KAISER PERMANENTE®

CHP+ Member Handbook

What you need to know about your Child Health Plan *Plus* benefits

Evidence of Coverage

Effective July 1, 2021
Kaiser Foundation Health Plan, Inc.
Colorado Region

Table of contents

Other languages and formats 5
Other languages 5
Other formats 5
Interpreter services 6
Welcome to Kaiser Permanente! 7
Member Handbook 7
1. Getting started as a Member 8
How to get help 8
Who can become a Member 8
Identification ("ID") cards 9
Ways to get involved as a Member 9
2. About your Health Plan 10
Child Health Plan *Plus* with Kaiser Permanente 10
Health Plan overview 10
How your Health Plan works 14
Continuity of Care 14
Costs 16
3. How to get care 18
Getting health care services 18
Where to get care 23
Moral objection 24
Provider Directory 24
CHP+ Provider Network 25
Primary Care Provider ("PCP") 29
4. Benefits and services, Exclusions, and Limitations 36
Benefits and services (What your Health Plan covers) 36
Kaiser Permanente CHP+ Health Plan Covered Benefits Summary 37
Kaiser Permanente CHP+ Health Plan Covered Benefits 46
Outpatient Care 46
Hospital Inpatient Care 47
Maternity Care Services 49
Ambulance Services 49

Dialysis Care 50
Drugs, Supplies, and Supplements 50
Durable Medical Equipment (DME) and Prosthetics and Orthotics 54
Emergency Services and Urgent Care Services....58
Family Planning Services 60
Health Education Services 61
Hearing Services 61
Home Health Care....61
Special Services Program 62
Hospice Care....63
Mental Health Services....64
Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services....65
Preventive Care Services 67
Reconstructive Surgery 68
Skilled Nursing Facility Care....69
Substance Use Disorder Services 70
Transplant Services....71
Vision Services 74
X-ray, Laboratory, and Advanced Imaging Procedures 75
Care Coordination 76
Services you cannot get through the Kaiser Permanente CHP+ Health Plan (Exclusions) 76

5. Rights and responsibilities 83
Your rights 83
Your responsibilities 84
Notice of Adverse Benefit Determination....84
Notice about changes to this Member Handbook....84

6. Reporting and solving problems 85
Complaints....85
Appeals 86
State Review 88
Fraud, waste and abuse 89

7. General policy provisions 91
Access Plan....91
Access to services for foreign language speakers....91
Coordination of benefits....91
Notice about third party liability....92

Contracts with Network Providers....92
Limitations....93
Surrogacy....93
Evaluation of new and existing technologies....93
Governing law....94
Nondiscrimination....94
Notices....94
Privacy Practices....94
Women's Health and Cancer Rights Act....95
8. Important numbers and words to know....96
Important phone numbers....96
Important websites....97
Words to know....97

Other languages and formats

Other languages

You can get this Member Handbook and other plan materials in other languages at no cost to you. Call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m. Read this Member Handbook to learn more about health care language assistance services, such as interpreter and translation services.

Puede obtener esta Guía para Miembros y otros materiales del plan en otros idiomas sin costo para usted. Llame a Servicio a los Miembros al **303-338-3800** o llame sin costo al **1-800-632-9700** (TTY **711**), de lunes a viernes, de 8 a. m. a 6 p. m. Lea esta Guía para Miembros para obtener más información sobre los servicios de asistencia en distintos idiomas para la atención médica, como servicios de interpretación y traducción.

Other formats

You can get this information in other formats, such as braille, 18-point font large print, and audio at no cost to you. Call Member Services at **303-338-3800** or toll-free

1-800-632-9700 (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m.

Interpreter services

You do not need a family member or friend to be an interpreter. For no-cost interpreter, linguistic, and cultural services, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m.

Welcome to Kaiser Permanente!

Thank you for choosing Kaiser Permanente for your Child Health Plan *Plus* (CHP+) healthcare coverage.

Member Handbook

This Member Handbook tells you about your coverage through Kaiser Permanente ("Health Plan"). Please read it carefully and completely. It will help you understand and use your benefits and services. It also explains your rights and responsibilities as a Member of the Kaiser Permanente CHP+ Health Plan. If you have special health needs, be sure to read all sections that apply to you.

In this Member Handbook, Kaiser Permanente is sometimes referred to as "we," "us," "our," and the "Health Plan." Enrolled persons are also sometimes called "Members" in this Member Handbook. Members are sometimes referred to as "you." Some capitalized terms have special meaning in this Member Handbook; please see Chapter 8 ("Important numbers and words to know") for terms you should know.

This Member Handbook is also called the Evidence of Coverage ("EOC"). It is a summary of our rules and policies and is based on the contract between Kaiser Permanente and the Colorado Department of Health Care Policy and Financing (the Department). We will mail you a written notice of any important change to this EOC at least 30 days before the change takes effect. Call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**) to ask for more information.

You may ask for a printed copy of the Member Handbook at no cost to you by calling Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**). Or visit our website at **kp.org/Colorado-CHP** to view and download the Member Handbook. You will receive a postcard when you enroll and annually that tells you how to get a printed copy of the EOC and other important Member documents.

1. Getting started as a Member

How to get help

We are here to help. We want you to be happy with your health care. If you have any questions or concerns about your care, we want to hear from you!

Kaiser Permanente Member Services

Kaiser Permanente Member Services is here to help you. We can:

- Answer questions about your Covered Services
- Help you choose or change a Primary Care Provider ("PCP")
- Tell you where to get the care you need
- Help you get interpreter services if you do not speak English
- Help you get information in other languages and formats

If you need help, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

You can also visit us online at any time at **kp.org**.

Who can become a Member

You qualify for our CHP+ Health Plan because you are eligible for CHP+ and live in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, or Jefferson County. For questions about CHP+ eligibility or enrollment, call CHP+ Customer Service at **1-800-**

359-1991, Monday through Friday, 8 a.m. to 6 p.m. Or visit **Colorado.gov/hcpf/child-health-plan-plus**.

Identification ("ID") cards

As a Member of our Health Plan, you will get a Kaiser Permanente ID card. You must show your Kaiser Permanente ID card or a photo ID when you get any health care services or prescriptions. You should carry your health card with you at all times.

If you do not get your Kaiser Permanente ID card within a few weeks of your enrollment, or if your card is damaged, lost, or stolen, call Member Services right away. We will send you a new card at no cost to you. Call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Your card will have a Health Record Number on it. You will be asked for your Health Record Number when you call for advice, make an appointment, or go to a Network Provider for care. The Health Record Number is used to identify your medical records and enrollment information. You should always have the same Health Record Number.

Please call **Member Services** if we ever make a mistake and issue you more than one Health Record Number. If you need to replace your Kaiser Permanente ID card, please call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Ways to get involved as a Member

We want to hear from you. We want to know what is working well and how we can improve.

Kaiser Permanente Health Advisory Council

The Health Advisory Council is a way for you to provide input and recommendations to Kaiser Permanente on how we can improve service to Members. If you are interested in learning more about the **Kaiser Permanente Health Advisory Council**, please call **303-859-9197** for more information.

2. About your Health Plan

Child Health Plan *Plus* with Kaiser Permanente

CHP+ is a public low-cost health coverage for children and pregnant women who qualify. This health benefit plan covers your costs for check-ups or if you get sick. To get CHP+ coverage, you must follow the CHP+ enrollment process. The enrollment process details who is eligible and what enrollment forms are required. To learn more about enrollment, please visit **Colorado.gov/hcpf/child-health-plan-plus**.

Health Plan overview

The Kaiser Permanente CHP+ Health Plan is a health plan for people who have CHP+ coverage and live in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, or Jefferson County. We work with the Department to help you get the health care you need. You may talk with one of Kaiser Permanente's Member Services representatives to learn more about Kaiser Permanente and how to make it work for you, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Kaiser Permanente provides health care services directly to Members through an integrated medical care program. The Kaiser Permanente CHP+ Health Plan, Network Facilities, and Network Providers work together to provide our Members with quality care. Our medical care program gives you access to Covered Services you may need, such as Routine Care, hospital care, medications, laboratory services, Emergency Services, Urgent Care Services, and other benefits described in this Member Handbook.

Starting your enrollment

When you enroll in our CHP+ Health Plan, you will get a Kaiser Permanente Member ID card within two weeks of enrollment. We will also send you a notice telling you when your enrollment starts and ends. Enrollment in this Health Plan is voluntary. You or the Department may end your enrollment with our Health Plan as described under the section “Ending your enrollment” below.

You will also receive a postcard when you enroll, and annually, that tells you how to get a printed copy of this Member Handbook. To request a printed copy of the Member Handbook at no cost to you, call Member Services and you will be mailed a copy within five (5) business days.

You can change your enrollment within the first 90 days of your enrollment and annual re-enrollment. If you would like to change your health plan, please contact the county department of human/social services in the county where you live or call CHP+ Customer Service at **1-800-359-1991**, Monday through Friday, 8 a.m. to 6 p.m.

For CHP+ Members under age 19, coverage needs to be renewed every year. For CHP+ prenatal care Members, your coverage will start the date your application is approved. Your coverage is good through 60 days after the end of your pregnancy. Call CHP+ Customer Service at **1-800-359-1991** for any questions about CHP+ eligibility or enrollment.

Ending your enrollment

The Department may end your enrollment by sending written notice to you at least 30 days before the termination (end) date if any of the following happen:

- You are disruptive, unruly, or abusive to us or a provider; or
- You give wrong or incomplete information to us on purpose; or
- You do not inform us of an important change in family status; or
- You commit any type of Fraud with regard to your enrollment

If you are an inpatient in a hospital or institution, your coverage will continue until your date of discharge. This does not apply if the Department terminates your enrollment due to Fraud or abuse.

All rights to benefits stop on the date your enrollment ends. You will be billed as a non-Member for any services received after the termination (end) date if you are no longer eligible for CHP+ coverage. You may file a Grievance about your enrollment ending by contacting Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**) or the Department:

- **By mail:** Mail form to **Department of Health Care Policy & Financing, CHP+ Health Plan Manager, 1570 Grant Street, Denver, CO 80203**
- **By phone:** Call the Department at **1-800-359-1991**

We may report any Member Fraud to the police and take legal action.

You may request to end your enrollment by sending a completed Change Form to the Department at the following address: **Department of Health Care Policy & Financing, CHP+ Health Plan Manager, P.O. Box 17548, Denver, CO 80217**

When coverage with CHP+ ends, the Department will send you a Certificate of Creditable Coverage. The Certificate of Creditable Coverage states the length of time you had coverage with CHP+. You may need this letter as proof of prior coverage when you enroll with other health plans.

