the development

- To mitigate the pollution of air, streams, and ponds; assure the adequacy of drainage facilities; safeguard the water table; and encourage the wise use and management of the natural environment
- To preserve and enhance to the extent reasonably possible the natural beauty and topography of the City and areas of historical or archeological importance and to ensure appropriate development with regard to such natural, historical and archaeological sites and features
- To otherwise plan for and regulate the use of land so as to provide planned and orderly use of land and protection of the environment in a manner consistent with constitutional rights

Design standards require consideration of steep land, areas having inadequate drainage, and other natural hazard areas and limit development as necessary.

Other

Most areas identified as geologic hazard areas are protected as open space, thus prohibiting development.

The City's Engineering Department has an ongoing maintenance program for inspecting storm drainage facilities. The department also provides detailed hydraulic modeling to identify any deficiencies and what improvements are necessary. The City is currently following the Louisville/Boulder County Outfall System Plan, as completed in 1982, for necessary improvements to the stormwater system. Developers are responsible for completing elements of the outfall system to meet the City's land development and engineering codes.

The City's Stormwater Storm Drainage Design and Technical Criteria (1982) presents the minimum design and technical criteria for the analysis and design of storm drainage systems.

Property Protection
Property protection activities are usually undertaken by property owners on a building-by-building or parcel basis.

No current projects/activities.

Natural Resource Protection
Natural protection activities preserve or restore natural areas or their natural functions. They are usually implemented by parks, recreation, or conservation agencies or organizations.

The City provides a balanced system of open space composed of environmentally sensitive areas, natural areas, wildlife corridors, habitat areas, trails, and greenways using a variety of conservation methods to meet both the needs of the citizens and the City's resource protection goals.

The City's Open Space Master Plan inventoried, classified, and provided management direction for 26 City-owned and 10 jointly owned properties. While it provides detailed direction for managing and enhancing the cultural, agricultural, recreational, and ecological resources, it does not target any land for future acquisition.

Emergency Services

Emergency services measures are taken during an emergency to minimize its impacts. These measures are the responsibility of city or county emergency management staff and the owners or operators of major or critical facilities.

The City's Drought Management Plan (2014) **(http://www.louisvilleco.gov/Portals/0/Public%20Works/droughtmgmtplan.pdf**) is a guide for the varying degrees of drought experienced in the normal variations of weather patterns. It identifies the conditions that formally place the City in a designated level of drought and pre-determine the general responses appropriate for given drought conditions. It also establishes the general framework for when drought conditions require special communications with residents and the type of information anticipated to be communicated.

The Louisville Fire Protection District provides fire protection and emergency medical services through a predominantly volunteer staff. The district has a comprehensive plan of fire and emergency services 2005–2015. The purposes of the plan are to provide a framework to review the basic organizational and performance requirements of the fire department, identify goals and objectives, and use as a basis to project programming and fire service policy.

The City's Public Works Operations Division has a Snow Control Plan to keep streets safe and accessible during periods of ice and snow. The goal is to provide snow and ice control services on all major City streets and to plow selected streets through subdivisions to provide access and egress to citizens' homes. Streets are cleared according to established priorities. Priorities are set based on traffic volume, public safety, and access to emergency facilities and schools.

Structural Projects

Structural projects keep hazards away from an area (e.g., levees, reservoirs, other flood control measures). They are usually designed by engineers and managed or maintained by public works staff.

No current projects/activities.

Public Information

Public information activities advise property owners, potential property owners, and visitors about the hazards, ways to protect people and property from the hazards, and the natural and beneficial functions of natural resources (e.g., local floodplains). They are usually implemented by a public information office.

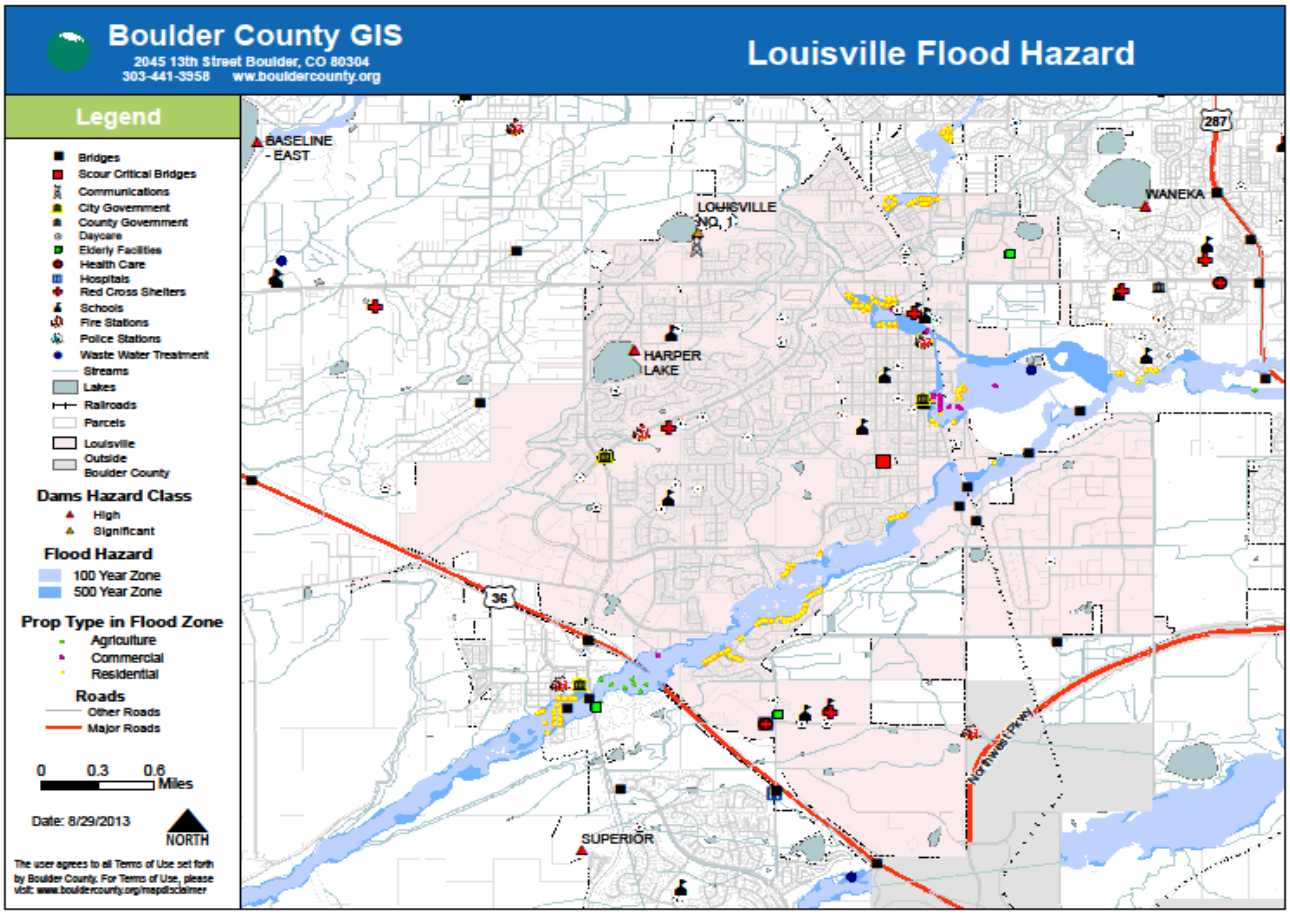
The City's Planning Department invites property owners to visit its office or email them for information regarding whether or not their property is in a flood zone (and if so, which one). A flood insurance rate map information form is available on the City's web site.

The City's Public Works Operations Division posts a snow removal map along with safety tips on their web site.

Table F 5.2.1. Louisville's Property and Values in 100- and 500-Year Flood Zones

Louisville's Property and Values in 100- and 500-Year Flood Zones				
Property Type	Improved Parcel Count	Improved Value ($)	Contents Value ($)	Total Value ($)
100-Year Flood Zone				
Residential	90	$29,890,700	$14,945,350	$44,836,050
Commercial	12	$16,856,752	$8,428,376	$25,285,128
Exempt	4	$1,340,300	$670,150	$2,010,450
Industrial	0	$0	$0	$0
Agricultural	0	$0	$0	$0
Total	**106**	**$48,087,752**	**$24,043,876**	$72,131,628
Population estimate for residences:			**215**	
500-Year Flood Zone				
Residential	103	$29,147,100	$14,573,550	$43,720,650
Commercial	5	$3,149,713	$1,574,857	$4,724,570
Exempt	5	$5,253,100	$2,626,550	$7,879,650
Industrial	0	$0	$0	$0
Agricultural	0	$0	$0	$0
Total	**113**	**$37,549,913**	**$18,774,957**	**$56,324,870**
Population estimate for residences:			**246**	
Combined 100- and 500- Year Flood Zones				
Residential	193	$59,037,800	$29,518,900	$88,556,700

Figure F 5.2.2 Louisville Flood Hazard



CITY COUNCIL COMMUNICATION
AGENDA ITEM 8A

SUBJECT: **PRESENTATION OF THE COLORADO CITY AND COUNTY MANAGEMENT ASSOCIATION MANAGER OF THE YEAR AWARD TO MALCOLM FLEMING**

DATE: **MARCH 8, 2016**

PRESENTED BY: **HEATHER BALSER, DEPUTY CITY MANAGER**

SUMMARY:
Jane Brautigam, representing the Colorado City and County Management Association will present the Manager of the Year Award to Malcolm Fleming. The award was originally presented at the CCCMA Winter Conference on February 26, 2016.

FISCAL IMPACT:
N/A

RECOMMENDATION:
N/A

ATTACHMENT(S):
1. Nomination Letter

City of Louisville
COLORADO • SINCE 1878

Office *of* the City Manager

January 12, 2016

Colorado City and County Management Association
Awards Committee

Dear Committee Members:

It is with great pleasure that we nominate Malcolm Fleming for Manager of the Year. Malcolm has been City Manager of Louisville for over eight years now and while we think every year has been noteworthy, 2015 was one of great accomplishment for which we feel Malcolm deserves recognition.

The number of significant projects that got underway or were completed in 2015 is notable and the scale of these projects is remarkable, but the fact that Malcolm was able to accomplish these, continue all basic City functions, and at the same time reopen major facilities damaged by the 2013 flood is truly an achievement.

2015 was the culmination of all of our efforts to clean up and reopen facilities damaged in the 2013 flood. This included rebuilding the Coal Creek Golf Course, reconstructing major portions of the Coal Creek Trail, and working with a veritable alphabet soup of entities (FEMA, CDOT, FHWA, etc.) to ensure the City receives reimbursement for costs. During all of this, Malcolm showed great leadership and patience. In the end, these facilities came back even better than before the flood.

Significant projects in 2015 included:

- Reopening of the Coal Creek Golf Course. A complete rebuild following the 2013 flood;
- Reopening of the Coal Creek Trail after all final fixes from the 2013 flood were complete;
- Completion of the new $14 million City Services Facility;
- Collaborated with CDOT, RTD, and the Town of Superior on the first Diverging Diamond Interchange (DDI) in the Metro Area and the only DDI with transit in the country (opened December 2015);
- Completion of an Urban Renewal Plan for former Sam's Club site;
- Implementation of new Enterprise Resource Planning;

749 Main Street | Louisville CO 80027

303.335.4533 (phone) | 303.335.4550 (fax) | www.LouisvilleCO.gov

- Approval of a Boulder County Housing Authority Project for 191 affordable units in Louisville;
- Began construction on a new $32 million wastewater facility;
- Continued work on two separate Small Area Plans;
- Approval of Preservation Master Plan;
- Approval of new franchise with Comcast Cable.

As a staff we know Malcolm's dedication to his job, his high ethical standards, the pride he takes in a job well-done, and his great appreciation of the work we all put in. We are proud to work for him and see him as roll model every day.

As a City Council we appreciate his fiscal responsibility, his open communication, and his ability to get things done under what can be convoluted and trying political circumstances.

We all agree Malcolm has proven himself to be a great leader and good steward for the City of Louisville. Our residents know Louisville is consistently ranked as one of the best places to live in the US (and it is). What residents don't always recognize is the tremendous effort Malcolm makes every day to ensure Louisville continues to be a wonderful place to live and work. For these reasons and many more too numerous to list here, we nominate Malcolm Fleming for Manager of the Year.

Thank you for your consideration of our nomination.

Sincerely,

Bob Muckle
Mayor

Heather Balser
Deputy City Manager

CITY COUNCIL COMMUNICATION
AGENDA ITEM 8B

SUBJECT: **NATIONAL NUTRITION MONTH PROCLAMATION**

DATE: **MARCH 8, 2016**

PRESENTED BY: **KATIE BEASLEY, SENIOR SERVICES SUPERVISOR**
JOE STEVENS, PARKS AND RECREATION DEPARTMENT

SUMMARY:
National Nutrition Month® is a nutrition education and information campaign created annually in March by the Academy of Nutrition and Diabetics. The campaign focuses attention on the importance of making informed food choices and developing sound eating and physical activity habits.

Senior Services within Parks and Recreation and Coal Creek Meals on Wheels are helping promote the importance of making healthy nutrition choices for older adults during the congregate lunch at the Brooks Café at the Louisville Recreation/Senior Center and delivering meals at home.

In 2015, the Brooks Café Congregate Meal Site at the Recreation/Senior Center served 8,970 meals to older adults, compared to 8,056 meals served in 2014.

Katie Beasley, Senior Services Staff, and Tricia Morgan, Meal Site Coordinator, as well as Lesley Jackson from Coal Creek Meals on Wheels will be in attendance.

FISCAL IMPACT:
N/A

RECOMMENDATION:
Proclaim March 2016 as Nutrition Month in the City of Louisville.