Newborn enrollment

Newborns who are born to CHP+ Members are eligible for CHP+ coverage for at least 12 months from the date of birth. You must call CHP+ Customer Service at **1-800-359-1991** to report the birth of your newborn and have them enrolled in CHP+.

Babies born to CHP+ Members will be automatically covered under the mom's health plan for up to 30 days. To apply for coverage for your newborn, please call CHP+ Customer Service at **1-800-359-1991** after you have your baby. Your baby may qualify for either Health First Colorado or CHP+.

IMPORTANT: Call CHP+ Customer Service at **1-800-359-1991** as soon as you have your baby, so you do not have any coverage problems. You will need your baby's name, date of birth, and the baby's social security number, if available. Your newborn child will be enrolled as of their date of birth. A CHP+ Eligibility and Enrollment specialist can help you. If you are unable to call CHP+ Eligibility and Enrollment yourself, a family member or your provider may call for you.

Presumptive eligibility

The Presumptive Eligibility (PE) program gives children under 19 and pregnant women temporary Health First Colorado or Child Health Plan *Plus* (CHP+) medical coverage right away. Your temporary medical coverage lasts for at least 45 days while your Medical Assistance application is processed. To qualify, you must:

- Be a child under 19 or a pregnant woman,
- Appear to qualify for Medicaid or CHP+, and
- Complete an application for Medical Assistance.

Note: Dental services are not covered while you are in the Presumptive Eligibility program.

For questions about applying or qualifying call CHP+ Customer Service at **1-800-359-1991**, Monday through Friday, 8 a.m. to 6 p.m.

Moving outside the Service Area

The Kaiser Permanente CHP+ Health Plan is for people who qualify for CHP+ and live in Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, or Jefferson County.

You must tell us right away if you move outside our Service Area or out of the state.

To notify us about your new address, contact both Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**) and CHP+ Customer Service at **1-800-359-1991**, Monday through Friday, 8 a.m. to 6 p.m. You can also update your address online by visiting **Colorado.gov/peak**.

Other Health Insurance coverage

If you are covered by any other insurance, you will no longer be eligible for CHP+. The exceptions to having more coverage are Medicare, dental, and vision insurance.

If you get any other health coverage, like Health First Colorado (Colorado's Medicaid program), private or group coverage, please call us. If you are found to have other health coverage, your CHP+ coverage with us will be terminated (ended). The Department may go back and end your coverage on the date that your other coverage started.

To notify us about other health coverage, contact Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

How your Health Plan works

CHP+ works with health plans to manage the health care and services you need. A health plan is a group of doctors, clinics, hospitals, pharmacies, and other providers who work together to help meet your health care needs. Kaiser Permanente is a health plan for CHP+.

Kaiser Permanente provides health care services directly to Members through an integrated medical care program. Our medical care program gives you access to Covered Services you may need, such as Routine Care, hospital care, medications, laboratory and services, Emergency Services, Urgent Care Services, and other benefits described in this Member Handbook. Plus, our health education programs offer you great ways to protect and improve your health.

A Kaiser Permanente Member Services representative can help you understand:

- How Kaiser Permanente works
- How to get the care you need, and
- How to schedule provider appointments within standard access times

To learn more, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**). You can also find information online at **kp.org/Colorado-CHP**.

Continuity of Care

If you are a new Member and have been getting care from providers who are not in the CHP+ Provider Network, you may be able to keep seeing them in certain situations. If your medical situation falls under one of the cases listed below under the section “Eligibility”, you can ask to continue care with your current provider.

Eligibility

The cases that are subject to this Continuity of Care provision are:

- **Maternity care.** We may cover these services while you are pregnant and right after you give birth
- **Special health care needs.** We may cover Medically Necessary Covered Services for Members with special health care needs. This may include Members with mental health problems, high risk health problems, functional problems, and other complex health problems.

Talk to your PCP about care or treatment you are receiving from an Out-of-Network Provider and the need for these services to be transitioned to Kaiser Permanente.

Kaiser Permanente does **not** cover Continuity of Care from Out-of-Network Providers if either of the following is true:

- The services are not covered by CHP+
- Your provider won't work with Kaiser Permanente. You will need to find a new provider

Our Health Plan has the right to direct your care to one of our Network Providers or Network Facilities.

Transition period

The transition period for Continuity of Care is for a limited time. For Members with special health care needs, the transition period is:

- 60 calendar days from the start of your enrollment for Covered Services provided by Out-of-Network Providers
- 75 calendar days from the start of your enrollment for Covered Services provided by ancillary Network Providers

CHP+ prenatal care Members can keep their current prenatal care provider from the start of their enrollment until after delivery. Members in their second or third trimester of pregnancy (more than 3 months pregnant) may continue to see their Out-of-Network Providers until they are finished with postpartum care.

You must let us know if you would like to keep your current provider, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

More information

For more information about Continuity of Care please call our Member Services. To find out if you qualify to get services from an Out-of-Network Provider or want more information, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Costs

Enrollment fee

Some families enrolled in CHP+ pay an enrollment fee each year. The amount of the fee is determined by the Department and is based on family size and income. Any questions you may have about enrollment or fees should be directed to the Department at **1-800-359-1991**.

Copayments and out-of-pocket maximums

Copayments, or Copays, are a dollar amount you pay in order to receive a specific service or medication. The Department sets CHP+ Copayments based on family size and income. Your Copayments are listed on your ID card.

There is a limit to the total amount of fees and Copayments you pay in a year for Covered Services. This is called an Out-of-Pocket Maximum.

Your Out-of-Pocket Maximum will be no more than five percent (5%) of your family's gross annual income. This includes all fees and Copayments for your family. CHP+ Members who are American Indians, Alaska Natives, or pregnant Members are exempt from Copayments and annual enrollment fees.

You are required to keep track of the money you spend on your health care Covered Services. Save your Copayment receipts. Notify the Department if your receipts exceed your Out-of-Pocket Maximum. Call CHP+ Eligibility and Enrollment at 1-800-359-1991. Or mail the Department at: **Department of Health Care Policy & Financing, P.O. Box 17548, Denver, CO 80217.**

Member costs

You can be billed if:

- You get medical care from an Out-of-Network Provider
- You get a Non-Covered Service or procedure from any provider
- You get certain Covered Services or procedures without getting approval first
- You receive Covered Services when they are not covered by CHP+

For non-emergency care, it is your responsibility to:

- Make sure that the provider you see is in the CHP+ Provider Network
- Make sure the care you receive is approved, if necessary, before you receive Covered Services

If you get services from Out-of-Network Providers, they may not be covered if you did not get Pre-Approval (Prior Authorization). In cases where the services are not covered, you may have to pay for the services.

You can go to Out-of-Network Providers for some Family Planning Services without Pre-Approval. For information on what Family Planning services are covered, go to the section “Family Planning Services” later in this Chapter 3.

You do not need Pre-Approval for Emergency Services, even when you go to Out-of-Network Providers.

3. How to get care

Getting health care services

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS CARE MAY BE OBTAINED.

You can begin to get health care services on your effective date of coverage. Always carry your Kaiser Permanente ID card with you. Never let anyone else use your Kaiser Permanente ID card.

The Kaiser Permanente CHP+ Health Plan provides services to our Members through our Network Providers. They work together to provide you with quality care. When you choose Kaiser Permanente as your Health Plan, you are choosing to get your care through our medical care program. To find where our Network Providers are located, visit our online CHP+ Provider Directory at **kp.org/Colorado-CHP** under CHP+ Resources**.**

New Members must choose a Primary Care Provider ("PCP") who is in the CHP+ Provider Network. If you do not choose a PCP, we will choose one for you. You may choose the same PCP or different PCPs for all family members in the Kaiser Permanente CHP+ Health Plan, as long as the PCP is available.

If you have a doctor you want to keep, or you want to find a new PCP, you can look in our CHP+ Provider Directory. It has a list of all PCPs in the CHP+ Provider Network. The Provider Directory has other information to help you choose. If you need a printed copy of the Provider Directory, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**). You can also find a Provider Directory on our website at **kp.org/Colorado-CHP** under CHP+ Resources**.**

If you cannot get the care you need from a Network Provider, your PCP must ask our Health Plan for approval to send you to an Out-of-Network Provider. You do not need approval to go to an Out-of-Network Provider to get Emergency Services, Urgent Care

Services, or Family Planning Services that are described under the section “Family Planning Services” later in this chapter.

Read the rest of this chapter to learn more about PCPs, the Provider Directory, and the CHP Provider Network.

Initial Health Assessment (“IHA”)

We recommend that, as a new Member, you visit your new PCP within the first 90 days for an initial health assessment (“IHA”). The purpose of the IHA is to help your PCP learn your health care history and needs. Your PCP may ask you some questions about your health history or may ask you to complete a questionnaire. Your PCP will also tell you about health education counseling and classes that may help you.

Take your Kaiser Permanente ID card to your appointment. It is a good idea to take a list of your medications and questions with you to your visit. Be ready to talk with your PCP about your health care needs and concerns.

Be sure to call your PCP’s office if you are going to be late or cannot go to your appointment.

Routine Care

Routine Care is regular health care. It includes preventive care, also called wellness or well care. It helps you stay healthy and helps keep you from getting sick. Preventive care includes regular checkups, health education, and counseling. Children can get much needed early preventive services like hearing and vision screening, assessments of developmental process and many more services that are recommended by pediatricians’ Bright Futures guidelines. In addition to preventive care, Routine Care also includes care when you are sick. Kaiser Permanente covers Routine Care from your PCP.

Your PCP will:

- Give you all your Routine Care, including regular checkups, shots, treatment, prescriptions and medical advice
- Keep your health records
- Refer (send) you to Specialists, if needed

- Order X-rays or lab work if you need them

When you need Routine Care, you can call the Appointment and Advice Contact Center at **303-338-4545** or **1-800-218-1059** (TTY **711**)), Monday through Friday, from 6 a.m. to 7 p.m., to schedule an appointment or you can make an appointment online. To request an appointment online, go to our website at **kp.org**.

For an emergency, call **911** or go to the nearest emergency room.

To learn more about health care and services we cover, and what we do not cover, read Chapter 4 ("Benefits and services, Exclusions, and Limitations") in this Member Handbook.

Urgent Care

Urgent Care is **not** for an emergency or life-threatening condition. It is for services you need to prevent serious damage to your health from a sudden illness, injury or complication of a condition you already have. Urgent Care appointments are available within 24 hours of your request for an appointment.