ATTACHMENT(S):
1. Nutrition Month Proclamation, March 2016

NATIONAL NUTRITION MONTH PROCLAMATION
MARCH 2016

WHEREAS, food is the substance by which life is sustained; and

WHEREAS, the type, quality, and amount of food that individuals consume each day plays a vital role in their overall health and physical fitness; and

WHEREAS, there is a need for continuing nutrition education and a wide-scale effort to enhance good eating practices; and

WHEREAS, the Congregate Meal Site at the Brooks Café in the Louisville Recreation/Senior Center enhances physical health, outlook on life and connects older adults; and

WHEREAS, provides an environment for fellowship, education, sharing hobbies, and getting to know one another; and

WHEREAS, provides enough to eat, the right kinds of foods to eat, is affordable; and

WHEREAS, the Meals On Wheels Association of America established the National March For Meals Campaign in March 2002 to recognize the historic month, the importance of Older Americans Act Senior Nutrition Programs and raise awareness about senior hunger in America;

WHEREAS, volunteer drivers for Coal Creek Meals On Wheels are the backbone of the program and they not only deliver nutritious meals to anyone in our communities in need of a hot meal, but also caring concern and attention to their welfare;

WHEREAS, Senior Nutrition Programs in Colorado provide nutritious meals to seniors throughout the State and help them to avoid premature or unnecessary institutionalization;

WHEREAS, Senior Nutrition Programs in Colorado deserve recognition for the contributions they have made and will continue to make to local communities, our State and our Nation; and

NOW THEREFORE, BE IT RESOLVED that I, Robert P. Muckle, hereby proclaim March as NUTRITION MONTH IN LOUISVILLE, COLORADO and call on all citizens to join with us in the campaign and work to improve the nutrition of older adults and all others in the hope of achieving optimum health for both today and tomorrow.

DATED this 8th day of March, 2016.

_____
Robert P. Muckle, Mayor

ATTEST:

_____
Carol Hanson, Acting City Clerk

CITY COUNCIL COMMUNICATION
AGENDA ITEM 8C

SUBJECT: **UPDATE: ONE ACTION 2016: ARTS + IMMIGRATION PROJECT**

DATE: **MARCH 8, 2016**

PRESENTED BY: **MANUELA SIFUENTES, ONE ACTION PROJECT MANAGER**
SUZANNE JANSSEN, CITY MANAGER'S OFFICE

SUMMARY:
On Saturday, January 23 the Longmont Museum hosted the One Action 2016: Arts + Immigration Project Kick-Off Celebration. This One Action 2016 Project is a yearlong, arts-based, countywide project that invites cultural, arts, immigrant and educational organizations to draw on their individual expertise to develop exhibitions, performances, presentations, music, films, displays and readings designed to raise the level of community knowledge, awareness and engagement on this important topic.

Project Overview
With One Action 2016, the arts will be the vehicle to catalyze, engage, and inform county residents on the many facets of immigration and make this county more welcoming and inclusive. Toward this end, the project will:

- Create cross-discipline arts collaborations on immigration themes;
- Use the knowledge of immigrant organizations to inform project content;
- Develop a broad range of arts experiences designed to educate and engage the public in conversations on immigration; and
- Celebrate the cultural richness of local immigrant communities

Throughout the year, artists and arts organizations throughout Boulder County will present collaborative arts-based programs that foster conversations on the historic and contemporary issues of immigration. In Louisville, there are over a dozen programs scheduled as part of this arts initiative. The first event, *Rocks Karma Arrows* presented by the Louisville Cultural Council and the Motus Theater on February 17th, was shown to a sold-out, standing room only crowd.

One Action Project Manager, Manuela Sifuentes and Suzanne Janssen will provide a review of the programs offered in the first quarter of 2016 and an overview of upcoming programs.

FISCAL IMPACT:
None

RECOMMENDATION:
No action required.

ATTACHMENT(S):

1. Images of January 23rd, 2016 One Action 2016 Kick-Off Meeting

one action 2016
arts + immigration project

one-action.org

ICE SKATING
Barrio E

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Wesley Jessup
one action

Wide Celebration!

What's your
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one action 2016
arts + immigration project

one-action.org

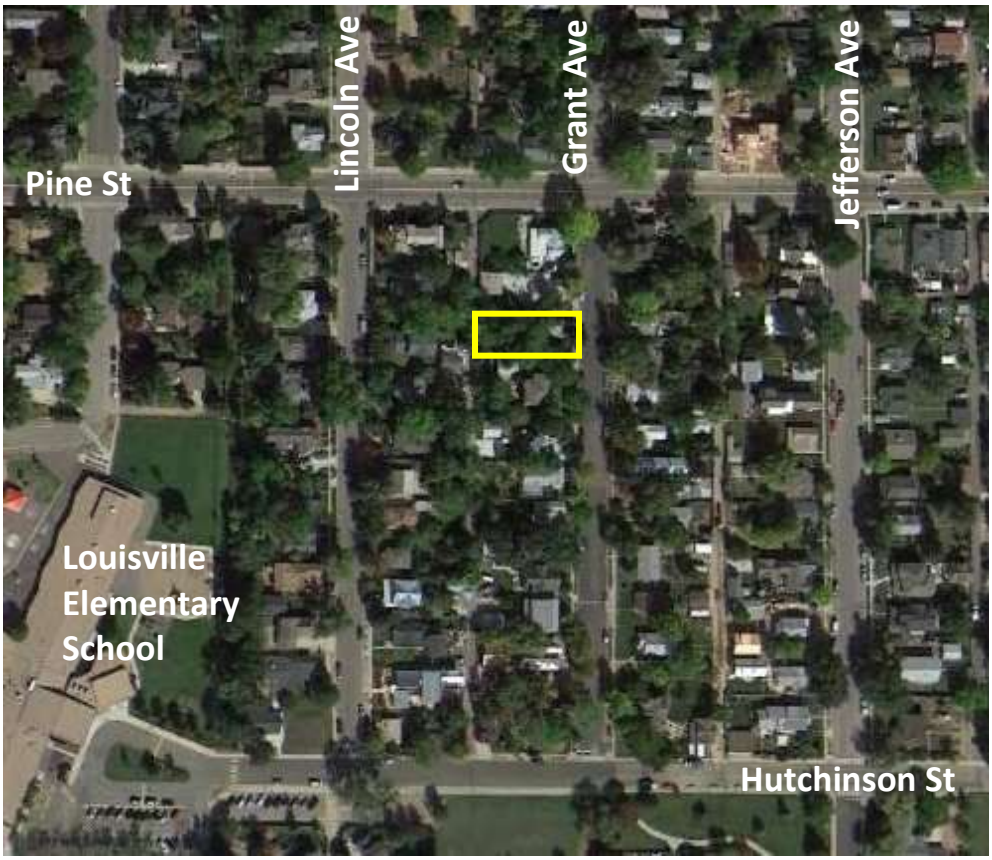
CITY COUNCIL COMMUNICATION
AGENDA ITEM 8D

SUBJECT: **RESOLUTION NO. 12, SERIES 2016 – A RESOLUTION DESIGNATING THE MUDROCK HOUSE AT 613 GRANT AVENUE A HISTORIC LANDMARK**

DATE: **MARCH 8, 2016**

PRESENTED BY: **LAUREN TRICE, AICP, PLANNING AND BUILDING SAFETY DEPARTMENT**

SUMMARY:
Case #2016-002-LA is a request to landmark the Mudrock House, 613 Grant Avenue (Lots 6-7, Block 11 Pleasant Hill). The home was constructed circa 1903. The applicants and owners are Susan Norris and Catherine Fletcher.



HISTORICAL BACKGROUND:
Information from Historian Bridget Bacon

The Mudrock (formerly "Mudrak" and "Mudrack") family from Slovakia owned this property and were residents of the house starting in 1903. The family's ownership extended until 1981. The parcel to the north, 625 Grant (Lots 4 & 5, Block 11), was also part of their property, with some Mudrock family members also residing in a house there starting at a later date.

(Please refer to attachment for complete history of the property.)

613 Grant Avenue (1948 Assessor's Photo)

613 Grant – Prior to 1998 addition

613 Grant- Current Photo (Northeast corner)

613 Grant - Current Photo (Southeast Corner)

ARCHITECTURAL INTEGRITY:

The house at 613 Grant Avenue was constructed in 1903. The original portion is wood frame with a hipped roof and a prominent porch. The porch has a battered foundation and square, sloping supports. There is a hipped roofed dormer above the porch. The structure has window openings with what appear to be 3/1 double hung sash.

Several changes have been made to the structure since the 1948 Assessor's photo including enclosing the porch with windows, cladding the structure in asbestos siding, and the addition of a 2-story structure. The porch enclosure has maintained the porch supports and foundation. The 2-story addition is on the rear of the property, constructed in 1998, and has a minimal impact on the streetscape of Grant Avenue.

HISTORICAL SIGNIFICANCE AND CRITERIA FOR LISTING AS A LOCAL LANDMARK:

Landmarks must be at least 50 years old and meet one or more of the criteria for architectural, social or geographic/environmental significance as described in Louisville Municipal Code (LMC) Section 15.36.050(A). The City Council may exempt a landmark

from the age standard if it is found to be exceptionally important in other significance criteria:

1. Historic landmarks shall meet one or more of the following criteria:

a. Architectural.

(1) Exemplifies specific elements of an architectural style or period.

(2) Example of the work of an architect or builder who is recognized for expertise nationally, statewide, regionally, or locally.

(3) Demonstrates superior craftsmanship or high artistic value.

(4) Represents an innovation in construction, materials or design.

(5) Style particularly associated with the Louisville area.

(6) Represents a built environment of a group of people in an era of history that is culturally significant to Louisville.

(7) Pattern or grouping of elements representing at least one of the above criteria.

(8) Significant historic remodel.

b. Social.

(1) Site of historic event that had an effect upon society.

(2) Exemplifies cultural, political, economic or social heritage of the community.

(3) Association with a notable person or the work of a notable person.

c. Geographic/environmental.

(1) Enhances sense of identity of the community.

(2) An established and familiar natural setting or visual feature that is culturally significant to the history of Louisville….

3. All properties will be evaluated for physical integrity and shall meet one or more of the following criteria:

a. Shows character, interest or value as part of the development, heritage or cultural characteristics of the community, region, state, or nation.

b. Retains original design features, materials and/or character.

c. Remains in its original location, has the same historic context after having been moved, or was moved more than 50 years ago.

d. Has been accurately reconstructed or restored based on historic documentation.

Staff has found this application complies with the above criterion by the following:

Architectural Significance - *Exemplifies specific elements of an architectural style or period.*
The vernacular structure has elements of the Craftsman style including the battered porch foundation, square porch supports, and hipped roof.

Social Significance - *Exemplifies cultural, political, economic or social heritage of the community.*
The property is associated with the Mudrock family who lived at 613 Grant for 78 years.

HISTORIC PRESERVATION COMMISSION ACTION:
The HPC held a public hearing on the application on February 8, 2016. The commission voted 5-0 to recommend approval of the landmark application to City Council. The HPC determined the structure had maintained significant architectural integrity and has a strong social history.

RECOMMENDATION:
There have been several modifications to the structure, including a 2-story rear addition, since the 1950s. The overall form and Craftsman elements have been maintained. The structure has a strong social significance due to its association with the Mudrock family. Staff recommends that the house be named for the Mudrock family who owned the house for over 70 years.

Staff recommends Council approve Resolution No. 12, Series 2016 designating the structure at 613 Grant Avenue (Mudrock House) a historic landmark.

ATTACHMENTS:
1. Resolution No. 12, Series 2016
2. Historic Preservation Commission Resolution No. 01, Series 2016
3. Historic Preservation Commission Minutes, February 8, 2016
4. Social History
5. Landmark Application
6. Presentation

RESOLUTION NO. 12
SERIES 2016

A RESOLUTION DESIGNATING THE MUDROCK HOUSE LOCATED AT 613 GRANT AVENUE A HISTORIC LANDMARK

WHEREAS, a historic landmark application for the Mudrock , located at 613 Grant Avenue, on property legally described as Lots 6-7, Block 11, Pleasant Hill; has been submitted to the City Council; and

WHEREAS, the City Staff and the Louisville Historic Preservation Commission have reviewed the application and found it to be in compliance with Chapter 15.36 of the Louisville Municipal Code; and

WHEREAS, the Louisville Historic Preservation Commission held a properly noticed public hearing on the proposed landmark application and has forwarded to the City Council a recommendation of approval; and

WHEREAS, the City Council has duly considered the proposed landmark application and the Commission's recommendation and report, and has held a properly noticed public hearing on the application; and

WHEREAS, the building was constructed around 1903, and has retained its architectural form, and represents the vernacular style of building in early 20th century Louisville with elements of the Craftsman style; and

WHEREAS, the building has social significance because of its association with the Mudrock family for over 70 years; and

WHEREAS, the City Council finds that these and other characteristics specific to the individual structures are of both architectural and social significance as described in Section 15.36.050 (A) of the Louisville Municipal Code and justify the approval of the historic landmark application.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF LOUISVILLE, COLORADO:

1. The proposed historic landmark application for the Mudrock House is hereby approved and is hereby designated a historic landmark to be preserved as such.

2. An incentive of $1,000 shall be awarded to the property owner pursuant to Chapter 15.36 of the Louisville Municipal Code, with the attendant protections for landmarks pursuant to that chapter.

3. The City Clerk shall provide written notification of such designation to the property owners and cause a copy of this resolution to be recorded with the Boulder County Clerk and Recorder.

PASSED AND ADOPTED this 8th day of March, 2016.

_____
Robert P. Muckle, Mayor

ATTEST:

_____
Carol Hanson, Acting City Clerk

RESOLUTION NO. 01
SERIES 2016

A RESOLUTION MAKING FINDINGS AND RECOMMENDATIONS REGARDING THE LANDMARK DESIGNATION FOR A HISTORICAL RESIDENTIAL STRUCTURE LOCATED ON 613 GRANT AVENUE

WHEREAS, there has been submitted to the Louisville Historic Preservation Commission (HPC) an application requesting a landmark eligibility determination for a historical residential structures located on 613 Grant Avenue, on property legally described as Lot 6-7, Block 11, Pleasant Hill Addition, Town of Louisville, City of Louisville, State of Colorado; and

WHEREAS, the City Staff and the HPC have reviewed the application and found it to be in compliance with Chapter 15.36 of the Louisville Municipal Code, including Section 15.36.050.A, establishing criteria for landmark designation; and

WHEREAS, the HPC has held a properly noticed public hearing on the proposed landmark application; and

WHEREAS, 613 Grant Avenue (Mudrock House) has social significance because it exemplifies the cultural, political, economic or social heritage of the community considering its association with the Mudrock family in Louisville; and

WHEREAS, the Mudrock House has architectural significance because it represents the vernacular style of early 20th century Louisville with elements of the Craftsman style and

WHEREAS, the HPC finds that these and other characteristics specific to the Mudrock House have social and architectural significance as described in Section 15.36.050.A of the Louisville Municipal Code; and

NOW, THEREFORE, BE IT RESOLVED BY THE HISTORIC PRESERVATION COMMISSION OF THE CITY OF LOUISVILLE, COLORADO:

The application to landmark the Mudrock House be approved for the following reasons:

1. Architectural integrity of Craftsman style elements.
2. Association with the Mudrock family.

PASSED AND ADOPTED this _____ day of _____, 2016.

_____
Lynda Haley, Chairperson

City of Louisville
COLORADO • SINCE 1878

Historic Preservation Commission
Meeting Minutes

February 8, 2016
City Hall, Council Chambers
749 Main Street
6:30 PM

Call to Order: Haley called the meeting to order at 6:31 pm.

Roll Call was taken and the following members were present:

Commission Members Present:	Lynda Haley, Chairman Mike Koertje, Vice Chairman Peter Stewart Cyndi Thomas Chuck Thomas
Commission Members Absent:	Debbie Fahey Jessica Fasick
Staff Members Present:	Lauren Trice, Planner I

- **PUBLIC HEARING – 613 Grant Landmark,** Case #2016-002-LANDMARK

Conflict of Interest and Disclosure:
Stewart says I work with the property owner on the addition built in 1998. We have not had any contract since. I feel this is enough time to give me objectivity. Haley says we will let you remain.

Staff Report of Facts and Issues:
Trice presents:

- This is a request to landmark 613 Grant Avenue.
- The Mudrock (formerly "Mudrak" and "Mudrack") family from Slovakia owned this property and were residents of the house starting in 1903. The family's ownership extended until 1981. The parcel to the north, 625 Grant (Lots 4 & 5, Block 11), was also part of their property, with some Mudrock family members also residing in a house there starting at a later date.

ARCHITECTURAL INTEGRITY:

- The house at 613 Grant Avenue was constructed in 1903. The original portion is wood frame with a hipped roof and a prominent porch. The porch has a battered foundation and square, sloping supports. There is a hipped roofed dormer above the porch. The structure has window openings with what appear to be 3/1 double hung sash.
- Several changes have been made to the structure since the 1948 Assessor's photo including enclosing the porch with windows, cladding the structure in asbestos siding, and the addition of a 2-story structure. The porch enclosure has

maintained the porch supports and foundation. The 2-story addition is on the rear of the property, constructed in 1998, and has a minimal impact on the streetscape of Grant Avenue.

Historical Significance and Criteria for finding Probable Cause for Listing as Local Landmark:
To receive grant funding, the HPC must find probable cause that the property meets the landmark criteria. Landmarks must be at least 50 years old and meet one or more of the criteria for architectural, social or geographic/environmental significance as described in Louisville Municipal Code (LMC) Section 15.36.050(A). Staff has found probable cause to believe this application complies with the above criterion by the following:

Architectural Significance - *Exemplifies specific elements of an architectural style or period.*
The vernacular structure has elements of the Craftsman style including the battered porch foundation, square porch supports, and hipped roof.
Social Significance - *Exemplifies cultural, political, economic or social heritage of the community.*
The property is associated with the Mudrock family who lived at 613 Grant for 78 years.

Staff Recommendations:
There have been several modifications to the structure, including a 2-story rear addition, since the 1950s. The overall form and Craftsman elements have been maintained. The structure has a strong social significance due to its association with the Mudrock family.

Staff recommends that the house be named for the Mudrock family who owned the house for over 70 years. Therefore, the staff recommends that the structure be landmarked by approving Resolution No. 1, Series 2016.

Commission Questions of Staff:
None.

Applicant Presentation:
Susan Norris, 613 Grant Avenue, Louisville, CO
I have lived in 613 Grant Avenue for 31 years. We love our home and we feel it is important for the character of our neighborhood and Louisville to have our house landmarked just in case we don't know the future. We have seen a lot of changes in Louisville and we want to be part of recognizing the historical significance of our house. We knew Al Mudrock who was born in our house. He was our neighbor for a few years until he died. We want to honor his memory and his home and his parents by having our house preserved. We had an historical assessment. Our original intent was to try to preserve our front porch area even though that wasn't part of the original structure, but it is a post WW II addition. The front porch does need some work. We have spoken with an architect and had some plans drawn to try and preserve the front street facing look so it does reflect the most recent look of the house. We would be happy to honor the Mudrock family by having a landmark designation.

Commission Questions of Applicant:

Haley says I think you have fully captured our vision so it is encouragement to us when residents feel that same vision.
Chuck Thomas asks outside of the noted outside assessment, do you have any other plans for the structure.
Norris says we thought about trying to make the front porch a little more energy efficient mostly by sealing the windows. They are single pane window with dried wood and we want to try and preserve that look and yet more energy efficient. We may possibly heat the front porch in some way. There would not be any particular structural changes such as footprint or exterior look.
Chuck Thomas asks if you would consider changing the siding out back to a style?
Norris says we have talked about removing the asbestos siding and restoring the lap siding look of the house. We want to do what is best for the house and for ourselves. The front has asbestos on it and we might remove that, just at least in the front. There is shingle underneath it but we don't know how much or what the condition is.

Public Comment:
None.

Commission Questions of Staff:
Stewart asks Staff if this is just a landmark application. Is there a grant request associated with it at this time? How would it work if they come back later? Would they fill out a grant application?
Trice says the applicant can fill out a grant application later. The $5,000 has to be done within 18 months of landmarking. The $15,000 has no associated time limit.
Cyndi Thomas asks Staff if the entire structure is landmarked.
Trice says in this instance, it would be the entire structure. They have not requested a partial landmarking.

Closed Public Hearing and discussion by Commission:
Koertje says thank you to the applicant for bringing this forward. This is a great house and it is great to see it coming forward as a landmark application. It meets the criteria as the building is over 50 years old, it has a high degree of architectural integrity, it has association with a long time Louisville family who lived in the house for 78 years, and the family held various civic positions, and there is an eastern European immigrant mining heritage involved.

Motion made by **Koertje** to approve Resolution No. 1, Series 2016: A resolution making findings and recommendations regarding the landmark designation for a historical residential structure located on 613 Grant Avenue, seconded by **Haley.** Roll call vote.

Name	Vote
Lynda Haley	Yes
Debbie Fahey	n/a
Peter Stewart	Yes
Mike Koertje	Yes
Jessica Fasick	n/a
Cyndi Thomas	Yes
Chuck Thomas	Yes
Motion passed/failed:	Pass

Motion passes 5-0.

Louisville Historical Museum
Department of Library & Museum Services
City of Louisville, Colorado
April 2015

613 Grant Avenue History

Legal Description: Lots 6 & 7, Block 11, Pleasant Hill Addition

Year of Construction: 1903

Summary: The Mudrock (formerly "Mudrak" and "Mudrack") family from Slovakia owned this property and were residents of the house starting in 1903. The family's ownership extended until 1981. The parcel to the north, 625 Grant (Lots 4 & 5, Block 11), was also part of their property, with some Mudrock family members also residing in a house there starting at a later date.

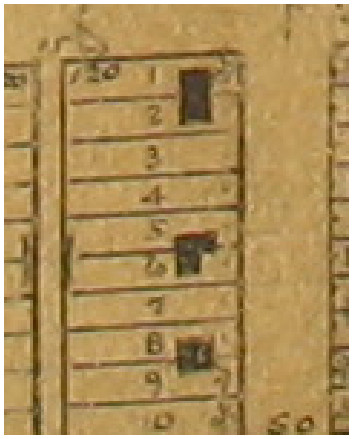
Development of the Pleasant Hill Addition; Date of Construction

The subdivision in which this house is located, Pleasant Hill Addition, was platted in 1894. It was developed by Orrin Welch, the half-brother of Charles C. Welch, the man who started the Welch Mine and played a prominent role in the founding of Louisville.

The 1948 Boulder County Assessor card for this property and the Boulder County Assessor's Office website both give 1903 as the date of construction of this house. Boulder County is sometimes in error with respect to the date of construction of Louisville buildings, so other evidence is looked to. In this case, the fact that the year given is so specific (unlike many other estimated dates given for Louisville houses such as "1900" or "1910"), along with the fact that the original family was living in the house at the time of the 1948 assessment and could have given the correct information, suggests that this date is correct. In addition, it is known that the Mudrock family arrived in Louisville in 1903. A deed of trust (like a mortgage) for the Mudrock property was recorded with Boulder County in 1904, and this would have followed the warranty deed. However, the warranty deed whereby John Mudrak purchased the parcels at 613 and 625 Grant from Orrin Welch was not recorded until 1905, though its effective date would have had to precede the deed of trust chronologically. No records were found that would contradict the 1903 date of construction. For these reasons, the date of construction is assumed to be 1903.

The house appears on the 1909 Drumm's Wall Map of Louisville (which showed main buildings, not secondary buildings or outbuildings on a parcel), though the house is shown as straddling lots 5 and 6 instead of being situated solely on lots 4 and 5. An excerpt of this map is shown below. Assuming that the map is accurate as to the location of the house, t is possible that the house was shifted slightly to

the south when the family added a house on the north side of their property, which eventually was given the address of 625 Grant.



Mudrock Family Ownership, 1903-1981

John "Mudrak" was born in what is now Slovakia in about 1868. Mary Mudrak was born in Slovakia in about 1872. They married in about 1888. Their son, John George, was born in 1890, and another son, Paul, was born in 1893. Records show that the family was from Lucka, Slovakia, which is along the southern border near Hungary. For purposes of this report, John and Mary, who were the first generation of Mudrocks to live in Louisville, will be referred to by their original last name of "Mudrack" to distinguish them from later generations of the family. Their son, John George, will be referred to as "John G." to distinguish him from his father and his son, also both named John.

In the 1890s, the family came to the U.S. It is believed that John, the father, arrived first in about 1891, and that he went back for his family. By 1899, the entire family was in the U.S. According to the obituary of John G., the family lived first in Pennsylvania, then moved to Rock Springs, Wyoming, then came to Louisville in 1903. The 1900 census shows the family to be living in Northside, Sweetwater, Wyoming, where John Mudrak worked as a coal miner. A third child, Michael, was born that year in Wyoming.

After the family came to Louisville, two more children, Mary and George, were born.

John G. Mudrock went to work in the mines at age 10, according to his wife, and worked as a coal miner for about 40 years. He retired in about 1941 from the Industrial Mine, according to the family. He also operated a gas station in Louisville and worked for an elevator company in Denver. He married Anna Kochan in Louisville in 1909. Anna Kochan was born in 1890 in New York to Slovak parents. She and her family moved among mining camps in Colorado when she was young. She and John G. met in Rockvale, Colorado, where he had been working.

In 1909, John and Mary Mudrak conveyed ownership of 613 Grant to their son, John G. Mudrock. This was the same year of his marriage. (By a deed recorded in 1950, John G. then transferred ownership of 613 Grant to both himself and his wife, Anna.)

A tax bill on the property for 1910 was donated to the Historical Museum by Tom Mudrock, the great-grandson of John and Mary Mudrak. It shows the assessed value of the property to be $130.00 and the property taxes to be $6.89.

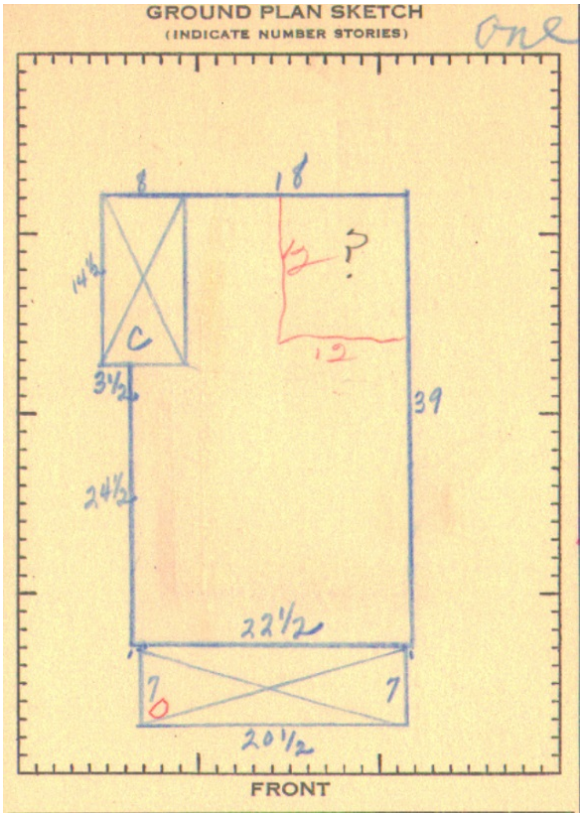
Two of John and Mary Mudrak's sons, Michael and Paul, served in World War I. Their names are on the World War I memorial in the Louisville Cemetery.

John Mudrak died in 1918 at the age of about 50, and Mary Mudrak died in 1939 at the age of about 67.

John G. and Anna Mudrock's son, Albert, served in the Navy in World War II. Albert's son, Tom Mudrock, in 2014 donated a photo of Albert Mudrock during his World War II service on the porch steps of 613 Grant, as shown here:

A photo of the house taken by the Boulder County Assessor in 1948, during the Mudrock ownership, appears here:

The layout of the house from the 1948 County Assessor card for 613 Grant appears here:



Anna Kochan Mudrock was interviewed at the age of 90 for the July 30, 1980 *Louisville Times*. The article sheds some light on the history of the house. “The newlywed Mudrocks moved in with John’s mother and brothers and sister in a [two-room] house on the same lot where Ann lives today. She has lived there since 1909.” This is a reference to 613 Grant, which was Anna’s home at the time of the article. She also told the reporter that because the house was so crowded, her husband John G. built a shack for their small family “in the back.” They had four children: John, born 1911; Helen, born 1912; Alice, born 1915; and Albert, born 1922.

Anna Mudrock also was quoted as saying, “We used to bring a bucket of water in from the hydrant every morning and put a dipper in it to drink from. Everybody used the same dipper. Not like today. We’ve got to have a glass for this one and a glass for that one.”