Urgent Care needs could be a cold, sore throat, fever, ear pain, sprained muscle or maternity services.

You do not need Pre-Approval (Prior Authorization) for urgent care.

We cover Urgent Care Services at Out-of-Network Facilities. We do not cover follow-up care from Out-of-Network Providers after you no longer need Urgent Care Services. After your Urgent Care issue has resolved, you must see a Network Provider for any needed follow-up care. If you need Durable Medical Equipment related to your Urgent Care Services, your Out-of-Network Provider must obtain Pre-Approval (Prior Authorization) from us.

For medical advice, call our Advice Line at **303-338-4545** or **1-800-218-1059** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

Emergency Care

For emergency care, call **911** or go to the nearest emergency room ("ER"). For emergency care, you do **not** need Pre-Approval (Prior Authorization) from us. You have the right to use any hospital or other setting for emergency care.

Emergency care is for Emergency Medical Conditions. It is for an illness or injury that a prudent (reasonable) layperson (not a health care professional) with average knowledge of health and medicine could expect that, if you don't get care right away, your health (or your unborn baby's health) could be in danger, or a body function, body organ or body part could be seriously harmed. Examples of Emergency Medical Conditions include, but are not limited to:

- Active labor
- Broken bone
- Severe pain
- Chest pain
- Severe burn
- Drug overdose
- Fainting
- Severe bleeding
- Psychiatric emergency conditions, such as severe depression or suicidal thoughts

Do not go to the ER for Routine Care. You should get Routine Care from your PCP, who knows you best. If you are not sure if you have an emergency, call your PCP. You may also call our Advice Line at **303-338-4545** or **1-800-218-1059** (TTY **711**) and talk to a licensed health care professional, 24 hours a day, 7 days a week.

If you need emergency care away from home, go to the nearest emergency room ("ER"), even if it is not in the CHP+ Provider Network. If you go to an ER, ask them to call us. You or the hospital to which you were admitted should call Kaiser Permanente within 24 hours after you get emergency care.

If you need emergency transportation, call **911**. You do not need to ask your PCP or Kaiser Permanente first before you go to the ER.

If you need care in an out-of-Network hospital after your emergency (post-stabilization care), the hospital will call Kaiser Permanente.

Remember: Do not call **911** unless it is an emergency. Get emergency care only for an emergency, not for Routine Care or a minor illness like a cold or sore throat. If it is an emergency, call **911** or go to the nearest emergency room.

Post-stabilization Care

Post-stabilization care is the Medically Necessary services in a hospital (including the ER) that you get after the doctor who is treating you finds that your Emergency Medical Condition is clinically stable.

We cover post-stabilization care from an Out-of-Network Provider only if we pre-approve it or if otherwise required by applicable law. The provider treating you must get authorization from us before we will pay for post-stabilization care.

To request Pre-Approval for you to receive post-stabilization care from an Out-of-Network Provider, the provider must call us at **303-338-4545** or **1-800-218-1059** (TTY **711**). They can also call the phone number on the back of your Kaiser Permanente ID card. The provider must call us before you get the services.

When the provider calls, we will talk to the doctor who is treating you about your health issue. If we determine you need post-stabilization care, we will authorize the Covered Services. In some cases, we may arrange to have a Network Provider provide the care.

If we decide to have a Network Facility, Skilled Nursing Facility, or other provider provide the care, we may authorize transport services that are medically needed to get you to the provider. This may include special transport services that we would not normally cover.

You should ask the provider what care (including any transport) we have authorized. We cover only the services or related transport that we authorized. If you ask for and get services that are not covered, we may not pay the provider for the services.

Maternity Care

We offer prenatal and postnatal care for pregnant Members. You do not need a Referral to see a Network Obstetrics/Gynecology (“OB/GYN”) provider for any care related to your pregnancy. CHP+ Prenatal Members are covered at least 60 days after your delivery or the end of the pregnancy.

If you become pregnant, please call the Appointment and Advice Contact Center at **303-338-4545** or **1-800-218-1059** (TTY **711**). We can help you find a doctor for your pregnancy and coordinate your prenatal and postnatal care.

Family Planning Services

For pregnancy testing, family planning, or birth control services, the doctor or clinic does not have to be part of the CHP+ Provider Network. You can choose any CHP+ provider and go to them without a Referral or Prior Authorization. In cases where the services are not covered, you may have to pay for the services.

Services from an Out-of-Network Provider that are not related to Family Planning Services may not be covered. For help finding a doctor or clinic giving these services, you can call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**). You may also call our Advice Line at **303-338-4545** or **1-800-218-1059** (TTY **711)** and talk to a licensed health care professional (24 hours a day, 7 days a week).

Minors can talk to a representative in private about their health concerns by calling our Advice Line at **303-338-4545** or **1-800-218-1059** (TTY **711)** and talk to a licensed health care professional (24 hours a day, 7 days a week).

Where to get care

You will get most of your care from your PCP. Your PCP will provide your routine preventive (wellness) care. You will also see your PCP for care when you are sick. Your PCP will refer (send) you to Specialists if you need them.

To find where Network Providers are located, visit our website at **kp.org/Colorado-CHP** under CHP+ Resources, or call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**)

Urgent Care is care you need soon but is not an emergency. It includes care for such things as cold, sore throat, fever, ear pain, or a sprained muscle. For emergencies, call **911** or go to the nearest emergency room.

To get help with your health questions, you can also call our Advice Line at **303-338-4545** or **1-800-218-1059** (TTY **711**) and talk to a licensed health care professional (24 hours a day, 7 days a week).

Moral objection

Some providers have a moral objection to providing some Covered Services. This means they have a right to **not** provide certain Covered Services if they morally disagree with the services. If your provider has a moral objection, they will help you find another provider for the needed services. Kaiser Permanente can also work with you to find a provider. If you need help getting a Referral to a different provider, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**).

Provider Directory

The Kaiser Permanente CHP+ Provider Directory ("Provider Directory") lists providers who are in the Kaiser Permanente CHP+ Provider Network. The Network is the group of providers that work with Kaiser Permanente. The Provider Directory has names, specialties, provider addresses, phone numbers, business hours, and languages spoken.

The Kaiser Permanente CHP+ Provider Directory lists the following types of providers that are in our Network:

- Hospitals
- Pharmacies
- PCPs
- Specialists
- Nurse midwives
- Family Planning providers

You can find the Provider Directory online at **kp.org/Colorado-CHP** under CHP+ Resources. If you need a printed Provider Directory, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

CHP+ Provider Network

The CHP+ Provider Network is the group of doctors, hospitals, and other providers that work with Kaiser Permanente to provide CHP+ Covered Services to our Members.

Kaiser Permanente is a health plan for CHP+. When you choose our CHP+ Health Plan, you are choosing to get your care through our medical care program. You must get most services from our Network Providers.

You can go to an Out-of-Network Provider without a Referral or Pre-Approval for Emergency Services, Urgent Care Services, and for Family Planning services. You must have a Referral and Pre-Approval for all other out-of-Network services, or they will not be covered.

Note: American Indians may choose an Indian Health Care Provider (IHCP) as their PCP, even if the IHCP is not in the CHP+ Provider Network.

If your Network Provider or Network Facility, including a PCP, hospital, or other provider, has a moral objection to providing you with a Covered Service, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**). See the Moral objection section earlier in this chapter for more about moral objections.

Network Providers

You will get care from providers in the CHP+ Provider Network for your health care needs. You will get preventive and Routine Care from your PCP. You will also get care from Specialists, hospitals, and other providers in the CHP+ Provider Network.

For more information on our Network Providers, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**). You can find the Provider Directory online at **kp.org/Colorado-CHP** under CHP+ Resources. If you need a printed Provider Directory, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

For Emergency Services, call **911** or go to the nearest emergency room.

Except for Emergency Services, Urgent Care Services, or Family Planning Services, you must get Pre-Approval from our CHP+ Health Plan before you see a provider outside the CHP+ Provider Network. If you do not get Pre-Approval and you go to a

provider outside of the Network for care that is not emergency care, Urgent Care Services, or Family Planning Services, you may have to pay for the services you get from that Out-of-Network Provider.

Out-of-Network

Out-of-Network Providers

Out-of-Network Providers are those providers who do not have an agreement to work with Kaiser Permanente.

You must get Pre-Approval (Prior Authorization) before you go to an Out-of-Network Provider, except for:

- Emergency Services
- Urgent Care Services
- Family Planning Services

For more information on Emergency Services, Urgent Care Services, and Family Planning Services, go to those sections in this chapter. If you are an American Indian, you can get care at an IHCP outside of our provider Network without a Referral or Prior Authorization.

If you need Medically Necessary services that are covered by CHP+ but are not available in the CHP+ Provider Network, we may refer and give you Pre-Approval to get those services from an Out-of-Network Provider. If you have a Referral and Pre-Approval to see an Out-of-Network Provider, your care will be covered by your CHP+ Health Plan.

If you need help with out-of-Network services, talk with your PCP, or call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Routine Care by Out-of-Network Providers is not covered, except for IHCPs and Family Planning Services.

For Emergency Services, call **911** or go to the nearest emergency room. Kaiser Permanente covers out-of-Network Emergency Services.

Note: American Indians may get services at out-of-Network IHCPs.

If you have questions about services available from Out-of-Network Providers, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**).

Doctors

You will choose your doctor or a Primary Care Provider (PCP) from our provider Network.

If you had a doctor before you were a Member of Kaiser Permanente, you may be able to keep that doctor for a limited time. This is called Continuity of Care. You can read more about Continuity of Care in Chapter 2 of this Member Handbook. To learn more, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**).

If you need a Specialist, your PCP will refer you to a Specialist in the CHP+ Provider Network.

Remember, if you do not choose a PCP, we will choose one for you. You know your health care needs best, so it is best if you choose.

You can change your PCP at any time. You must choose a PCP from the CHP+ Provider Network. To learn how to select or change your PCP, please visit our website at **kp.org**, or call Member Services at **303-338-4545** or **1-800-218-1059** (TTY **711**).

Hospitals

In an emergency, call **911** or go to the nearest hospital.