Later, when the Mudrock family built a house at 625 Grant, it was said by the family to have been a combination of an old house with a new addition. It is conceivable that the house that John G. Mudrock built behind 613 Grant that was described in the interview with Anna was moved to 625 Grant and formed the original part of that house. Evidence suggests that there was a house at 625 Grant with its own address by around 1915-1920. (It was remodeled in 1950.) This then became the home of John and Mary Mudrak, the parents, and their other children, while 613 Grant continued to be the home of John G. and Anna Mudrock. In 1943, following the death of Mary Mudrak, John G. Mudrock as the administrator of his mother’s estate conveyed ownership of 625 Grant to Anna, who then in 1947

conveyed ownership to their son, Albert Mudrock. Albert Mudrock and his wife, Cleo, lived at 625 Grant for many years and raised their children there.

John G. Mudrock died in 1963. At that time, Anna Mudrock became the sole owner of 613 Grant. Her son, Albert, continued to live with his family next door at 625 Grant.

While it is not known whether the sections of Lincoln and Grant south of Pine had so many Slovaks and other Eastern European families to constitute an actual ethnic enclave, there were at least 12 other houses in this neighborhood besides the two Mudrock houses at 613 and 625 Grant that were associated with Eastern European families.

In 1980, Anna Mudrock died at the age of 90. In 1981, 613 Grant was sold to Barbara Glinsky. In 1984, Barbara Glinsky sold the property to Catherine Fletcher. By 1986, both Cathy Fletcher and Sue Norris were the owners of 613 Grant. They are still the current owners today.

In terms of later generations of Mudrocks connected to this property, Albert Mudrock married Cleo Damiana in 1945. Cleo Mudrock was a much-loved resident who worked for the City of Louisville for many years and served as City Clerk for three years. Louisville's Cleo Mudrock Park is named for her. John Mudrock (1910-1993), who also grew up at 613 Grant, had a son, Phil Mudrock, who emerged from Louisville's strong baseball culture to be a professional baseball player from 1956 until 1965, according to his Wikipedia entry. Mudrock's Tap and Tavern on South Boulder Road is said to have been named in his honor, but is not owned by the family.

The preceding research is based on a review of relevant and available online County property records, census records, oral history interviews, Louisville directories, and Louisville Historical Museum maps, files, obituary records, and historical photographs from the collection of the Louisville Historical Museum.

City of Louisville

Landmark Designation Nomination Form

(6/09)

DATE: 12/4/15

LANDMARK APPLICATION FOR:

☑ Individual Site/Building Landmark ☐ Historic District

NOMINATION MADE BY:

☑ Owner ☐ City Council
☐ Historic Preservation Commission ☐ Third Party

Name: Susan Norris and Catherine Fletcher
Address: 613 Grant Avenue, Louisville 80027
Phone: 303-513-0980 Email Sunorris@ecentral.com
Relationship to Owner:

LOCATION OF PROPOSED LANDMARK:

Address: 613 Grant Avenue
Legal Description (Lot Number, Block Number, and Subdivision):
Lots 6-7 Blk 11 Pleasant Hill
Property Name (Historic and/or Common):

Former Addresses (If Known):

OWNER INFORMATION
(For district applications, please attach separate sheet)

Name: See above
Address:
Phone:

BOUNDARIES and TYPE OF DESIGNATION

Description of Boundary Determination:

CLASSIFICATION

Category	Ownership	Status	Present Use	Existing Designation
☑ Building	☐ Public	☑ Occupied	☑ Residential	☐ National Register
☐ Structure	☑ Private	☐ Unoccupied	☐ Commercial	☐ Colorado Register
☐ Site			☐ Educational	
☐ District			☐ Religious	
☐ Object			☐ Agricultural	
			☐ Government	
			☐ Other	

SIGNIFICANCE

☑ **Site/Building is Over 50 Years Old and meet one of the following standards**

☑ ***Historic Landmark of Significance – must meet one (1) or more of the following criteria***

☑ **Architectural Significance:** The property:

- exemplifies specific elements of an architectural style or period;
- is an example of the work of an architect or builder who is recognized for expertise nationally, statewide, regionally, or locally;
- demonstrates superior craftsmanship or high artistic value; represents an innovation in construction, materials or design; is of a style particularly associated with the Louisville area;
- represents a built environment of a group of people in an era of history that is culturally significant to Louisville;
- shows a pattern or grouping of elements representing at least one of the above criteria; or
- is a significant historic remodel.

☑ **Social Significance:** The property is the site of a historic event that had an effect upon society; exemplifies cultural, political, economic or social heritage of the community or is associated with a notable person or the work of a notable person.

☐ **Geographic or Environmental Significance:** The property enhances the sense of identity of the community or is an established and familiar natural setting or visual feature that is culturally significant to the history of Louisville.

☐ ***Prehistoric or Archaeological Site*** The property has yielded, or may be likely to yield, information important in prehistory or history.

HISTORICAL INFORMATION

Please attach a narrative of the historical significance of the property. Include a title search or city directory research if the property is important for its association with a significant person.

ARCHITECTURAL and PHYSICAL DESCRIPTION
(Attach a separate sheet if needed)

Construction Date:
1903

Architect/Builder:

Building Materials:
cement foundation; wood frame

Architectural Style:
Bungalow

Special Features/Surroundings:

Describe any additions or alterations to the property:
Residential addition added in rear of house to expand living space - 1998.

REFERENCE LIST or SOURCES OF INFORMATION
(Attach a separate sheet if needed)

PHOTOS
Please include photos of EACH ELEVATION of EACH BUILDING and STRUCTURE on the property.

FOR OFFICE USE ONLY
Application Number _____
Date Filed with Planning Department _____
Date Determined "Eligible" _____ Date Determined "Ineligible" _____
Application ☐ Approved ☐ Denied
HPC Resolution # _____, CC Resolution # _____,
Date Recorded _____

Historic Landmark Agreement

Property Address: 613 Grant Ave. ***, Louisville, CO 80027***
Property Legal Description: Lots 6-7 Blk 11 Pleasant Hill

The undersigned owner(s) hereby agrees that the property above described be considered for local historic landmark designation, pursuant to the Louisville Landmark Preservation Ordinance, Ordinance No. 1463, Series 2005, as codified in Chapter 15.36 of the Louisville Municipal Code and amended from time to time (the "Ordinance").

I understand that upon designation, I or my successors in ownership of the property will be required to submit to the review process of the Historic Preservation Commission of the City of Louisville as set forth in the Ordinance prior to the occurrence of any of the following:

1. Reconstruction or alteration of the exterior of the improvements on the property, or;
2. Construction of, addition to, or demolition of improvements on the property.

I further understand that I or my successors in ownership will be required to submit to the review process of the Historic Preservation Commission of the City of Louisville as set forth in the Ordinance if a building permit for the property is requested for any one of the following:

1. Alteration or reconstruction of or an addition to the exterior of any improvement which constitutes all or part of a landmark structure or landmark district;
2. Demolition or relocation of any improvement which constitutes all or part of a landmark structure or landmark district; or
3. Construction or erection of or an addition to any improvement upon any land included in a landmark district.

I understand that as part of any such review process, the Historic Preservation Commission shall be under the time constraints and other requirements as set forth in the Ordinance.

I also understand that any historic landmark designation for the property transfers with the title of the property should the property be sold.

DATED this 5th day of January, 200__. 2016

Susan Norris and Catherine Fletcher
Owner Name (please print)

Owner Signature

State of Colorado)
)ss.
County of Boulder)

Subscribed and sworn before me this 6th day of January 2016,
by Susan Norris

Witness my hand and official seal. My commission expires

Nancy Varra
Notary Public

NANCY VARRA
NOTARY PUBLIC
STATE OF COLORADO
NOTARY ID 19984012639
MY COMMISSION EXPIRES MAY 6, 2018

City Council – Public Hearing

613 Grant Avenue

Landmark Request

Resolution No. 12, Series 2016

A request to landmark the Mudrock House at 613 Grant Avenue.

Prepared by:

Dept. of Planning & Building Safety

613 Grant Avenue– Location

613 Grant Avenue– Social History

1948 Assessor's Photo

- Constructed circa 1903
- Owned by the Mudrock family from 1903 until 1981
- The Mudrock family was originally from Slovakia and worked in the Louisville coal mines

613 Grant Avenue– Architectural Integrity

- Vernacular with Craftsman style elements
- Maintained form
- Porch enclosed
- Rear addition constructed in 1998

613 Grant Avenue – Conclusion

Staff recommends approval of Resolution No. 12, Series 2016, designating the Mudrock House a historic landmark, for the following reasons:

1. The structure represents the vernacular style of early 20th century Louisville.
2. The house was associated with the Mudrock family for over 70 years.

SUBJECT: **DISCUSSION/DIRECTION/ACTION – 2016 CITIZEN SURVEY INSTRUMENT**

DATE: **MARCH 8, 2016**

PRESENTED BY: **COUNCIL MEMBERS CHRIS LEH & DENNIS MALONEY**
CITY MANAGER MALCOLM FLEMING

SUMMARY:
Councilmembers Leh and Maloney have been working with staff and survey consultant National Research Center (NRC) to draft the survey instrument for the 2016 Citizen Survey. The survey consists of questions regarding Departmental and Citywide performance issues as well as questions concerning specific policy issues. The group considered many policy questions but narrowed the list considerably to keep the survey concise while also getting the information the Council needs for decision making. The group also reviewed and discussed many iterations of the survey and presents this one to the full City Council for consideration and discussion.

The survey will be mailed to 2,000 randomly selected Louisville addresses to get a statistically valid, cross section of residents. All households located within the City's boundaries are eligible for the survey. NRC will identify the precise location of each address to assure it is within Louisville boundaries and identify in which Ward each address is located to select a proportionate or equal number of households from each.

Presentation of instrument at Council .....March 8
Materials printed week of .....March 14
Mail pre-notification postcard .....March 17
Mail first wave of surveys .....March 23
Mail second wave of surveys..... March 30
Data collection through ..... April 29
Electronic data entry through .....May 3
Data analysis and report writing through .....May 25
Report finalized .....June 8
Presentation to Council after .....June 8

FISCAL IMPACT:
Following a bid process, the City hired NRC to complete the survey for $24,000. The 2016 budget includes $35,000 for the survey.

RECOMMENDATION:
Discuss and approve the 2016 citizen survey instrument.

ATTACHMENT(S):
1. Draft 2016 Citizen Survey Instrument

2016 Louisville Citizen Survey

Please complete this questionnaire if you are the adult (age 18 or older) in the household who most recently had a birthday. The adult's year of birth does not matter. Please circle the response that most closely represents your opinion for each question. Your responses are anonymous and will be reported in group form only.

1. Please circle the number that comes closest to your opinion about the quality of life in Louisville:

	Excellent	Good	Fair	Poor	Don't know
How do you rate Louisville as a place to live?	1	2	3	4	5
How do you rate Louisville as a place to raise children?	1	2	3	4	5
How do you rate Louisville as a place to retire?	1	2	3	4	5
How do you rate Louisville as a place to work?	1	2	3	4	5
How do you rate the overall quality of life in Louisville?	1	2	3	4	5

2. Please rate Louisville as a community on each of the items listed below:

	Excellent	Good	Fair	Poor	Don't know
Sense of community	1	2	3	4	5
Openness and acceptance of the community towards people of diverse backgrounds	1	2	3	4	5
Overall appearance of Louisville	1	2	3	4	5
Opportunities to attend cultural activities	1	2	3	4	5
Shopping opportunities	1	2	3	4	5
Opportunities to participate in special events and community activities	1	2	3	4	5
Opportunities to participate in community matters	1	2	3	4	5
Recreational opportunities	1	2	3	4	5
Employment opportunities	1	2	3	4	5
Variety of housing options	1	2	3	4	5
Availability of affordable quality housing	1	2	3	4	5
Ease of car travel in Louisville	1	2	3	4	5
Ease of bus travel in Louisville	1	2	3	4	5
Ease of bicycle travel in Louisville	1	2	3	4	5
Ease of walking in Louisville	1	2	3	4	5
Traffic flow on major streets	1	2	3	4	5
Quality of overall natural environment in Louisville	1	2	3	4	5
Overall image or reputation of Louisville	1	2	3	4	5

3. Please rate how safe you feel:

	Very safe	Somewhat safe	Neither safe nor unsafe	Somewhat unsafe	Very unsafe	Don't know
From violent crime (e.g., rape, assault, robbery)	1	2	3	4	5	6
From property crimes (e.g., burglary, theft)	1	2	3	4	5	6
In your neighborhood during the day	1	2	3	4	5	6
In your neighborhood after dark	1	2	3	4	5	6
In Louisville's downtown area during the day	1	2	3	4	5	6
In Louisville's downtown area after dark	1	2	3	4	5	6
In Louisville's parks during the day	1	2	3	4	5	6
In Louisville's parks after dark	1	2	3	4	5	6

4. Please circle the number that comes closest to your opinion about the performance of the following areas of the City of Louisville Administration:

	Excellent	Good	Fair	Poor	Don't know
City response to citizen complaints or concerns	1	2	3	4	5
Information about City Council, Planning Commission & other official City meetings	1	2	3	4	5
Information about City plans and programs	1	2	3	4	5
Availability of City Employees	1	2	3	4	5
Programming on Louisville cable TV, municipal channel 8	1	2	3	4	5
Louisville Web site (www.louisvilleco.gov)	1	2	3	4	5
Overall performance of Louisville City government	1	2	3	4	5

5. Please circle the number that comes closest to your opinion about the following areas related to the Louisville Police Department:

	Excellent	Good	Fair	Poor	Don't know
Visibility of patrol cars	1	2	3	4	5
911 service	1	2	3	4	5
Enforcement of traffic regulations	1	2	3	4	5
Municipal code enforcement issues (dogs, noise, weeds, etc.)	1	2	3	4	5
Overall performance of the Louisville Police Department	1	2	3	4	5

6. Please circle the number that comes closest to your opinion about the following areas of Louisville Planning and Building Safety Department:

	Excellent	Good	Fair	Poor	Don't know
The public input process on City planning issues	1	2	3	4	5
Planning review process for new development	1	2	3	4	5
Overall performance of the Louisville Planning Department	1	2	3	4	5
Overall performance of the Louisville Building Safety Division	1	2	3	4	5

7. Please circle the number that comes closest to your opinion about the following areas of the Louisville Parks and Recreation Department:

	Excellent	Good	Fair	Poor	Don't know
Current recreation programs for youth	1	2	3	4	5
Current recreation programs for adults	1	2	3	4	5
Current programs and services for seniors	1	2	3	4	5
Recreation fees in Louisville	1	2	3	4	5
Overall quality of the Louisville Recreation Center	1	2	3	4	5
Overall quality of the Louisville Senior Center	1	2	3	4	5
Overall quality of the Coal Creek Golf Course	1	2	3	4	5
Maintenance and cleanliness of the Louisville Recreation Center	1	2	3	4	5
Adequacy of parks, bike paths, playing fields and playgrounds	1	2	3	4	5
Maintenance of parks (maintenance, management, playgrounds, picnic areas, etc.)	1	2	3	4	5
Maintenance of open space	1	2	3	4	5
Maintenance of the trail system	1	2	3	4	5
Overall performance of the Louisville Parks and Recreation Department	1	2	3	4	5

8. Please circle the number that comes closest to your opinion about the Louisville Public Library & Historical Museum and their services:

	Excellent	Good	Fair	Poor	Don't know
Louisville Public Library programs (e.g., story time, One Book program, etc.)	1	2	3	4	5
Services at the Louisville Public Library (e.g., reference desk, check out, etc.)	1	2	3	4	5
Internet and computer services at the Louisville Public Library	1	2	3	4	5
Louisville Public Library services online at www.louisville-library.org accessed from home or elsewhere (e.g., book holds, access databases, research, etc.)	1	2	3	4	5
Louisville Public Library materials and collections	1	2	3	4	5
Louisville Public Library building	1	2	3	4	5
Overall performance of the Louisville Public Library	1	2	3	4	5
Overall performance of the Louisville Historical Museum	1	2	3	4	5

9. Please circle the number that comes closest to your opinion about the performance of the following areas of Louisville Public Works Department:

	Excellent	Good	Fair	Poor	Don't know
Street maintenance in your neighborhood	1	2	3	4	5
Street maintenance in Louisville	1	2	3	4	5
Street sweeping	1	2	3	4	5
Snow removal/street sanding	1	2	3	4	5
Street lighting, signage and street markings	1	2	3	4	5
Waste water (sewage system)	1	2	3	4	5
Storm drainage (flooding management)	1	2	3	4	5
Bike lanes on Louisville streets	1	2	3	4	5
Access on sidewalks/crosswalks for disabled persons	1	2	3	4	5
Quality of Louisville water	1	2	3	4	5
Overall performance of Louisville Public Works Department	1	2	3	4	5

	Excellent	Good	Fair	Poor	Don't know
10. Overall, how do you rate the quality of services provided by the City of Louisville?	1	2	3	4	5

11. What was your impression of employees of the City of Louisville in your <u>most recent contact</u>? (Rate each characteristic below.)

	Excellent	Good	Fair	Poor	Don't know
Knowledge	1	2	3	4	5
Responsiveness/promptness	1	2	3	4	5
Availability	1	2	3	4	5
Courtesy	1	2	3	4	5
Overall impression	1	2	3	4	5

11a. In which department did the employee you most recently contacted work: _____

12. In the last 12 months, about how many times, if ever, have you or other household members participated in the following activities in Louisville?

	Never	Once or twice	3 to 12 times	13 to 26 times	More than 26 times
Played golf at the Coal Creek Golf Course	1	2	3	4	5
Used the Louisville Public Library or its services	1	2	3	4	5
Used the Louisville Recreation Center	1	2	3	4	5
Used Memory Square Pool	1	2	3	4	5
Visited the Louisville Historical Museum	1	2	3	4	5
Attended the Downtown Louisville Street Faire (9 nights in 2016)	1	2	3	4	5
Attended an event, show or activity at the Arts Center	1	2	3	4	5
Attended another event downtown (Art Walk, Taste of Lsvl, parade, Winter Skate)	1	2	3	4	5

13. Currently, the City's trash service (through Western Disposal) provides once per week trash pickup and compost and recycling pickup every two weeks. To what extent would you support or oppose changing the service to compost pickup weekly and trash service every two weeks (leaving recycling pickup every two weeks)?

❑ Strongly support ❑ Somewhat support ❑ Somewhat oppose ❑ Strongly oppose ❑ No opinion

14. The City of Louisville currently has a Historic Preservation Tax, which is a dedicated sales tax (0.125 cents on every dollar spent). Revenue from this tax is used to help property owners rehabilitate and preserve historic landmarks which contribute to the character of Historic Old Town Louisville. This tax was approved by voters in 2008 and is set to expire in 2018. To what extent would you support or oppose each of the following options to continue the tax?

	Strongly support	Somewhat support	Somewhat oppose	Strongly oppose	No opinion
Continue the sales tax until 2028	1	2	3	4	5
Continue the sales tax until 2028 and also dedicate a portion of the tax to help operate the Louisville Historical Museum	1	2	3	4	5

15. To what extent would you support or oppose the City considering each of the following as it relates to development in Louisville?

	Strongly support	Somewhat support	Somewhat oppose	Strongly oppose	No opinion
Encouraging a mix of housing types for all ages	1	2	3	4	5
Subsidizing affordable housing	1	2	3	4	5
Encouraging mixed-use* development in areas in need of redevelopment	1	2	3	4	5
Allowing higher density in mixed-use* areas	1	2	3	4	5
Limiting residential growth (construction of new homes/apartments)	1	2	3	4	5
Limiting commercial growth	1	2	3	4	5

* Mixed-use development combines residential, commercial, cultural or institutional uses into a physically and functionally integrated area with pedestrian connections.

16. Beyond basic City services (police, water, sewer, etc.), the City has limited resources and must make hard decisions about funding priorities. First, indicate how important to you each of the following areas are as the City considers residents' current and future needs. Then please select <u>up to three (3) issues</u> the City Council should invest in today.

	Essential	Very important	Somewhat important	Not at all important	Please select 3 top issues
Maintaining, repairing, and paving streets	1	2	3	4	❑
Encouraging sustainability (in buildings, energy and water use, recycling, etc.) for both residential and commercial properties	1	2	3	4	❑
Creating indoor community gathering space (arts center, community center, etc.)	1	2	3	4	❑
Creating outdoor community gathering space (amphitheater, commons, etc.)	1	2	3	4	❑
Providing additional recreation facilities and amenities	1	2	3	4	❑
Expanding Internet/broadband options	1	2	3	4	❑
Using incentives to create business and employment opportunities	1	2	3	4	❑
Maintaining the City's appearance/attractiveness	1	2	3	4	❑
Providing additional parking in Downtown Louisville	1	2	3	4	❑
Facilitating the redevelopment of existing vacant commercial properties	1	2	3	4	❑

18. Following is a list of information sources. First, please select how often you use each source to gain information about the City of Louisville. Then, indicate the quality and reliability of the information from that source.

	Always	Frequently	Sometimes	Never	Excellent	Good	Fair	Poor	Don't know
Attend, watch or stream a City Council meeting or other program on Comcast channel 8 (government access) or streaming through the City's website	1	2	3	4	1	2	3	4	5
Community Update (City Newsletter)	1	2	3	4	1	2	3	4	5
The Daily Camera	1	2	3	4	1	2	3	4	5
The City of Louisville website (www.louisvilleco.gov)	1	2	3	4	1	2	3	4	5
Utility bill inserts	1	2	3	4	1	2	3	4	5
Word of Mouth	1	2	3	4	1	2	3	4	5

19. What sources, other than those listed above, would you or do you use to get information about the City of Louisville?

_____

20. How likely, if at all, would you be to look for official City information on social media websites (e.g., Facebook, Twitter, Instagram, etc.) if the City were to increase its presence or activity using such media?

- ❑ Very likely
- ❑ Somewhat likely
- ❑ Somewhat unlikely
- ❑ Very unlikely
- ❑ Don't know

Our last questions are about you and your household. Again, all of your responses to this survey are completely anonymous and will be reported in group form only.

D1. How many years have you lived in Louisville?

- ❑ Less than 1 year
- ❑ 1-5 years
- ❑ 6-10 years
- ❑ 11-15 years
- ❑ More than 15 years

D2. Which best describes the building you live in?

- ❑ One family house detached from any other houses
- ❑ House attached to one or more houses (e.g., a duplex or townhome)
- ❑ Building with two or more apartments or condominiums
- ❑ Mobile home
- ❑ Other

D3. Do you rent or own your home?

- ❑ Rent
- ❑ Own

D4. What is your gender?

- ❑ Female
- ❑ Male

D5. In which category is your age?

- ❑ 18-24 years
- ❑ 25-34 years
- ❑ 35-44 years
- ❑ 45-54 years
- ❑ 55-64 years
- ❑ 65-74 years
- ❑ 75 years or older

D6. How many people (including yourself) currently live in your household? _____ people

D7. Do any children 17 or under live in your household?

- ❑ No
- ❑ Yes

D8. Are you or any other members of your household aged 60 or older?

- ❑ No
- ❑ Yes

Thank you for completing this survey. Please return the completed survey in the postage-paid envelope to: National Research Center, Inc., PO Box 549, Belle Mead, NJ 08502

SUBJECT: **ORDINANCE NO. 1716, SERIES 2016 – AN ORDINANCE AMENDING TITLE 17 OF THE LOUISVILLE MUNICIPAL CODE TO ADD HEALTH OR ATHLETIC CLUBS, SPAS, DANCE STUDIOS AND FITNESS STUDIOS AS A LISTED USE GROUP AND SPECIFYING IN WHICH ZONE DISTRICTS THESE USES MAY BE DEVELOPED**

DATE: **MARCH 8, 2016**

PRESENTED BY: **LAUREN TRICE, AICP, PLANNER I**

SUMMARY:

Section 17.12.030 of the Louisville Municipal Code (LMC) lists all of the potential land uses allowed in the City of Louisville, and states in which zone districts these land uses are expressly permitted, prohibited, or permitted through special review. This use group table is referenced any time development of a new use is proposed in the City, to determine if it is permitted in its proposed location.

Planning staff has reviewed and processed numerous applications in recent years for the development of specific unique instructional fitness related businesses such as yoga and pilates studios, cross-fit studios, climbing gyms, and dance studios. Although these types of businesses are fairly common throughout the City, they are only expressly listed in the mixed use zone districts regulations in Section 17.14.050 of the LMC. Such uses are not expressly listed as a use group in Section 17.12.030 (Use groups), Section 17.72.090.B (Commercial and Office Uses Permitted), and Section 17.13.030 (Special review uses in the AO-T zone district).

Currently, staff classifies fitness related studios under Use Group #9: *"Public and private schools (Other than items 10, 11 and 12), studios for professional work or teaching of any form of fine arts, photography, music, drama, dance, but not including a commercial gymnasium".* Staff interprets these small scale businesses based on their unique instruction oriented fitness classes as private schools, not general use commercial gymnasiums.

City Council recently directed staff to add a new use group which better represents these types of businesses within the LMC use tables and to determine the most appropriate zone districts City-wide to allow their use. Staff agrees with City Council that Use Group #9 does not accurately define these instructional fitness related land uses because they may be perceived as a "commercial gymnasium" while their specific business model is specifically similar to a private school. The attached ordinance is written to add a new use group (#62) that defines these types of uses, and specifies in which zone districts they may be allowed.

TITLE 17 AMENDMENTS

Staff recommends modifying Title 17 of the LMC in four areas to add "health or athletic clubs, spas, dance studios, and fitness related studios" as uses in the land use code and specifying where these uses may be allowed:

1) Section 17.12.030 – Use Groups
2) Section 17.14.050 – Permitted uses within the Mixed Use Zone District
3) Section 17.72.090 – Permitted Commercial and Office Uses in the Planned Community Zone District (PCZD)
4) Section 17.13.030 – Special Review Uses in the AO-T zone district

Section 17.12.030 – Use Groups

Chapter 17.12 of the LMC identifies which land uses are allowed in the City, where they can be located, and how they may fit on a specific property. Staff suggests the land use table in Section 17.12.030 be modified, as shown below, to add "health or athletic clubs, spas, dance studios, or yoga studios" as the 62nd use group. These uses would be permitted by right in the Commercial Neighborhood (CN), Community Commercial (CC) and Commercial Business Zone Districts. The uses could be approved by Special Review in the Administrative Office (AO), Business Office (BO), Administrative Office Transitional (AO-T), and Industrial (I) zone districts.

Staff also recommends amending use group #9 to delete "dance," from the Use Group description contained therein to eliminate redundancy between the two use groups.

Use Group		Zoning Districts																	
		A	AO	BO	AOT*	RR-R	SFR	SFE	RR RE RL	SFLD SFMD SFHD	RM	RH	CN	CC	CB	I	PCZD**	MU R/CC ***	OS ****
22	**Public and private schools (Other than items 10, 11 and 12), studios for professional work or teaching of any form of fine arts, photography, music, drama, ~~dance~~, but not including a commercial gymnasium**	R	R	R		R	R	R	R	R	R	R	R	R	R	R			
62	**Health or athletic clubs, spas, dance studios, fitness studios**	N	R	R		N	N	N	N	N	N	N	Y	Y	Y	R			

** AO-T uses are described in chapter 17.13.*
*** PCZD uses are discussed in chapter 17.72.*
**** MU-R uses are discussed in chapter 17.14.*
***** OS The designated classifications of open space lands are set forth in the Open Space Master Plan approved by city council. Provisions regarding the use and management of open space lands are found in the Open Space Master Plan, Article 15 of the City Charter, and Title 4 of this Code.*

Section 17.14.050.A: Table 1 - Permitted uses within the Mixed Use Zone District
Staff recommends amending Table 1 in Section 17.14.050.A of the LMC to delete the phrase "Health or athletic clubs, spas, dance studios, yoga studios" and insert in its place the phrase "Health or athletic clubs, spas, dance studios, fitness studios."

Section 17.72.090 – Uses in the Planned Community Zone District
The Use Group Table in Section 17.12.030 defers to Section 17.72.090.B of the LMC to define the uses permitted in the Planned Community Zone District (PCZD). The uses that may be permitted in the PCZD – Commercial District are defined Section 17.72.090 B. This list of uses does not include fitness studios. Staff proposes adding a 23rd item to that list of uses titled "health or athletic clubs, spas, dance studios, or fitness studios".

Section 17.13.030 – Special Review Uses in the AO-T zone district
The Use Group Table in Section 17.12.030 defers to Section 17.13 of the LMC to define the uses permitted by Special Review in the Administrative Office Transitional (AO-T) zone district. This list of uses does not include fitness studios either. Staff proposes adding a new item "I" to that list of uses titled "health or athletic clubs, spas, dance studios, or fitness studios".