If it is not an emergency and you need hospital care, your PCP may decide which hospital you go to. You will need to go to a hospital in our Network. To find our Network hospitals, you can look online at **kp.org/Colorado-CHP** under CHP+ Resources. You can also call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Timely access to care

Service Type	Scheduling Guideline
Urgently needed services	Within twenty-four (24) hours of the time your Primary Care Provider is notified of your need for services.
Non-emergent, non-urgent medical problems	Within thirty (30) calendar days of the request for service. Note: This standard does not apply to appointments for routine physical examinations, nor for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty (30) calendar days.
Non-urgent, symptomatic care or non-urgent, symptomatic behavioral health services	Within seven (7) calendar days of the request for service.
Routine well care physical examinations or behavioral health screening	Within one (1) month of the request for service.
Follow-up appointment	Within seven (7) calendar days after discharge from a hospital.
Emergency behavioral health care	Within fifteen (15) minutes after the initial contact by phone, including TTY accessibility; in person, within one (1) hour of contact in urban and suburban areas and within two (2) hours of contact in rural and frontier areas.

If you prefer to wait for a later appointment that will better fit your schedule or to see the Network Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed in the chart above, if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to preventive services. Your doctor may recommend a specific schedule for preventive services, depending on your

needs. The standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to Specialists.

Interpreter services

If you need interpreter services when you call us or when you get Covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. We highly discourage the use of minors or family members as interpreters. For more information on the interpreter services we offer, please call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Travel time and distance to care

Kaiser Permanente must follow travel time and distance standards for your care. Those standards help to make sure you can get care without having to travel too long or too far from where you live. Travel time and distance standards are different depending on the county you live in.

If you need care from a provider and that provider is located far from where you live, you can call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**) to get help finding a provider located closer to you.

Primary Care Provider ("PCP")

To help you find a doctor who is right for you, call the Appointment and Advice Contact Center at **303-338-4545** or **1-800-218-1059** (TTY **711**). You can find out which doctors are taking new patients and choose one who matches your needs.

Adults can choose a PCP from:

- Adult medicine/internal medicine
- Family medicine

Parents can choose a doctor from pediatrics/adolescent medicine or family medicine (for children up to age 18) to be their child's PCP.

Each covered family member may choose their own personal doctor. Depending on the type of the provider, you may be able to choose one PCP for all family Members.

You can also choose to get your primary health care at a Federally Qualified Health Center ("FQHC") or an Indian Health Care Provider ("IHCP").

If you do not choose a PCP within 30 days of enrollment, we will assign you to a PCP.

You can change to another available PCP at any time, for any reason. You can change your doctor online anytime at **kp.org** or you can call the Appointment and Advice Contact Center at **303-338-4545** or toll-free at **1-800-218-1059** (TTY **711**).

Your PCP will:

- Get to know your health history and needs
- Keep your health records
- Give you the preventive and routine health care you need
- Refer (send) you to a Specialist if you need one
- Arrange for hospital care if you need it

You can look in the CHP+ Provider Directory to find a PCP in the CHP+ Provider Network.

You can find the Provider Directory online at **kp.org/Colorado-CHP** under CHP+ Resources. Or you can request a Provider Directory to be mailed to you by calling Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**).

Choice of doctors and other providers

You know your health care needs best, so it is best if you choose your PCP.

It is best to stay with one PCP so they can get to know your health care needs. However, if you want to change to a new PCP, you can change any time. You must choose a PCP who is in the CHP+ Provider Network and is taking new patients.

To learn how to select or change your PCP, call the Appointment and Advice Contact Center at **303-338-4545** or toll-free at **1-800-218-1059** (TTY **711**).

We may ask you to change your PCP if the PCP is not taking new patients, has left our Network, or does not give care to patients your age. If we need to change your PCP, we will tell you in writing.

Appointments

When you need health care:

- Call the Appointment and Advice Contact Center at **303-338-4545** or toll-free at **1-800-218-1059** or schedule an appointment online at **kp.org**.
- Have your Kaiser Permanente medical record number (located on your Kaiser Permanente ID card) ready when you call
- Take your Kaiser Permanente ID card to your appointment
- Ask for language assistance or interpreter services, if needed
- Be on time for your appointment
- Call right away if you cannot keep your appointment or will be late
- Have your questions and medication information ready

If you have an emergency, call **911** or go to the nearest emergency room.

Payment

You are responsible to pay your Copays. Pregnant women, American Indians, and Native Alaskans should not be charged Copays. You should not get a bill from a provider for Covered Services. You may get an Explanation of Benefits (“EOB”) or a statement from Kaiser Permanente or a provider. EOBs and statements are not bills.

If you do get a bill, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**). Tell us the amount charged, the date of service, and the reason for the bill. You do not need to pay a provider for any amount owed by Kaiser Permanente for a Covered Service.

You must get Pre-Approval (Prior Authorization) before you go to an Out-of-Network Provider, except for:

- Emergency Services

- Urgent Care Services
- Obstetrics/Gynecology (OB/GYN) visits
- Family Planning Services

If you do not get Pre-Approval, you may have to pay for care from providers who are out of the Network. For more information on Emergency Services, Urgent Care Services, and Family Planning Services, go to those sections in this chapter.

If you need Medically Necessary services that are covered by CHP+ but there is no available Network Provider, we will refer and approve you to see an Out-of-Network Provider to get those services.

If you get a bill, or you paid a Copay you feel you shouldn't have paid, you can also submit a medical claim form. You can get a medical claim form online at **kp.org**. You can also call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**). We will be happy to help you if you need help completing our medical claim form.

Referrals

Your PCP will request a Referral to send you to a Specialist if you need one. A Specialist is a doctor who has extra training in one area of medicine. Your PCP will work with you to choose a Specialist. We can help you set up a time to go to the Specialist. Call the Appointment and Advice Contact Center at **303-338-4545** or toll-free at **1-800-218-1059** or schedule an appointment online at **kp.org**.

Examples of Specialists who require a Referral include:

- Surgery
- Orthopedics
- Cardiology
- Oncology
- Dermatology
- Physical, occupational, and speech therapies

If you have questions about Referrals, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

You do not need a Referral for:

- PCP visits
- Obstetrics/Gynecology ("OB/GYN") visits
- Urgent or emergency care visits
- Family Planning

Although a Referral or Pre-Approval is not required to receive most care from the providers listed directly above, you may need a Referral and Pre-Approval in the following situations:

- The provider may have to get Pre-Approval for certain Covered Services
- The provider may have to refer you to a Specialist who has a clinical background related to your illness or condition

Pre-approval (Prior Authorization)

For some types of care, your PCP or Specialist will need to ask Health Plan for permission before you get the care. This is called asking for Prior Authorization, prior approval, or Pre-Approval. This means that Health Plan must make sure that the care is Medically Necessary or needed.

Once your request is reviewed, we will mail you a notice telling you if we approve or deny the services or procedure being requested. This process may take 10 calendar days from when we receive the request. We can extend the review time up to 14 calendar days if you ask us to. We can also extend the time if more information is needed and the delay is in your best interest.

For requests in which a provider indicates or the applicable Health Plan designee determines that following the standard timeframe could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function, Health Plan will make an expedited (fast) authorization decision. We will give notice as quickly as your health condition requires and no later than 72 hours after receiving the request for services.

For questions about services that require Pre-Approval, and the criteria that are used to make authorization decisions, please call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**). We can provide interpreter services at no cost.

You never need Pre-Approval for Emergency Services or Urgent Care Services, even if they are out of Network. This includes labor and delivery if you are pregnant. You do not need Pre-Approval for most Family Planning Services. For more information on Family Planning Services, go to the section “Family Planning Services” in this chapter.

Post-Service requests

A request for services you have already received is called a post-service request.

This includes requests for services from Out-of-Network Providers and Non-Covered Services.

We may take 30 calendar days to pay or deny a post-service request. If we have all the information we need, we will give you a written notice of our decision to pay or deny the request. If Health Plan does not approve the request, we will send you a Notice of Adverse Benefit Determination (“NABD”) letter. The NABD letter will tell you how to file an Appeal if you do not agree with the decision.

Kaiser Permanente does **not** pay the reviewers to deny coverage or services. Kaiser Permanente does not deny coverage or services based on the grounds of moral or religious beliefs. If you are refused a Covered Service based on moral or religious beliefs, please contact Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**). We will help you find a different provider who will provide the Covered Services you need.

Second opinions

You might want a second opinion about care your provider says you need or about your diagnosis or treatment plan. For example, you may want a second opinion if you are not sure you need a prescribed treatment or surgery, or you have tried to follow a treatment plan and it has not worked.

To get a second opinion, call your PCP. Your PCP can refer you to a Network Provider who is an appropriately qualified medical professional for your medical condition for a second opinion. You may also call Member Services at **303-338-3800** or toll-free at

1-800-632-9700 (TTY **711**) to help you arrange a second opinion with a Network Provider. A Pre-Approval is also needed for a second opinion from an Out-of-Network Provider. See “Referrals” above.

We will pay for a second opinion if you or your Network Provider asks for it and you get the second opinion from a Network Provider. You must pay the Copayment that applies to the visit.

If we deny your request for a second opinion, you may file an Appeal (or Grievance). To learn more about Appeals, see Chapter 6 (“Reporting and solving problems”) in this Member Handbook.

Utilization Management

Utilization Management is used to decide if you are getting the right services at the right time. Utilization criteria are applied along with medical expert opinions, when necessary, in making decisions to approve or deny services. If your request is denied, you can request, at no cost to you, a copy of the Utilization criteria used in the decision by calling **1-877-895-2705**.

Women’s health Specialists

You may go to a women’s health Specialist within the CHP+ Provider Network for covered care necessary to provide women’s routine and preventive health care services. You do not need a Referral from your PCP to get these services. For help finding a women’s health Specialist, you can call the Appointment and Advice Contact Center at **303-338-4545** or **1-800-218-1059** (TTY **711**).

4. Benefits and services, Exclusions, and Limitations

Benefits and services (What your Health Plan covers)

This section explains your Covered Services as a Member of Kaiser Permanente. Most services must be provided by a Network Provider. The services described in this "Benefits and services" section are covered only if all the following conditions are satisfied:

- The services are Medically Necessary as defined in this Member Handbook; and
- The services are provided, prescribed, recommended, or directed by a Network Provider. This does not apply where noted to the contrary in the "Emergency Services" section, the "Urgent Care Services" section, and "Family Planning Services" section; and
- You receive the services from Network Providers inside our Service Area. The only services you can get from Out-of-Network Providers are the following:
  - Care at an Indian Health Service facility
  - Emergency ambulance services
  - Emergency Services and Post-Stabilization Care
  - Urgent Care Services
  - Family Planning services

- ♦ Pre-Approval to see an Out-of-Network Provider
- ♦ Some Family Planning Services, as described in the Chapter 3 section called “Family Planning Services”
- ♦ Medically Necessary services that are covered by CHP+ but there is no available Network Provider; and

- Your provider has received Pre-Approval (Prior Authorization) for your services, as appropriate.