ADDITIONAL INFORMATION REQUESTED AT FIRST READING
At City Council's first reading of Ordinance 1716, Series 2016, Council members Stolzmann and Maloney raised some questions which staff has attempted to address below.

1. *The land use table in the ordinance does not match the table shown in the Council Communication.*

It was staff's intention the newly created "health or athletic clubs, spas, dance studios, and fitness related studios" use group could be permitted by Special Review in all of the office zone districts (Administrative Office, Business Office, and Administrative Office-Transition). The ordinance was presented this way in the Planning Commission Staff Report and in Staff's presentation at the Planning Commission hearing. Unfortunately, there was an error in the Ordinance which showed the newly created use group as a use by right in all of the Office zone districts. Staff has revised the ordinance to reflect the "health or athletic clubs, spas, dance studios, and fitness related studios" use group can be permitted by special review in all Office zone districts. A redline copy of the ordinance which illustrates these changes has been included as an attachment to this report.

2. *A typo was identified in the "Whereas" clauses.*

Staff identified two typos in the sixth *"Whereas"* clause. An extra space was deleted and the year of the Planning Commission hearing was changed from 2015 to 2016. These changes are highlighted in the attached redline copy of the ordinance.

3. *Can the word "gymnasium" be added to the new use group?*

It is staff's opinion that adding the word "gymnasium" to the use group may make the category too broad. Gymnasium is not a defined term in the LMC. Absent a definition in the LMC, staff would refer to the Merriam Webster dictionary which defines gymnasium as *"a large room used for various indoor sports (as basketball or boxing) and usually equipped with gymnastic apparatus".* Staff's concern is to add a broad term like gymnasium may allow for a number of uses not contemplated as part of the proposed change. If there is a more specific use that Council would like to include in this use group, staff can provide some suggested amendments to the use group. It may be the desired use is already included in a separate use group in the existing use group table.

4. How broad is this new use group – what types of uses does it include?

The intent of this code change was to add a specific use group for instructional and fitness related businesses, as there is not an existing category for those types of uses. The new use group is not intended to include things like private golf or tennis clubs, bowling alleys, or other recreational commercial operations. These types of uses fall into other use categories in the existing use group table.

FISCAL IMPACT

Amending the LMC to add health or athletic clubs, spas, dance studios, or fitness studios to the list of uses that may be permitted throughout the City will have no discernable fiscal impact on the City. These uses already operate legally in the City. The proposed action will only clarify where they are permitted and likely simplify their development review process.

PLANNING COMMISSION ACTION

The Planning Commission held a public hearing January 14, 2016. After some discussion about the nuances of the language in the LMC, and how certain uses are classified, the Planning Commission voted unanimously (7-0) to recommend the City Council approve the Ordinance amending Title 17 of the Louisville Municipal Code. The complete minutes from the Planning Commission hearing are included as an Attachment to this communication.

RECOMMENDATION

Staff recommends City Council adopt Ordinance No. 1716, Series 2016, an ordinance amending title 17 of the Louisville Municipal Code (LMC) to add health or athletic clubs, spas, dance studios and fitness studios as a listed use group and specifying in which zone districts these uses may be developed.

ATTACHMENTS:

1. Redline changes to Ordinance No. 1716, Series 2016 since first reading
2. Ordinance No. 1716, Series 2016 (Clean)
3. January 14, 2016 - Planning Commission Minutes
4. Presentation

ORDINANCE NO. 1716
SERIES 2016

AN ORDINANCE AMENDING TITLE 17 OF THE LOUISVILLE MUNICIPAL CODE TO ADD HEALTH OR ATHLETIC CLUBS, SPAS, DANCE STUDIOS AND FITNESS STUDIOS AS A LISTED USE GROUP AND SPECIFYING IN WHICH ZONE DISTRICTS THESE USES MAY BE DEVELOPED

WHEREAS, the City of Louisville is a Colorado home rule municipal corporation duly organized and existing under laws of the State of Colorado and the City Charter; and

WHEREAS, health or athletic clubs, spas, dance studios, and fitness studios are located within the City of Louisville and are uses the City Council desires to allow in certain parts of the City; and

WHEREAS, while such uses are expressly listed in the mixed use zone districts regulations in Section 17.14.050 of the Louisville Municipal Code (LMC), such uses are not expressly listed in the other use category sections of the LMC; and

WHEREAS, specifically, Section 17.12.030 (Use Groups), Section 17.72.090.B (Commercial and Office Uses Permitted), and Section 17.13.020 (Use Groups) of the LMC do expressly list health or athletic clubs, spas, dance studios, and fitness studios as uses that may be developed in the City; and

WHEREAS; City Council desires to add a new use group titled "Health or athletic clubs, spas, dance studios, and fitness studios to Section 17.12.030 (Use groups), Section 17.72.090.B (Commercial and Office Uses Permitted), and Section 17.13.03~~2~~0 (~~Use Groups~~Special review uses) of the LMC, and determine where these types of uses may be permitted; and

WHEREAS, afte~~-~~r a duly noticed public hearing held January 14, 201~~5~~6, where evidence and testimony were entered into the record, including the Louisville Planning Commission Staff Report dated January 14, 201~~5~~6, the Louisville Planning Commission has recommended the City Council adopt the amendments to the Louisville Municipal Code set forth in this ordinance; and

WHEREAS, City Council has provided notice of a public hearing on said ordinance by publication as provided by law and held a public hearing as provided in said notice;

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF LOUISVILLE, COLORADO, THAT:

Section 1. The Use Group table in Section 17.12.030 of the Louisville Municipal Code is hereby amended by the addition of a new use group 62 to read as follows:

Use Group		Zoning Districts																	
		A	AO	BO	AOT *	RRR	SFR	SFE	RR RE RL	SFLD SFMD SFHD	RM	RH	CN	CC	CB	I	PCZD **	MU R/CC ***	OS ****
62	Health or athletic clubs, spas, dance studios, fitness studios	N	~~Y~~R	~~Y~~R	~~Y~~	N	N	N	N	N	N	N	Y	Y	Y	R			

** AO-T uses are described in chapter 17.13.*
*** PCZD uses are discussed in chapter 17.72.*
**** MU-R uses are discussed in chapter 17.14.*
***** OS The designated classifications of open space lands are set forth in the Open Space Master Plan approved by city council. Provisions regarding the use and management of open space lands are found in the Open Space Master Plan, Article 15 of the City Charter, and Title 4 of this Code.*

Section 2. Use Group 9 within the Use Group table in Section 17.12.030 of the Louisville Municipal Code is hereby amended to delete "dance," from the Use Group description contained therein.

Section 3. Table 1 in Section 17.14.050.A of the Louisville Municipal Code is hereby amended to delete the phrase "Health or athletic clubs, spas, dance studios, yoga studios" and insert in its place the phrase "Health or athletic clubs, spas, dance studios, fitness studios."

Section 4. Section 17.72.090.B of the Louisville Municipal Code is hereby amended by the addition of a new subsection B.23 to read as follows:

23. Health or athletic clubs, spas, dance studios, and fitness studios.

Section 5. Section 17.13.03~~2~~0 of the Louisville Municipal Code is hereby amended by the addition of a new subsection I~~D~~ to read as follows:

I~~D~~. Health or athletic clubs, spas, dance studios, and fitness studios.

Section 6. If any portion of this ordinance is held to be invalid for any reason such decisions shall not affect the validity of the remaining portions of this ordinance The City Council hereby declares that it would have passed this ordinance and each part hereof irrespective of the fact that any one part be declared invalid.

Section 7. The repeal or modification of any provision of the Municipal Code of the City of Louisville by this ordinance shall not release, extinguish, alter, modify, or change in whole or in part any penalty, forfeiture, or liability, either civil or criminal, which shall have been incurred under such provision, and each provision shall be treated and held as still remaining in force for the purpose of sustaining any and all proper actions, suits, proceedings, and prosecutions for the enforcement of the penalty,

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forfeiture, or liability, as well as for the purpose of sustaining any judgment, decree, or order which can or may be rendered, entered, or made in such actions, suits, proceedings, or prosecutions.

Section 7. All other ordinances or portions thereof inconsistent or conflicting with this ordinance or any portions hereof are hereby repealed to the extent of such inconsistency or conflict.

INTRODUCED, READ, PASSED ON FIRST READING, AND ORDERED PUBLISHED this 16th DAY OF FEBRUARY, 2016.

_____
Robert P. Muckle, Mayor

ATTEST:

_____
Nancy Varra, City Clerk

APPROVED AS TO FORM:

_____
Light, Kelly, P.C.
City Attorney

PASSED AND ADOPTED ON SECOND AND FINAL READING this 8th day of MARCH, 2016.

_____
Robert P. Muckle, Mayor

ATTEST:

_____
Nancy Varra, City Clerk

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ORDINANCE NO. 1716
SERIES 2016

AN ORDINANCE AMENDING TITLE 17 OF THE LOUISVILLE MUNICIPAL CODE TO ADD HEALTH OR ATHLETIC CLUBS, SPAS, DANCE STUDIOS AND FITNESS STUDIOS AS A LISTED USE GROUP AND SPECIFYING IN WHICH ZONE DISTRICTS THESE USES MAY BE DEVELOPED

WHEREAS, the City of Louisville is a Colorado home rule municipal corporation duly organized and existing under laws of the State of Colorado and the City Charter; and

WHEREAS, health or athletic clubs, spas, dance studios, and fitness studios are located within the City of Louisville and are uses the City Council desires to allow in certain parts of the City; and

WHEREAS, while such uses are expressly listed in the mixed use zone districts regulations in Section 17.14.050 of the Louisville Municipal Code (LMC), such uses are not expressly listed in the other use category sections of the LMC; and

WHEREAS, specifically, Section 17.12.030 (Use Groups), Section 17.72.090.B (Commercial and Office Uses Permitted), and Section 17.13.020 (Use Groups) of the LMC do expressly list health or athletic clubs, spas, dance studios, and fitness studios as uses that may be developed in the City; and

WHEREAS; City Council desires to add a new use group titled "Health or athletic clubs, spas, dance studios, and fitness studios to Section 17.12.030 (Use groups), Section 17.72.090.B (Commercial and Office Uses Permitted), and Section 17.13.030 (Special review uses) of the LMC, and determine where these types of uses may be permitted; and

WHEREAS, after a duly noticed public hearing held January 14, 2016, where evidence and testimony were entered into the record, including the Louisville Planning Commission Staff Report dated January 14, 2016, the Louisville Planning Commission has recommended the City Council adopt the amendments to the Louisville Municipal Code set forth in this ordinance; and

WHEREAS, City Council has provided notice of a public hearing on said ordinance by publication as provided by law and held a public hearing as provided in said notice;

NOW, THEREFORE, BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF LOUISVILLE, COLORADO, THAT:

Section 1. The Use Group table in Section 17.12.030 of the Louisville Municipal Code is hereby amended by the addition of a new use group 62 to read as follows:

Use Group		Zoning Districts																	
		A	AO	BO	AOT *	RRR	SFR	SFE	RR RE RL	SFLD SFMD SFHD	RM	RH	CN	CC	CB	I	PCZD **	MU R/CC ***	OS ****
62	**Health or athletic clubs, spas, dance studios, fitness studios**	N	R	R		N	N	N	N	N	N	N	Y	Y	Y	R			

** AO-T uses are described in chapter 17.13.*
*** PCZD uses are discussed in chapter 17.72.*
**** MU-R uses are discussed in chapter 17.14.*
***** OS The designated classifications of open space lands are set forth in the Open Space Master Plan approved by city council. Provisions regarding the use and management of open space lands are found in the Open Space Master Plan, Article 15 of the City Charter, and Title 4 of this Code.*

Section 2. Use Group 9 within the Use Group table in Section 17.12.030 of the Louisville Municipal Code is hereby amended to delete "dance," from the Use Group description contained therein.

Section 3. Table 1 in Section 17.14.050.A of the Louisville Municipal Code is hereby amended to delete the phrase "Health or athletic clubs, spas, dance studios, yoga studios" and insert in its place the phrase "Health or athletic clubs, spas, dance studios, fitness studios."

Section 4. Section 17.72.090.B of the Louisville Municipal Code is hereby amended by the addition of a new subsection B.23 to read as follows:

23. Health or athletic clubs, spas, dance studios, and fitness studios.

Section 5. Section 17.13.030 of the Louisville Municipal Code is hereby amended by the addition of a new subsection I to read as follows:

I. Health or athletic clubs, spas, dance studios, and fitness studios.

Section 6. If any portion of this ordinance is held to be invalid for any reason such decisions shall not affect the validity of the remaining portions of this ordinance The City Council hereby declares that it would have passed this ordinance and each part hereof irrespective of the fact that any one part be declared invalid.

Section 7. The repeal or modification of any provision of the Municipal Code of the City of Louisville by this ordinance shall not release, extinguish, alter, modify, or change in whole or in part any penalty, forfeiture, or liability, either civil or criminal, which shall have been incurred under such provision, and each provision shall be treated and held as still remaining in force for the purpose of sustaining any and all

proper actions, suits, proceedings, and prosecutions for the enforcement of the penalty, forfeiture, or liability, as well as for the purpose of sustaining any judgment, decree, or order which can or may be rendered, entered, or made in such actions, suits, proceedings, or prosecutions.

Section 7. All other ordinances or portions thereof inconsistent or conflicting with this ordinance or any portions hereof are hereby repealed to the extent of such inconsistency or conflict.

INTRODUCED, READ, PASSED ON FIRST READING, AND ORDERED PUBLISHED this 16th DAY OF FEBRUARY, 2016.

_____
Robert P. Muckle, Mayor

ATTEST:

_____
Carol Hanson, Acting City Clerk

APPROVED AS TO FORM:

_____
Light, Kelly, P.C.
City Attorney

PASSED AND ADOPTED ON SECOND AND FINAL READING this 8th day of MARCH, 2016.

_____
Robert P. Muckle, Mayor

ATTEST:

_____
Carol Hanson, Acting City Clerk

City of Louisville
COLORADO • SINCE 1878

Planning Commission

Meeting Minutes

January 14, 2016
City Hall, Council Chambers
749 Main Street
6:30 PM

- **Land Use Modification: Resolution 1, Series 2016.** A resolution recommending approval of an ordinance amending Title 17 of the Louisville Municipal Code (LMC) to add health or athletic clubs, spas, dance studios and yoga studios as allowable uses in the City of Louisville and specifying in which zone districts these uses may be developed.
  - Staff member: Troy Russ, Interim Director of Planning and Building Safety

Conflict of Interest and Disclosure:
None.