For more information on your Covered Services, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Kaiser Permanente CHP+ Health Plan Covered Benefits Summary

The benefits chart below shows examples of Copayments for Covered Services.

Most services must be provided by a Network Provider. We may cover Medically Necessary services from an Out-of-Network Provider in some cases.

You must ask us for Pre-Approval (Prior Authorization) if the care is out of Network, except for Family Planning Services, emergencies, or Urgent Care Services.

Members who are American Indians, Alaska Natives, or pregnant Members are exempt from Copayments and enrolled onto Plan 200.

All benefits are subject to the Exclusions listed in this handbook and some services may need a Prior Authorization.

For more information call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**), Monday through Friday, 8 a.m. to 6 p.m.

Kaiser Permanente CHP+ Health Plan Benefits Summary		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Outpatient Care	Primary care visits: Services from family practice, internal medicine, pediatrics	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Specialty care visits: Services from providers that are not primary care	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Office administered drugs	$0	$0	$0	$0
	Virtual care services:				
	Chat with a doctor online via kp.org	$0	$0	$0	$0
	Email	$0	$0	$0	$0
	Telephone visits	$0	$0	$0	$0
	Video visits	$0	$0	$0	$0
	Outpatient surgery at designated outpatient facilities	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit

Kaiser Permanente CHP+ Health Plan Benefits Summary		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Outpatient Care	Preventive Services: Health maintenance visits Well child and well baby visits Behavioral health screening Immunization visits Routine screenings such as blood cholesterol and Pap smears Flexible sigmoidoscopy screening (or screening colonoscopy when ordered by your Network Provider) Screening mammograms and clinical breast exams Prostate screening Eye wellness exams	$0	$0	$0	$0
Ambulance Service	Covered only if Member's condition requires medical services that only a licensed ambulance can provide	$0	$2 Copay per trip	$15 Copay per trip	$25 Copay per trip
Emergency Services	Network and Out-of-Network emergency rooms Covered 24 hours a day	$3 Copay each visit Waived if admitted as an inpatient	$3 Copay each visit Waived if admitted as an inpatient	$30 Copay each visit Waived if admitted as an inpatient	$50 Copay each visit Waived if admitted as an inpatient
Urgent Care	Network and Out-of-Network urgent care facilities	$1 Copay each visit	$1 Copay each visit	$20 Copay each visit	$30 Copay each visit

Kaiser Permanente CHP+ Health Plan Benefits Summary		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Hospital Inpatient Care (No limit on covered days)	Room and Board and Critical Care Units Intensive care and related hospital services General nursing care Other hospital services and supplies such as: Lab, X-ray, and other diagnostic services Prescribed drugs and medicines Dressings, splints, casts, and sterile tray services Anesthetics Professional services of physicians and other health care providers	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
Maternity Care	Outpatient: Prenatal and postpartum visits	$0	$0	$0	$0
	Inpatient: Physician and hospital services	$0 for delivery of baby and inpatient well-baby care			

Kaiser Permanente CHP+ Health Plan Benefits Summary		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Drugs, Supplies, and Supplements	Outpatient Prescription Drugs Copayment (except as listed below):	$0	$1 Generic $1 Brand name	$3 Generic $10 Brand name	$5 Generic $15 Brand name
	Prescription contraceptives	$0	$0	$0	$0
	Diabetic supplies	$0	$1 Generic $1 Brand name	$3 Generic $10 Brand name	$5 Generic $15 Brand name
	Infertility drugs	Not Covered			
	Sexual dysfunction drugs	Not Covered			
	Travel immunizations	Not Covered			
		SUPPLY LIMIT			
	Day supply limit	30-day supply			
	Mail-order supply limit	90 days @ 2 Copayments			

Kaiser Permanente CHP+ Health Plan Benefits Summary		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	YOU PAY	YOU PAY	YOU PAY
Durable Medical Equipment (DME) and Prosthetics and Orthotics	Durable Medical Equipment	$0	$0	$0	$0
	Prosthetic Devices	$0	$0	$0	$0
	Internally implanted Prosthetic Devices	See Hospital Inpatient Care or Outpatient Care	See Hospital Inpatient Care or Outpatient Care	See Hospital Inpatient Care or Outpatient Care	See Hospital Inpatient Care or Outpatient Care
	Orthotic Devices	$0	$0	$0	$0
	Oxygen	$0	$0	$0	$0
	Annual combined maximum benefit paid by Health Plan for the items listed above	$2,000 per year	$2,000 per year	$2,000 per year	$2,000 per year
	Prosthetic arm or leg	$0	$0	$0	$0
Hearing Services	Hearing exams and tests to determine the need for hearing correction through age 18	$0	$0	$0	$0
	Hearing aids for persons through age 18	$0	$0	$0	$0

Kaiser Permanente CHP+ Health Plan Benefits Summary		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Mental Health	Outpatient: • Individual therapy visits • Partial hospitalization	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Inpatient: Hospital and facility services for psychiatric conditions	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
	Residential Care: Treatment in a Network hospital-based program	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
Substance Use Disorder	Outpatient: • Outpatient services for treatment of alcohol and drug dependency • Partial hospitalization	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Inpatient: Diagnosis, medical treatment including medical detoxification, and referral services	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
	Residential rehabilitation: Inpatient services in a residential rehabilitation program	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission

Kaiser Permanente CHP+ Health Plan Benefits Summary		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	YOU PAY	YOU PAY	YOU PAY
Physical, Occupa-tional, and Speech Therapy	Rehabilitation outpatient therapy: limited to 30 visits per year, any combination of physical, occupational, or speech therapy Visit limit not applicable to therapy visits for developmental delays age 0 up to 3rd birthday Visit limit not applicable to speech therapy for cleft lip/cleft palate	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Applied Behavior Analysis (ABA) therapy	Not Covered			
	Inpatient rehabilitation: Limited to 30 days per year	$0	$2 Copay per admission	$20 Copay per admission	$50 Copay per admission
Skilled Nursing Facility Care	Limited to 30 days per calendar year for Members who need skilled nursing care 24 hours a day. Custodial care is not covered.	$0	$0	$0	$0
Home Health Care	Health services provided in your home and prescribed by a Network Provider. Home health services are Medically Necessary part-time or intermittent services.	$0	$0	$0	$0
Hospice Care	For terminally ill patients with life expectancy of 6 months or less	$0	$0	$0	$0

Kaiser Permanente CHP+ Health Plan Benefits Summary		PLAN 201	PLAN 202	PLAN 203	PLAN 204
		<101% FPL	101-156% FPL	157-200% FPL	201-260% FPL
		YOU PAY	**YOU PAY**	**YOU PAY**	**YOU PAY**
Vision Services and Optical	Routine eye exam and refraction test: Limited to 1 per year	$0	$2 Copay each visit	$5 Copay each visit	$10 Copay each visit
	Optical hardware	**Credit** $50 credit every 12 months			
X-rays, Lab, and Advanced Imaging Procedures	Diagnostic laboratory services	$0	$0	$5 Copay	$10 Copay
	Diagnostic X-ray services	$0	$0	$5 Copay	$10 Copay
	Therapeutic X-rays	$0	$0	$0	$0
	Advanced imaging procedures such as CT, PET, MRI, nuclear medicine	$0	$0	$5 Copay per scan	$10 Copay per scan
Out-of-Pocket Maximum	This limit is based on services received during the current calendar year.	Five percent (5%) of annual family gross income	Five percent (5%) of annual family gross income	Five percent (5%) of annual family gross income	Five percent (5%) of annual family gross income

Kaiser Permanente CHP+ Health Plan Covered Benefits

Read each of the sections below to learn more about the Covered Services you can get.

The health care services provided to Members of our CHP+ Health Plan are subject to the terms, conditions, limitations and Exclusions of the contract between Kaiser Permanente and the Department and as listed in this Member Handbook and any amendments.

Note: Copayments may apply to the benefits listed below. To see how much a benefit or Service will cost you, please go to the CHP+ Health Plan Covered Benefits Summary.

Outpatient Care

Outpatient Care for Preventive Care, Diagnosis, and Treatment

We cover the following Outpatient Care for preventive care, diagnosis, and treatment. This includes 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.

Your Outpatient Care includes:

- Primary care visits: Services from family medicine, internal medicine, and pediatrics.
- Specialty care visits: Services from providers that are not primary care, as defined above.
- Allergy testing and treatment.

- Fluoride Varnish treatment.
- Consultations with clinical pharmacists.
- Drugs, dressings and casts administered during a covered visit (No charge).
- Outpatient surgery.
- Blood, blood products and their administration.
- Second opinion.
- House calls.
- Medical social services.
- Preventive care services (see “Preventive Care Services” in this “Benefits and Services” section for more details).
- Virtual care services.

Outpatient Care Exclusions

These services are not covered by this plan:

- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.

Hospital Inpatient Care

Inpatient Services in a Network Facility

We cover inpatient services in a Network Facility, when the services are typically provided by acute care general hospitals in our Service Area. The following services are covered:

- Room and board in a semi-private room (with two or more beds). A private room or private duty nursing care is provided if a Network Provider determines it is Medically Necessary.
- Intensive care and related hospital services.

- Professional services of physicians and other health care professionals during your hospital stay.
- General nursing care.
- Bariatric surgery is covered if you meet Health Plan criteria.
- Meals and special diets.
- Other hospital services and supplies, such as:
  - Operating, recovery, maternity and other treatment room.
  - Prescribed drugs and medicines.
  - Diagnostic laboratory tests and X-rays.
  - Blood, blood products and their administration.
  - Dressings, splints, casts and sterile tray services.
  - Anesthetics, including nurse anesthetist services.
  - Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

Hospital Inpatient Care Exclusions

These services are not covered by this plan:

- Dental services, except that we cover hospitalization and general anesthesia for dental services provided to Members as required by state law.
- Cosmetic surgery related to bariatric surgery.
- Sex change operations, preparation for a sex change operation, or complications arising from a sex change operation.

Maternity Care Services

We cover the following Outpatient Care for prenatal and postnatal treatment. This includes professional medical services of physicians and other health care professionals:

- Routine prenatal and postpartum visits (No charge). The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit.

We cover inpatient services in a Network Facility. The following services are covered:

- Obstetrical care and delivery. This includes cesarean section.
  - ♦ If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning.
  - ♦ Your Network Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. This may happen if you are discharged within 48 hours after delivery, or 96 hours if the delivery is by cesarean section.
  - ♦ If your newborn stays in the hospital after your discharge, there will be Copayments for the services they receive. You must pay the newborn's Copayments.