Public Notice Certification:
Posted in City Hall, Public Library, Recreation Center, the Courts and Police Building, and City Web-Site January 7, 2016.

Staff Report of Facts and Issues:
Troy Russ presented from Power Point:
TITLE 17 AMENDMENTS

- Staff is recommending modifications to Title 17 of the LMC in four areas to add "health or athletic clubs, spas, dance studios, and fitness related studios" as uses in the land use code and specifying where these uses may be allowed:
  - Section 17.12.030 – Use Groups
  - Section 17.14.050 – Permitted uses within the Mixed Use Zone District
  - Section 17.72.090 – Permitted Commercial and Office Uses in the Planned Community Zone District (PCZD)
  - Section 17.13.020 – Use Groups in the AO-T zone district

As PC knows, over the last several years, we have received applications for fitness studios, yoga studios, dance studios, and CrossFit, and we have put them through the rigors of a Special Review Use (SRU). Nowhere in the LMC other than Chapter 17.14 are these uses specifically allowed. Staff has interpreted 17.13 Use Group 9 to look within the use groups allowed where the land use could be used. Because of the scale of requested uses and the business plans of requested use, we actually align them with Use Group 22 which is "public or private schools, studios for professional work or teaching any form of the fine arts, photography, music, drama, dance, but not including a commercial gymnasium". We do not have commercial gymnasiums anywhere defined in the LMC. Based on the business plan and the scale of those investments, we put them in General Use Group 22 which is largely throughout the City, both residential zone district as well as commercial zone district, a use by SRU. We recognize that this is an old Use Group table. We have fitness studios as a common business practice and we

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have several operating in the City, so it is time we updated our Use Group Table. We recommend creating Use Group 62, specifically called health or athletic clubs, spas, dance studios, fitness studios. This is similar to what is in Chapter 17.14 in the Mixed Use Zone District, but we modified it specifically call out fitness studios. They are a very unique business model. Concurrently with this, we are going into Use Group 22 and deleting "dance"; it is now being put into Use Group 62. We are not changing anything in Use Group 22 other than eliminating "dance" studios. It will now be art class, music class, private or public school that appropriately could fit within a residential zone district. We are not changing the Use Group category and are leaving them in SRU throughout the residential zone districts as well as throughout the City. Use Group 62, now being much more of a commercial activity, will specifically prohibit "dance" in the residential zone district, Allowing it as a use by SRU within the office zone district, and giving it a Use By Right within the commercial zone district. You will see us amend not only Chapter 17.12 Use Groups but will amend 17.14 Mixed Use Zone District as well as 17.72 Planned Community Zone District and 17.13 Office Zone District.

Use Group		Zoning Districts																	
		A	AO	BO	AOT*	RR-R	SFR	SFE	RR RE RL	SFLD SFMD SFHD	RM	RH	CN	CC	CB	I	PCZD**	MU R/CC ***	OS ****
22	**Public and private schools (Other than items 10, 11 and 12), studios for professional work or teaching of any form of fine arts, photography, music, drama, ~~dance~~, but not including a commercial gymnasium**	R	R	R		R	R	R	R	R	R	R	R	R	R	R			
62	**Health or athletic clubs, spas, dance studios, fitness studios**	N	R	R		N	N	N	N	N	N	N	Y	Y	Y	R			

** AO-T uses are described in chapter 17.13.*
*** PCZD uses are discussed in chapter 17.72.*
**** MU-R uses are discussed in chapter 17.14.*
***** OS The designated classifications of open space lands are set forth in the Open Space Master Plan approved by city council. Provisions regarding the use and management of open space lands are found in the Open Space Master Plan, Article 15 of the City Charter, and Title 4 of this Code.*

DRAFT

Staff Recommendations:
Staff recommends Planning Commission move to approve Land Use Modification: Resolution 1, Series 2016, a resolution recommending approval of an ordinance amending Title 17 of the Louisville Municipal Code (LMC) to add health or athletic clubs, spas, dance studios and yoga studios as allowable uses in the City of Louisville and specifying in which zone districts these uses may be developed.

Commission Questions of Staff:
Moline asks why on page 2 of the Staff Report, there is the grid showing the Use Groups within the zoning districts and then there are zoning districts that have asterisks. It seems odd that we are not able to show those uses whether they are allowed by right or not, yes or no, in those categories in that grid.
Russ says I agree. The user friendliness of the LMC has its challenges and what you are seeing here is evidence that the municipal codes evolve over time. We didn't have this business use category ten years ago. You see this throughout the LMC. The first column, the planned

community zone district, is Chapter 17.72. In Chapter 17.72, there are 23 allowed land uses. In Chapter 17.12, we have 62 allowed land use categories. Chapter 17.12 is City wide. The planned community zone districts are only the PCZD zone districts. This table can be upgraded over time to mix in the Mixed Use Zone District, the planned community zone district, and office zone district. What you are seeing is evidence of the incremental change over time as new business or land uses are discovered. We put them in incrementally. You are bringing up an obvious point from a Planning staff perspective. We know it is frustrating to applicants and it is equally frustrating to staff. Do we need to do a wholesale update to Chapter 17 itself? I would support that as you get through the Small Area Plans. PC has done the Comprehensive Plan. The Small Area Plans and Neighborhood Plans cover every different aspect of the City. You have Staff that supports it.

Tengler asks what is the distinction of a commercial gymnasium and when does a fitness or an athletic club turn into a commercial gym? What are they?
Russ says we don't allow commercial gymnasiums in the City of Louisville. We don't know what they are. They are not defined in the LMC. We don't have a definition in Chapter 17. Staff then goes to the common interpretation of it in the Webster's or Oxford dictionary and interpret it. Generally, commercial gymnasiums are large commercial facilities. They are similar to health clubs. Multiple sporting events go on within them that are commercial-related. They are slightly different than a health spa. A health spa introduces sales, massage, and other types of businesses. Commercial gym is a really antiquated use. You are seeing evidence of an old land use that was common in the 1950s, 1960s, and 1970s that is no longer common now.

Tengler says if an ice rink proposal came up, how would it be handled? Would it be considered a commercial gym or would it fall under one of these other health or athletic clubs?
Russ says I would go through all 62 of the Use Groups. If a specific land use is not identified, it is not allowed. The Use Groups in Chapter 17.12 are very general and leave room for interpretation and some flexibility as new businesses come on time. A publicly-operated ice rink is very different than a private operation. Is it a City municipal service? We have a land use code called Municipal Services and that is where the Downtown Ice Rink falls.

Hsu asks about Use Group 16 of private recreational and social facilities such as tennis clubs, swimming clubs, and golf courses. How is that different than what you are proposing? Why haven't gyms been used in this one instead of vocational schools?
Russ says I don't think a fitness studio is a recreational item because of the way their business plan works. They are based on instruction. In a yoga studio, you have an instructor with classes that sign up. In a tennis club, you don't. You can interpret it all sorts of ways. I don't think we have a Use Group that clearly defines or accurately reflects a yoga studio, a Crossfit studio, or a climbing gym, which is a very specific single user group. These are nuances on why we kept it in a school because their business plan is school-based, not free use-based.

O'Connell asks if we have a definition of spa.
Russ says he does not have the LMC in front of me. I suspect we do not.
O'Connell asks if we have a definition of massage parlor. Can a massage parlor apply under a spa?
Russ says we do have a definition of massage parlor and we heavily regulate them. That specific business model requires licensure to be a massage therapist. If within your business plan, you call for massage, we have codes that specifically call it out. This is different than a spa. A business comes to the Finance Department and applies for a business license and use and licensure are entered. The Finance Department gives it to the Planning Department to determine concurrence.

DRAFT

Pritchard says these changes over overdue. We have bigger issues when it comes to these changes. I think we need to move forward. I am favor of making these changes as Russ and Staff have recommended. I would like Council to know that we'd like this to be on their radar.

Closed Public Hearing and discussion by Commission:
Motion made by **Brauneis** to approve Land Use Modification: Resolution 1, Series 2016, seconded by **O'Connell.** Roll call vote.

Name	Vote
Chris Pritchard	Yes
Cary Tengler	Yes
Ann O'Connell	Yes
Jeff Moline	Yes
Steve Brauneis	Yes
Tom Rice	Yes
David Hsu	Yes
Motion passed/failed:	Pass

Motion passes 7-0.

tchard adjourned meeting at 7:45 PM.

DRAFT

City Council– Public Hearing

Amendment to Title 17 of the LMC to add health or athletic clubs, spas, dance studios and fitness studios as a listed use group and specifying in which zone districts these uses may be developed.

Prepared by:
Dept. of Planning & Building Safety

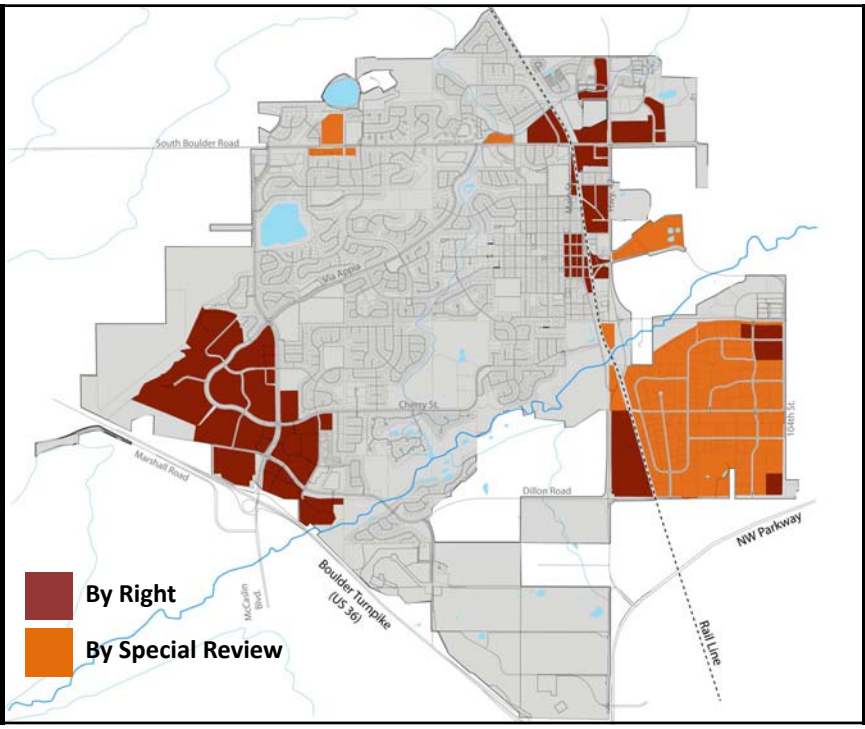
Title 17 Amendments

Staff is recommending modifications to Title 17 of the LMC in four areas to add "health or athletic clubs, spas, dance studios, and fitness related studios" as uses in the land use code and specifying where these uses may be allowed:

1. Section 17.12.030 – Use Groups
2. Section 17.14.050 – Permitted uses within the Mixed Use Zone District
3. Section 17.72.090 – Permitted Commercial and Office Uses in the Planned Community Zone District (PCZD)
4. Section 17.13.020 – Use Groups in the AO-T zone district

Section 17.12.030

Use Group		Zoning Districts																
		A	A O	BO	AOT*	RR-R	SFR	SFE	RR RE RL	SFLD SFMD SFHD	R M	R H	C N	C C	C B	I	PCZD**	MU R/CC***	OS****
22	Public and private schools (Other than items 10, 11 and 12), studios for professional work or teaching of any form of fine arts, photography, music, drama, ~~dance~~, but not including a commercial gymnasium	R	R	R		R	R	R	R	R	R	R	R	R	R	R			
62	Health or athletic clubs, spas, dance studios, fitness studios	N	R	R		N	N	N	N	N	N	N	Y	Y	Y	R			



Planning Commission

Planning Commission held a public hearing January 14, 2016. Planning Commission voted unanimously (7-0) to recommend the City Council approve the Ordinance amending Title 17 of the Louisville Municipal Code.

Recommendation

Staff recommends City Council adopt Ordinance No. 1716, Series 2016, an ordinance amending title 17 of the Louisville Municipal Code (LMC) to add health or athletic clubs, spas, dance studios and fitness studios as a listed use group and specifying in which zone districts these uses may be developed.

CITY COUNCIL COMMUNICATION
AGENDA ITEM 8G

SUBJECT: **RESOLUTION NO. 13, SERIES 2016 – A RESOLUTION APPROVING THE 9557 PARADISE LANE AMENDMENT TO THE SOUTHEAST BOULDER COUNTY, SOUTH 96TH STREET, DILLON ROAD AND US 287 AREA COMPREHENSIVE DEVELOPMENT PLAN INTERGOVERNMENTAL AGREEMENT**

DATE: **MARCH 08, 2016**

PRESENTED BY: **MALCOLM FLEMING, CITY MANAGER**
HEATHER BALSER, DEPUTY CITY MANAGER

SUMMARY:
The Rock of Panama City, Inc. submitted an application for a site plan review to Boulder County in March of 2015 for the development of a 5,000 square foot church on land located at 9557 Paradise Road (on the northwest corner of 96th Street and Paradise Lane). The parcel in question is currently designated Rural Preservation Area located within unincorporated Boulder County and subject to the provisions of the Southeast Boulder County, South 96th Street, Dillon Road and US 287 Area Comprehensive Development Plan Intergovernmental Agreement (IGA). The request was placed on hold pending approval of an amendment to the IGA as the current provisions do not specially address the development of a church on the parcel. Approval of an amendment to the IGA requires consent by all parties, which include Boulder County, Broomfield, Lafayette and Louisville. Boulder County recently approved the proposed IGA amendment on February 18, 2016 and such amendment is now before the Louisville City Council for consideration.