Ambulance Services

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

Ambulance Services Exclusions

The following are not covered by this plan:

- Non-Emergency routine ambulance services to home or other non-acute health care setting.
- Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation, even if it is the only way to travel to a Network Provider.

Dialysis Care

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

- The services are provided inside our Service Area; and
- You must meet all medical criteria developed by Health Plan; and
- The facility is certified by the Centers for Medicare & Medicaid Services (CMS) and contracts with Health Plan; and
- A Network Provider provides a written Referral for care at the facility.

After the Referral, we cover: equipment; training; and medical supplies required for home dialysis.

Drugs, Supplies, and Supplements

We use a drug Formulary. A drug Formulary is a list of Prescription Drugs (including Biologics and Biosimilars) that have been approved by our Formulary committee for our Members. Our committee is made up of physicians and pharmacists. It is known as the Pharmacy and Therapeutics Committee. The committee selects Prescription Drugs for our drug Formulary based on several factors. This includes safety and effectiveness, as determined from a review of medical literature and research. The committee meets on a regular basis to consider adding and removing Prescription Drugs on the drug Formulary. If you would like information about whether a drug is included in our drug Formulary, please call **Member Services**.

Outpatient Prescription Drug Coverage

This section tells you what drugs, supplies, and supplements are covered when you go to a Network pharmacy. You can find a facility with a Network pharmacy by visiting our website. Go to **kp.org**, click on “Locate our services” then “Find doctors & locations.” You can also call **Member Services** for help.

The following drugs are covered only when prescribed by:

- a Network Provider; or

- a provider to whom a Member has been referred by a Network Provider; or
- a dentist (when prescribed for acute conditions), and when you get them at Network pharmacies:
    - Insulin
    - Drugs for which a prescription is required by law.

Prescribed covered drugs are provided in prescribed quantities at the Copayment shown in the CHP+ Health Plan Covered Benefits Summary. If your Prescription Drug Copayment shown in the CHP+ Health Plan Covered Benefits Summary is more than the cost for your prescribed medication, then you pay the cost of the medication instead of the Copayment.

Network pharmacies may substitute a generic equivalent for a brand name drug unless not allowed by the Network Provider. If you request a brand name drug when a generic equivalent drug is the preferred product, you must pay any difference in price between the preferred generic equivalent drug prescribed by the Network Provider and the requested brand name drug. If the brand name drug is prescribed due to Medical Necessity, you pay only the brand name Copayment.

Generic drugs available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) Health Plan subscribes to are provided at the brand name Copay. The amount covered will be the lesser of the quantity prescribed or the Day Supply Limit. A Day Supply Limit is the amount of a drug that can be dispensed at a time. For example, you may receive a 30 day supply.

The amount covered cannot exceed the Day Supply Limit for each maintenance drug or up to the Day Supply Limit for each non-maintenance drug. Certain drugs have a higher potential for waste and diversion. Those drugs will be provided for up to a 30 day supply, at the Prescription Drug Copayment. 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 prescribed amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription. Kaiser Permanente may establish quantity limits for specific Prescription Drugs.

Administered Drugs Coverage

We cover the following administered drugs as part of your Hospital Inpatient Care and Skilled Nursing Facility benefit. They are covered without charge if the following drugs are:

- administered in a Network medical office or urgent care facility; or
- during home visits if administration or observation by medical personnel is required.
- Drugs (including Biologics and Biosimilars) 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.

Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail order prescription service with no charge for postage and handling. You may get refills of maintenance drugs prescribed by Network Providers up to the mail order day supply, at the related Copayment. Maintenance drugs are defined by Health Plan. Certain drugs have a higher potential for waste and diversion. Those drugs are not available by mail order service. For information about our mail order prescription service and drugs not available by mail order, please contact **Member Services**.

Food Supplements

The following are provided under your Hospital Inpatient Care benefit: prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism; elemental enteral nutrition and parenteral nutrition; formulas for gastrostomy tubes; and formulas for children with gastrointestinal disorders, malabsorption syndromes or a condition that affects growth pattern or normal absorption or nutrition. Such products are covered at the related Copayment for self-administered use. Food products for enteral feedings are not covered.

Diabetic Supplies and Accessories

Diabetic supplies will be provided when you get them at a Network pharmacy or from sources approved by Health Plan. Such items include, but may not be limited to: home glucose monitoring supplies; disposable syringes for the administration of insulin; glucose test strips; acetone test tablets; and nitrate screening test strips for pediatric patient home use. For more information, see the CHP+ Health Plan Covered Benefits Summary.

Limitations

- Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice.
- Some drugs may require Prior Authorization. You do not need Prior Authorization for any FDA-approved Prescription Drug listed on our Formulary, for the treatment of substance use disorder.
- With the exception of substance use disorder drugs, we may apply step therapy to certain drugs.
- Compound medications are covered as long as they are on the Formulary.

Drugs, Supplies, and Supplements Exclusions

The following are not covered by this plan:

- Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings and ace-type bandages.
- Drugs and injections for treatment of sexual dysfunction.
- Drugs or injections for the treatment of infertility.
- Prescribed drugs necessary for services excluded under the **CHP+** contract.
- Drugs to shorten the length of the common cold.
- Drugs to enhance athletic performance.
- Drugs for the treatment of weight control.
- Drugs available over the counter and by prescription for the same strength.

- Individual drugs and/or drug classes determined excluded by our Pharmacy and Therapeutics Committee.
- Unless approved by Health Plan, drugs;
  - ♦ Not approved by the FDA; and
  - ♦ Not in general use as of March 1 of the year prior to your effective date or last renewal.
- Any packaging of Prescription Drugs except the dispensing pharmacy's standard packaging.
- Replacement of Prescription Drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
- Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.

Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME, prosthetics, and orthotics listed on our DME formulary.

- They need to be prescribed by a Network Provider.
- They require Prior Authorization from the Health Plan.
- You need to get them from sources approved by the Health Plan.

Health Plan determines whether the items should be purchased or rented. Replacements needed due to normal wear are covered if the DME is still medically needed. Replacements will not be covered if they were:

- damaged due to neglect or abuse; or
- lost

See the CHP+ Health Plan Covered Benefits Summary for more information.

Needed fittings, repairs and adjustments, other than those needed due to misuse, are covered. The Health Plan may repair or replace a device at its option. Repair or

replacement of defective equipment is covered at no charge. You will be charged as a non-Member for any DME, prosthetics, orthotics and/or needed repairs and adjustments after the annual maximum benefit is paid by the Health Plan each year.

Limitations: Coverage is limited to:

- A standard item of DME, Orthotic Device or Prosthetic Device that meets a Member's medical needs, and
- The annual maximum benefit paid by the Health Plan as shown in the CHP+ Health Plan Covered Benefits Summary.

Durable Medical Equipment (DME) Coverage

- DME that is Medically Necessary and listed on our DME formulary.
- DME is Medically Necessary equipment that can be used in the home. It is able to withstand repeated use, only of use to a person with an illness or injury. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
- Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when you get them from sources named by the Health Plan. The annual maximum benefit does not apply to insulin pumps or insulin pump supplies.
- 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 named by the Health Plan.
- When use is no longer prescribed by a Plan Physician, DME must be returned to the Health Plan or its designee. If the equipment is not returned, you must pay the Health Plan or its designee the fair market price, established by the Health Plan, for the equipment.
    - ♦ Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by the Health Plan.

Durable Medical Equipment Exclusions

The following are not covered by this plan:

- Electronic monitors of bodily functions, except infant apnea monitors.
- Devices to perform medical testing of body fluids, excretions or substances. Note: Nitrate urine test strips for home use for pediatric patients are covered and not excluded.
- Non-medical items such as sauna baths or elevator features.
- Exercise or hygiene equipment.
- Comfort, convenience, or luxury equipment or features.
- Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings and ace-type bandages.
- Replacement of lost equipment.
- Repair, adjustments or replacements as a result of misuse.
- More than one piece of DME serving essentially the same function, except for replacements; spare equipment or alternate use equipment is not covered.

Prosthetic Devices Coverage

Prosthetic Devices are those devices that replace all or any part of a body organ or extremity. Coverage of Prosthetic Devices includes:

- Internally implanted devices for functional purposes. For example, pacemakers and hip joints. The annual maximum benefit does not apply.
- Prosthetic Devices for Members who have had a mastectomy. Health Plan lets you know where to get the devices. Replacement will be made when a device is no longer functional. Custom made prostheses will be provided when needed. The annual maximum benefit does not apply.
- Prosthetic Devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate. These need to be prescribed by a Network Provider and you must get them from sources approved by the Health Plan. The annual benefit maximum benefit does not apply.
- Prosthetic Devices intended to replace, in whole or in part, an arm or leg when prescribed by a Network Provider as Medically Necessary. You must get them

from sources approved by the Health Plan. Payment by the Health Plan will be based on this EOC. The annual maximum benefit does not apply.

Prosthetic Device Exclusions

The following are not covered by this plan:

- Dental prostheses, except for those Medically Necessary to treat cleft lip and cleft palate, as described above.
- Internally implanted devices, equipment and prosthetics related to treatment of sexual dysfunction.
- More than one Prosthetic Device for the same part of the body, except for replacements. Spare devices or alternate use devices not provided.
- Replacement of lost Prosthetic Devices.
- Repairs, adjustments or replacements needed due to misuse.

Orthotic Devices Coverage

Orthotic Devices are rigid or semi-rigid external devices (other than casts) that:

- are required to support or correct a defective form or function of an inoperative or malfunctioning body part; or
- restrict motion in a diseased or injured part of the body.

Orthotic Device Exclusions

The following are not covered:

- Corrective shoes and Orthotic Devices for podiatric use and arch supports. This exclusion does not include: diabetic or therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
- Dental devices and appliances. Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Network Provider. If a Member is covered for these services under a dental insurance policy or contract, they are not covered by us.
- Experimental and research braces.

- More than one Orthotic Device for the same part of the body, except for replacements. Spare devices or alternate use devices are not covered.
- Replacement of lost Orthotic Devices.
- Repairs, adjustments, or replacements needed due to misuse.

Emergency Services and Urgent Care Services

Emergency Services

If you think you have an Emergency, call 911 or go to the nearest hospital emergency room.

Emergency Services are available at all times – 24 HOURS A DAY, 7 DAYS A WEEK. You do not need Prior Authorization or a referral. You have the right to use any hospital or other setting for emergency care.

We cover Emergency Services you receive from Network Providers and Out-of-Network Providers anywhere in the world. For information about Emergency benefits away from home, please call **Member Services.**

The exclusions and limitations of your plan will still apply if Non-Covered Services are provided by an Out-of-Network Provider or Out-of-Network Facility.

After Your Emergency is Stabilized (Post-Stabilization)

After your Emergency is Stabilized (whether inside or outside our Service Area) we cover services you may need when approved by Health Plan. These services are called Post-Stabilization Services. These are Services that an Emergency Services provider says are needed before you can go home or be moved to a Network Facility to continue needed care.

Once you are Stabilized, ongoing care is no longer considered an Emergency Medical Condition. At this time we will decide whether you should be transferred to a Network Facility for ongoing care. Ongoing services out-of-Network will need to be preauthorized

by us to be covered. When approved by us, we will help transfer you to a Network Facility inside the Service Area.

Non-Emergency Services are not covered after we have approved your transfer to a Network Facility. You will be responsible for payment for any Post-Stabilization treatment if you decide to stay at the Out-of-Network Facility.

Notice to the Health Plan of Receipt of Emergency Services

We request if you are admitted to an Out-of-Network Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf tell us within 24 hours, or as soon as possible. Please call **Member Services**.

Please note: If you receive services unrelated to the Emergency, you may be charged a separate Copayment.

Emergency Services Exclusions

These services are not covered by this plan:

- Routine Care that is **not** treatment for an Emergency Medical Condition provided in an emergency medical facility.
- Follow-up care that is not preauthorized. Any services you need after you are Stabilized should be provided by a Network Provider, not in an emergency medical facility.

Urgent Care Services

Urgent Care Services are services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition. You do not need Pre-Approval (Prior Authorization) for urgent care.

If you have an illness or injury and you are not sure what kind of care you need, our **Advice Nurses** can help. They are available 24 hours a day, 7 days a week. 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. This may include

making an appointment for you, or referring you to an urgent care facility or an emergency room.

Family Planning Services

This section tells you about Covered Services and Exclusions for Family Planning services. Family Planning services are Medically Necessary services that prevent or delay pregnancy. These services do not require Prior Authorization or Referral for any provider regardless of whether they are in the CHP+ Provider Network or not. This could be a PCP or OB/GYN.

We cover the following Family Planning services:

- Prescription birth control.
- Depo-Provera for birth control purposes.
- Fitting of a diaphragm or cervical cap.
- Surgical implantation and removal of an Implantable Contraceptive Device.
- Fitting, inserting, or removing Intrauterine Device (IUD).
- IUDs, diaphragms, Implantable Contraceptive Devices, and cervical caps given in a provider's office.

Family Planning Services Exclusions

These services are not covered by this plan:

- Surgical sterilization (for example, tubal ligation or vasectomy) and related services.
- Reversals of sterilization procedures.
- Some over-the-counter contraceptive products such as spermicide.
- Preconception, paternity, or court-ordered genetic counseling and testing (for example, tests to determine the sex or physical characteristics of an unborn child).

- Choosing to end (elective termination) a pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

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.

Hearing Services

We cover hearing exams and tests for you through age 18 to determine the need for hearing correction. If you have a verified hearing loss, coverage includes:

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

Home Health Care

We cover skilled nursing care, home infusion therapy, physical therapy, occupational therapy, speech therapy, home health aide services, and medical social services:

- only on an Intermittent Care basis (as described below); and
- only within our Service Area; and
- only to an eligible Member when ordered by a Network Provider. Care must be provided under a Home Health Care plan established by the Network Provider and the approved home health services provider; and

- if a Network Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

Intermittent Care means skilled nursing, therapy, social work, and home health aide services, that are not custodial, and require a skilled professional, and are provided less than 8 hours (combined) each day and 28 or fewer hours each week.

Note: X-ray, laboratory, and advanced imaging procedures are not covered under this section (see “X-ray, Laboratory, and Advanced Imaging Procedures”).

Home Health Care Exclusions

These services are not covered by this plan:

- Custodial (non-medical) care. Custodial care is care that helps with activities of daily living (like bathing, dressing, using the bathroom, and eating) or personal needs that could be done safely and reasonably without professional skills or training.
- Homemaker Services.
- Care that Health Plan determines may be appropriately provided in a Network Facility or Skilled Nursing Facility.

Special Services Program

If you are 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 to receive home health visits through the Special Services Program (“Program”). These visits are without charge until you elect Hospice Care coverage. Coverage of Hospice Care is described below.

This Program gives you and your family time to become more familiar with hospice services and to decide what is best for you. When you have the option to participate in this Program, it can help 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. The services available through this Program are provided by professionals with specific training in end-of-life issues.

Hospice Care

We cover Hospice Care for terminally ill Members inside our Service Area. If a Network Provider diagnoses you with a terminal illness with a life expectancy of six (6) months or less, you can choose Hospice Care instead of traditional services provided for the 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 Hospice Care services and other benefits when:

- prescribed by a Network Provider and the Hospice Care team; and
- received from a licensed hospice approved in writing by Health Plan:
  - Physician care.
  - Nursing care.
  - Physical, respiratory, occupational, or speech therapy.
  - Medical social services.
  - Home health aide and homemaker services.
  - Medical supplies, drugs, biologicals, and appliances.
  - Physician Services.
  - Palliative drugs based on our drug Formulary guidelines.
  - Short-term inpatient care, including respite care and care for pain control and acute and chronic pain management.
  - Counseling and bereavement services.

- Services of volunteers.

Mental Health Services

Medical services for mental health treatment are covered in the same way as for other medical conditions.

Inpatient Services

We cover mental health services as shown below.

Medical and Hospital Services

- We cover psychiatric hospitalization in a facility designated by Health Plan. You pay the Copayment, if any, shown in the CHP+ Health Plan Covered Benefits Summary. Hospital Services for psychiatric conditions include all services of Network Providers and mental health professionals and the following services and supplies as prescribed while you are a registered bed patient:
  - Room and board.
  - Psychiatric nursing care.
  - Group therapy.
  - Electroconvulsive therapy.
  - Occupational therapy.
  - Drug therapy and medical supplies.

Residential Care

We cover residential treatment services in a Network hospital-based program at the Copayment shown in the CHP+ Health Plan Covered Benefits Summary, if you are admitted directly from an inpatient hospital admission into a partial hospitalization treatment program. If your inpatient hospital stay does not come right before admission into a residential treatment program, a separate inpatient hospital Copayment may apply.

Outpatient Services

We cover individual visits, group visits, and intensive outpatient therapy.

Partial hospitalization treatment may be used in place of inpatient days, if approved by Health Plan.

In addition, visits for the following are covered:

- Monitoring of drug therapy.
- Psychological testing as part of diagnostic evaluation.

Mental Health Services Exclusions

These services are not covered by this plan:

- 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 Network Provider determines such evaluations are Medically Necessary.
- Mental health services on court order, to be used in a court proceeding, or as a condition of parole or probation, unless a Network Provider determines such care is Medically Necessary.
- Marital and social counseling.
- Services which are custodial in nature.

Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services

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 if, in the judgment of a Network Provider, significant improvement is possible within a two-month period.

Outpatient Care

We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Network Facility, if in the judgment of a Network Provider, significant improvement is possible within a two-month period. See the CHP+ Health Plan Covered Benefits Summary for more benefit information.

We cover children from birth up to the child's third (3rd) birthday:

- if diagnosed with significant delays in development; or
- has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law.

See the CHP+ Health Plan Covered Benefits Summary for additional benefit information.

Inpatient Rehabilitation

We cover treatment for up to 30 days per year while you are an inpatient in an organized, inpatient rehabilitation services program in a designated facility.

Therapies for Congenital Defects and Birth Abnormalities

After the first 31 days of life, the limitations and Exclusions in this EOC apply, except that we cover Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for children from birth up to the child's fifth (5th) birthday. We cover 30 therapy visits per year for physical, occupational, and speech therapy combined. Such visits are distributed as Medically Necessary throughout the year 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.

Limitations

- Speech therapy is limited to treatment for speech impairments due to injury or illness of specific organic origin. Many pediatric conditions do not qualify for coverage because they lack a specific organic cause and may be long-term and chronic in nature.

- Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.
- Speech therapy visits for treatment of cleft lip or cleft palate are unlimited if Medically Necessary.

Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services Exclusions

These services are not covered by this plan:

- Cardiac rehabilitation programs.
- Maintenance therapy or care after the Member has reached rehabilitative potential.
- Membership at health spas or fitness centers.
- Any therapeutic exercise equipment prescribed for home use.
- Therapies for learning disorders, developmental delays, stuttering, voice disorders, or rhythm disorders.
- Long-term rehabilitation.
- Speech therapy that is not Medically Necessary, such as:
  - therapy for educational placement or other educational purposes; or
  - training or therapy to improve articulation in the absence of injury, illness or medical condition affecting articulation; or
  - therapy for tongue thrust in the absence of swallowing problems.

Preventive Care Services

Preventive care services are services to keep you healthy or to prevent illness. These services are not intended to treat an existing illness, injury or condition. Please refer to the CHP+ Health Plan Covered Benefits Summary for Copayments that may apply to preventive care services. Should you receive services for an existing illness, injury, or

condition **during** a preventive care examination, you may be charged an additional office visit Copayment.

- Preventive care services include the following:
- Health maintenance visits.
- Well child and well baby visits.
- Behavioral health screening.
- Immunization visits.
- Routine screenings such as blood cholesterol, colorectal cancer screening and Pap smears.
- Screening mammograms and clinical breast exams.
- Prostate screening.

Reconstructive Surgery

See “Outpatient Care” and “Hospital Inpatient Care” for your Copayment.

We cover Reconstructive Surgery when a Network Provider determines it:

- will correct a significant disfigurement resulting from an injury or Medically Necessary surgery; or
- will treat a congenital defect, disease or anomaly in order to produce a major improvement in physical function; or
- is necessary to treat congenital hemangioma (known as port wine stains) on the face and neck.

Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast. We also cover surgery and reconstruction of the other breast to produce a symmetrical appearance and treatment of physical complications, including lymphedemas.

Reconstructive Surgery Exclusions

These services are not covered by this plan:

- Plastic surgery or other cosmetic services and supplies intended primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

Skilled Nursing Facility Care

We cover up to 30 days per year of skilled inpatient services in a licensed Skilled Nursing Facility. Prior Authorization from the Health Plan is required. The skilled inpatient services must be those generally provided by Skilled Nursing Facilities. A prior three (3) day stay in an acute care hospital is not required. We cover the following services:

- Medical and biological supplies.
- Nursing care.
- Room and board.
- Medical social services.
- 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 state law; and
- is approved in writing by Health Plan.