BACKGROUND:
In February 1999, Louisville, Lafayette, Broomfield and Boulder County entered into the IGA, which has a term of 30 years. The IGA has been amended four times since its adoption, the most recent amendment being the Campus Drive Amendment occurring in 2010. Among other things, the IGA, as amended by the Campus Drive Amendment, designated the unincorporated parcels adjacent to Paradise Lane as Rural Preservation Area. Under the current IGA, Rural Preservation parcels allow right-of-way uses, agriculture, and low density residential development. Low density residential development for this nine-acre parcel is limited to 1 parcel per 4.5 acres provided that a perpetual conservation easement with the same density allowance is secured as part of the approval process. As stated above, the current provisions of the IGA do not specifically address development of a church on this specific parcel. The proposed IGA amendment attempts to control the development potential in a manner consistent with the intent and purposes of the original IGA. The proposed IGA amendment and its restrictions are similar to the Metro Fire District Amendment, which conditionally permitted the development of a fire station in the area.

The application to Boulder County received in March of 2015, included a site plan for development of a 5,000 square foot structure and associated parking on parcel 157520000004. The IGA amendment adds Section 4.16(b)(v) of the IGA to address the potential of church development on this specific parcel. The IGA amendment also adds back into Section 4.16(a) a statement that future use under the Rural Preservation designation shall be limited to agriculture and low density residential development as further specified in the detailed parcel provisions. Except for this re-inserted statement and the addition of Section 4.16 (b)(v), the IGA terms remain the same as currently in effect. (The IGA text changes proposed by this amendment are highlighted on the attached copy.)

The new language regarding this use states that if Boulder County finds that a proposed church at 9557 Paradise Lane meets the applicable criteria in the Boulder County Land Use Code, it may approve construction of a church, subject to the following conditions:

1. The building shall be located on the southwest corner of the parcel,
2. The building shall be oriented with its narrowest elevation facing east to preserve views through the parcel,
3. The building and site plan shall incorporate design and landscape features furthering rural and agricultural character while preserving views through the parcel,
4. The building(s) on the parcel shall not exceed 10,000 square feet in the aggregate, which is the current limit under the Code for this type of use on the parcel, while the Plan remains in effect, and
5. Upon approval of a church on this parcel, whether unincorporated or annexed, will no longer be eligible for density of 1 unit per 4.5 acres. That is, if the church is developed the parcel would no longer be eligible for residential development.

Boulder County approved the IGA amendment on February 18, 2016 and a copy of the Board of Commissioners' packet concerning the request can be found at the following link: http://www.bouldercounty.org/doc/landuse/iga160001boccrec.pdf, which includes copies of the full IGA and Campus Drive Amendment. Broomfield and Lafayette are currently reviewing the IGA amendment and plan to take the matter up for consideration in March.

FISCAL IMPACT:
N/A

RECOMMENDATION:
City staff recommends approval of the proposed IGA amendment as it would allow the requested use as an alternative use in a manner consistent with the Boulder County land use code and additional IGA provisions intended to mitigate the impacts of such use upon the objectives of the Plan including the rural and agricultural character of the surrounding area. The proposed amendment also specifies that upon approval of a

church, the current low density residential allowed on the site of 1 unit per 4.5 acres will no longer apply, thus reducing the future development potential.

ATTACHMENT(S):

1. Resolution No. 13, Series 2016
2. 9557 Paradise Lane Amendment to IGA
3. Boulder County Board of County Commissioners packet (link): http://www.bouldercounty.org/doc/landuse/iga160001boccrec.pdf

RESOLUTION NO. 13
SERIES 2016

A RESOLUTION APPROVING THE 9557 PARADISE LANE AMENDMENT TO THE SOUTHEAST BOULDER COUNTY, SOUTH 96TH STREET, DILLON ROAD AND US 287 AREA COMPREHENSIVE DEVELOPMENT PLAN INTERGOVERNMENTAL AGREEMENT

WHEREAS, the City of Louisville, City of Lafayette, City and County of Broomfield and County of Boulder (the "Parties") have entered into to the Southeast Boulder County, South 96th Street, Dillon Road and US 287 Area Comprehensive Development Plan Intergovernmental Agreement, dated February 18, 1999, as amended (hereinafter the "Plan"); and

WHEREAS, the Parties entered into the Plan to plan for and regulate the use of the lands within the Plan area through joint adoption of a mutually binding and enforceable comprehensive development plan; and

WHEREAS, the Rock of Panama City, Inc., the owner of Assessor's parcel number 157520000004, desires to construct a 5,000 square foot church on the Southwest corner of such parcel, which use was not specifically addressed in the original Plan or amendments thereto; and

WHEREAS, the City Council has determined that it is appropriate to amend the Plan to accommodate church use on the parcel, with amendments to Section 4.16 of Exhibit A (Text Portion) of the Plan intended to mitigate the impact of such use upon the objectives of the Plan; and

WHEREAS, there has been proposed for such purpose an amendment to the Plan entitled the "9557 Paradise Lane Amendment to Southeast Boulder County, South 96th Street, Dillon Road and US 287 Area Comprehensive Development Plan Intergovernmental Agreement" (hereinafter the "Amendment"), a copy of which is attached hereto; and

WHEREAS, the City is authorized to execute the proposed Amendment pursuant to law, including without limitation C.R.S. § 29-20-101 et seq., which authorizes the parties to the Plan to cooperate and contract with each other for the purpose of planning and regulating the development of land by means of a comprehensive development plan; and

WHEREAS, pursuant to C.R.S. § 29-20-105, the City Council has held a duly-noticed public hearing on the proposed Amendment; and

WHEREAS, the City Council by this Resolution desires to approve the Amendment and authorize its execution;

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF LOUISVILLE, COLORADO:

Section 1. The proposed 9557 Paradise Lane Amendment to Southeast Boulder County, South 96th Street, Dillon Road and US 287 Area Comprehensive Development Plan Intergovernmental Agreement (the "Amendment"), a copy of which is attached hereto, is hereby approved.

Section 2. The Mayor is hereby authorized to execute the attached Amendment on behalf of the City Council of the City of Louisville; provided, however, that the Mayor is hereby further authorized to negotiate and approve such revisions to the Amendment as the Mayor determines are necessary or desirable for the protection of the City, so long as the essential terms and conditions of such Amendment are not altered.

PASSED AND ADOPTED this 8th day of March, 2016.

_____
Robert P. Muckle, Mayor

ATTEST:

_____
Carol Hanson, Acting City Clerk

9557 PARADISE LANE AMENDMENT TO SOUTHEAST BOULDER COUNTY, SOUTH 96TH STREET, DILLON ROAD AND US 287 AREA COMPREHENSIVE DEVELOPMENT PLAN INTERGOVERNMENTAL AGREEMENT

This 9557 Paradise Lane Amendment to Southeast Boulder County, South 96th Street, Dillon Road and US 287 Area Comprehensive Development Plan Intergovernmental Agreement ("Amendment"), by, between and among the City and County of Broomfield ("Broomfield"); the City of Lafayette, a Colorado home rule municipal corporation ("Lafayette"); the City of Louisville, a Colorado home rule municipal corporation ("Louisville") and the County of Boulder, a body corporate and politic of the State of Colorado ("Boulder County"); (collectively the "Parties") is made to be effective on the _____ day of _____, 20___.

WITNESSETH:

WHEREAS, § 29-20-101 et seq., C.R.S., as amended, enables the Parties to enter into Intergovernmental Agreements to plan for and regulate land uses to minimize the negative impacts of development on the surrounding areas and protect the environment, and it specifically authorizes local governments to cooperate and contract with each other for the purpose of planning and regulating the development of land by means of a "comprehensive development plan"; and

WHEREAS, the Parties entered into the Southeast Boulder County, South 96th Street, Dillon Road and US 287 Area Comprehensive Development Plan Intergovernmental Agreement, as previously amended (the "Plan" or "IGA") to plan for and regulate the use of the lands within the Plan Area through joint adoption of a mutually binding and enforceable comprehensive development plan; and

WHEREAS, the Parties amended the IGA with the Campus Drive Amendment, which modified the map portion of the IGA and Section 4.16 of Exhibit A (Text Portion) of the IGA; and

WHEREAS, the Rock of Panama City, Inc., the owner of parcel number 157520000004, desires to construct a 5000 square foot church on the Southwest corner of the parcel, which use was not specifically addressed in the IGA or the Campus Drive Amendment; and

WHEREAS, the Plan permits the Parties to amend the Plan to ensure that the proposed development or use of a parcel is consistent with the Plan; and

WHEREAS, this change in the IGA is consistent with the Plan's goals of reducing rural development, buffering, and traffic-reduction; and

WHEREAS, the Parties have determined it is appropriate to amend the Plan to accommodate a church use on the parcel, with amendments to Section 4.16 of Exhibit A (Text Portion) intended to mitigate the impacts of such use upon the objectives of the Plan; and

WHEREAS, the Parties have held public meetings or hearings after proper public notice to consider entering into this Amendment.

NOW THEREFORE, in consideration of the above and the mutual covenants and commitments made, the Parties agree as follows:

1. Section 4.16 of Exhibit A (Text Portion) of the IGA is amended to read as follows:

4.16

(a) Parcels numbered 157520000002, 157520000003, 157520000004, 157520000005, 157520000020, 157520000019, and 157520000007 (now 157520000034) (a total of approximately 78 acres) on the attached map are currently unincorporated Boulder County and are designated Rural Preservation. Future use shall be limited to agriculture and low density residential development as further specified below. The parties agree that Louisville may annex these Parcels in that the community of interest for these parcels is with Louisville for annexation purposes and that, if and when annexed to the City of Louisville, future use shall be as set forth below. Upon annexation, said Parcels are designated City Preservation Area.

(b) If and when parcels 157520000019 and 157520000007 (now 157520000034) (a total of approximately 20 acres) are annexed to the City of Louisville, future use shall be limited to right-of-way uses, agriculture, and open space, subject to the following:

(i) no residential units shall be permitted on these parcels;

(ii) prior to the commencement of development of new right-of-way uses on these parcels, there shall be dedicated by the owner(s) thereof a conservation easement to all IGA parties limiting the use of these parcels to right-of-way uses, agriculture, and open space; and

(iii) at the time of annexation of these parcels, Louisville shall annex the full length of the existing Paradise Lane right-of-way and the proposed Campus Drive right-of-way. Boulder County hereby consents to annexation by Louisville of said rights-of-way. Right-of-way, agriculture, and open space uses on parcels 157520000019 and 157520000034 may include, without limitation, street and streetscape improvements; pedestrian and bicycle paths and trails; trailhead facilities (including parking, interpretative/education kiosks or similar structures, and accessory picnic and shade structures, provided there are no more than 3,200 square feet of covered structures); fencing; utilities; and entry and gateway signage.

(c) If and when parcels 157520000002 and 157520000003 (a total of approximately 30 acres) are annexed to the City of Louisville, future use shall be limited to right-of-way uses, agriculture, and low density residential development, subject to the following:

(i) the total, aggregate residential density on Parcel 157520000002 shall not exceed 6 units, which units and any accessory residential buildings/uses shall be clustered together;

(ii) no residential units shall be permitted on Parcel 157520000003;

(iii) all existing residential improvements on parcel 157520000003 must be removed prior to the issuance of a building permit for any residential structure on parcel 157520000002;

(iv) new residential density on parcel 157520000002 may only be approved provided that a perpetual conservation easement granted to all IGA parties and limiting development of said parcel to the density and location limits of this Section 4.16(c) is secured as part of the approval of the new density; and

(v) right-of-way uses may include, without limitation, street and streetscape improvements, pedestrian and bicycle trails and paths, fencing, and utilities.

(d) If and when parcels 157520000004, 157520000005 and 157520000020 (a total of approximately 30 acres) are annexed to the City of Louisville, future use shall be limited to right-of-way uses, agriculture, and low density residential development , subject to the following:

(i) Louisville agrees to consider approval of residential use on said parcels with a density of no more than 1 unit per 4.5 acres, provided that a perpetual conservation easement granted to all IGA parties and limiting development to no more than 1 unit per 4.5 acres is secured as part of the approval of the new density;

(ii) within or among such parcels, residential units and any accessory residential buildings/uses may be clustered together; and

(iii) right-of-way uses may include, without limitation, street and streetscape improvements, pedestrian and bicycle trails and paths, fencing, and utilities.

(iv) While any such parcel remains unincorporated, Boulder County agrees to consider approval of residential use with a density of no more than 1 unit per 4.5 acres on said parcel(s),

provided that a perpetual conservation easement limiting development to no more than 1 unit per 4.5 acres is secured as part of the approval of such additional density.

(v) Subject to all required approvals and conditions established by the Boulder County Land Use Code or associated approval process, parcel 157520000004 may be used for the construction and operation of a church, subject also to the following: (i) the building shall be located on the Southwest corner of the parcel; (ii) the building shall be oriented with its narrowest elevation facing east to preserve views through the parcel; (iii) the building and site plan shall incorporate design and landscape features furthering rural and agricultural character while preserving views through the parcel; and (iv) the building(s) on the parcel shall not exceed a total size of 10,000 square feet in the aggregate, which is the current limit under the Boulder County Land Use Code for this type of use on the parcel, while the Plan remains in effect. Upon approval of a church use on parcel 157520000004, the parcel, whether unincorporated or annexed, will no longer be eligible for a density of 1 unit per 4.5 acres.

2. This Amendment shall be recorded with the County Clerk and Recorder of Boulder County. The provisions of this Amendment shall be covenants running with the land and shall be binding upon all persons or entities having an interest in the lands described in and subject to this Amendment.

3. All other terms and conditions of the IGA shall remain in force and effect.

IN WITNESS WHEREOF, the Parties have executed this Amendment to be effective as of the date first set forth above.

CITY AND COUNTY OF BROOMFIELD

By:_____ _____
Randy Aherns, Mayor Date

ATTEST: APPROVED AS TO FORM:

By:_____ _____
City Clerk William A. Tuthill III
City and County Attorney

CITY OF LAFAYETTE

By:_____ _____
Christine Berg, Mayor Date

ATTEST: APPROVED AS TO FORM:

By:_____ _____
City Clerk David Williamson
City Attorney

CITY OF LOUISVLLE

By:_____ _____
Robert P. Muckle, Mayor Date

ATTEST: APPROVED AS TO FORM:

By:_____ _____
City Clerk Samuel J. Light
City Attorney

COUNTY OF BOULDER
BY: BOARD OF COUNTY COMMISSIONERS

By:_____ _____
Elise Jones, Chair Date

By:_____ _____
Deb Gardner, Vice Chair Date

By:_____ _____
Cindy Domenico, Commissioner Date

ATTEST:

By:_____
Clerk to the Board

APPROVED AS TO FORM:

_____
Ben Pearlman
County Attorney