Note: Drugs are covered, but not under this section. See “Drugs, Supplies, and Supplements.”

DME and prosthetics and orthotics are covered, but not under this section. See “Durable Medical Equipment and Prosthetics and Orthotics.”

X-ray, laboratory, and advanced imaging procedures are covered, but not under this section. See “X-ray, Laboratory, and Advanced Imaging Procedures.”

Skilled Nursing Facility Care Exclusion

The following is not covered by this plan:

- Custodial Care, as defined in “Services you cannot get through the CHP+ Health Plan (Exclusions)” section.

Substance Use Disorder Services

Inpatient Services

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. See the CHP+ Health Plan Covered Benefits Summary.

Residential Rehabilitation Services

We cover inpatient services and partial hospitalization in a residential rehabilitation program approved by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction. See the CHP+ Health Plan Covered Benefits Summary.

A Network Provider supervises the decision about the need for residential rehabilitation services and the referral to such a facility or program.

Outpatient Services

We cover outpatient rehabilitative services for treatment of alcohol and drug dependency when referred by a Network Provider. See the CHP+ Health Plan Covered Benefits Summary.

We cover substance use disorder Services, whether they are voluntary or are court ordered as a result of contact with the criminal justice or juvenile justice system. We do not cover court ordered treatment that exceeds the scope of coverage under this plan. We cover substance use disorder services when:

- they are Medically Necessary; and
- they are otherwise Covered Services under this plan; and
- supplied by a Network Provider.

Partial hospitalization treatment may be used in place of inpatient days, if approved by Health Plan.

Mental health services required in connection with treatment for substance use disorder are covered as provided in the “Mental Health Services” section.

Members who are disruptive or abusive may have their enrollment terminated for cause.

Substance Use Disorder Services Exclusion

The following is not covered by this plan:

- Counseling for a patient who is not responsive to therapeutic management as determined by Health Plan.

Transplant Services

Transplants are covered on a **limited** basis as follows:

- Bone marrow transplants (autologous stem cell or allogenic stem cell) for Hodgkin’s disease, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and stage III breast cancer and Wiskott-Aldrich syndrome.
- Cornea.
- Kidney.
- Liver.
- Heart.

- Heart-lung.
- Lung (single or double) for end stage pulmonary disease only.
- Kidney and pancreas transplants at the same time.
- Stem cell rescue and transplants of organs, tissue or bone marrow when all medical criteria developed by Health Plan are met.

Related Prescription Drugs

Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant are covered at the outpatient Prescription Drug Copayment as shown in the "Drugs, Supplies, and Supplements" section.

Terms and Conditions

- The Health Plan, Medical Group, and Network Providers 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
  - the availability or capacity of referral transplant facilities approved by Health Plan.
- Based on our guidelines for living transplant donors, we provide certain donation-related services for a donor, or a person a Network Provider 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 Kaiser Permanente transplant offices.
- Network Providers determine that the Member satisfies Health Plan medical criteria before the Member receives the services.
- A Network Provider must provide a written Referral for care to a transplant facility. The transplant facility must be from a list of approved facilities selected by Health Plan. The Referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Health Plan

selects for the transplant, even if another facility within the Service Area could also perform the transplant.

- After Referral, if Health Plan or the medical staff of the referral facility determines that the Member does not satisfy its respective criteria for the service involved, the Health Plan's obligation is only to pay for Covered Services provided prior to such determination.

Transplant Lifetime Maximum (LTM) Benefit

The Transplant LTM is the maximum benefit paid by the Health Plan for covered Transplant Services.

We will pay the accumulated cost of Transplant Services you receive up to the Transplant LTM of $1,000,000 while you are enrolled under this plan.

The following will not apply toward the Transplant LTM:

- The cost of transplant medications.
- Covered traveling and lodging expenses.

Bone Marrow Donor Search Maximum Benefit

The Bone Marrow Donor Search Maximum is the maximum benefit paid by the Health Plan for bone marrow donor searches.

We will pay the cost of bone marrow donor searches up to $25,000 while you are enrolled under this plan.

Transplant Services Exclusions and Limitations

These services are not covered or are limited by this plan:

- Non-human and artificial organs and their implantation.
- Bone marrow transplants associated with high dose chemotherapy for solid tissue tumors (except bone marrow transplants covered under this EOC).
- Travel and lodging expenses.

For information specific to your case, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Vision Services

We cover routine eye exams and refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses. We also cover professional examinations and the fitting of Medically Necessary contact lenses when a Network Provider or Network 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 you get them at a Kaiser Permanente medical office building.

When prescribed by a physician or an optometrist and you get them at a Kaiser Permanente medical office building, you receive a credit, as shown in the “Vision Services and Optical” section of the CHP+ Health Plan Covered Benefits Summary toward the purchase of one pair of:

- regular lenses; or
- frames; or
- Medically Necessary contact lenses.

Covered Services include the frame, mounting of lenses in the frames, and the first fitting and adjustment of the frame. The credit can only be used when you make your purchase.

Vision Services Exclusions

These items and services are not covered by this plan:

- Contact lenses not Medically Necessary.
- Professional exams for fittings and dispensing of contact lenses except when Medically Necessary.
- Miscellaneous services and supplies, such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.

- 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).
- Orthoptic (eye training) therapy.

X-ray, Laboratory, and Advanced Imaging Procedures

Outpatient

We cover the following services:

- Diagnostic X-ray and laboratory tests, services and materials, which includes, but is not limited to isotopes, electrocardiograms, electroencephalograms, mammograms, and ultrasounds.
- Therapeutic X-ray services and materials.
- Advanced imaging procedures such as MRI, CT, PET, and nuclear medicine. **Note:** Members will be billed for each separate procedure performed. If more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined based on the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association.

Inpatient

During hospitalization, the following are covered at the Copayment shown in the CHP+ Health Plan Covered Benefits Summary: prescribed diagnostic X-ray and laboratory tests; services and materials, including diagnostic and therapeutic X-rays and isotopes; electrocardiograms and electroencephalograms.

X-ray, Laboratory, and Advanced Imaging Procedures Exclusions

These services are not covered by this plan:

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

Care Coordination

We offer services to help you coordinate your health care needs at no cost to you. If you have questions or concerns about your health or the health of your child, call the Appointment and Advice Contact Center at **303-338-4545** or **1-800-218-1059** (TTY **711**.)

Services you cannot get through the Kaiser Permanente CHP+ Health Plan (Exclusions)

There are some services that the Kaiser Permanente CHP+ Health Plan will not cover. Some Exclusions are listed in the CHP+ “Benefits and services” section above.

The list of Exclusions below explains services that are not covered by your plan. These are general Exclusions that apply to all services described in this Member Handbook. Exclusions that apply only to a specific Covered Service are listed in the description of that service in the “Benefits and services” section. You do have to pay for services that are not covered.

- **Applied Behavioral Analysis (ABA) Therapy**
- **Alternative Medical Services.** Acupuncture services, naturopathy services, massage therapy, chiropractic services and services of chiropractors.
- **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.
- **Biofeedback Services and Services Related to Biofeedback.**
- **Convalescent Care.**
- **Cosmetic Services.** Services that are intended primarily to change or maintain your appearance and that will not result in significant improvement in physical function. Exception: Services covered under “Reconstructive Surgery” in the “Benefits and services” section.
- **Cryopreservation.** Any and all services related to cryopreservation, including but not limited to the procurement and/or storage of semen, sperm, eggs, reproductive materials, and/or embryos.

- **Custodial Care.** Custodial care is

  - assistance with activities of daily living which include, but are not limited to, walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine; or

  - care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

- **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:

  - Medically Necessary services for the treatment of cleft lip or cleft palate for newborns when prescribed by a Network Provider, unless the Member is covered for these services under a dental insurance policy or contract; or

  - hospitalization and general anesthesia for dental services, prescribed or directed by a Network Provider for children who:

    - have a physical, mental, or medically compromising condition; or

    - have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or

    - are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or

    - have sustained extensive orofacial and dental trauma; or

  - medical coverage for accidental injury to sound natural teeth, if treatment is performed by a physician or legally licensed dentist, and treatment is begun within 72 hours after the accidental injury.

  - Unless otherwise specified herein, treatment of cleft lip or cleft palate for newborns and hospitalization and general anesthesia for dental services must be received at a Network Facility or Skilled Nursing Facility.

- **Directed Blood Donations.**

- **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices, not specifically listed as covered in the “Benefits and services” section.

- **Domiciliary Care.** Care provided in a non-treatment institution, halfway house, or school.

- **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:

  - Items and services to increase academic knowledge or skills;

  - Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;

  - Teaching and support services to increase academic performance;

  - Academic coaching or tutoring for skills such as grammar, math, and time management;

  - Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Network Provider acting within the scope of their license under Colorado law that is intended to address speech impediments;

  - Teaching you how to read, whether or not you have dyslexia;

  - Educational testing; testing for ability, aptitude, intelligence, or interest;

  - Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, swimming, or teaching you how to play.

- **Employer or Government Responsibility.** Financial responsibility for services that an employer or government agency is required by law to provide, other than those **CHP+** services covered by the Department under its **CHP+** program.

- **Experimental or Investigational Services:**

  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:

- has not been approved by the U.S. Food and Drug Administration (FDA); or
- is the subject of a current new drug or new device application on file with the FDA; or
- 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
- 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
- is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety; toxicity or efficacy of services; or
- 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 the Health Plan; or
- 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 evaluated for its safety, toxicity or efficacy; or
- is a part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that use of the Service should be substantially confined to research settings, or further research is necessary to determine the safety, toxicity or efficacy of the service.

In determining whether a service is experimental or investigational, the following sources of information will be solely relied upon:

- Your medical records; and

- The written protocols or other documents under which the Service has been or will be provided; and
- Any consent documents you or your representative has executed or will be asked to execute, to receive the Service; and
- 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
- The published authoritative medical or scientific literature on the Service, as applied to your illness or injury; and
- 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.

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

- **Genetic testing.** The Health Plan does not cover genetic testing unless determined to be Medically Necessary and meets Health Plan criteria.
- **Habilitation.** Health care services that help you keep, learn, or improve skills and functioning for daily living. CHP+ does not cover Habilitation Services.
- **Hair Loss Treatments.** The Health Plan does not cover treatment for hair loss even if there is a prescription and a medical reason for the hair loss.
- **Hypnosis.** The Health Plan does not cover services related to hypnosis whether for medical or anesthesia purposes.
- **Illegal Conduct.** The Health Plan does not cover any loss caused by attempting or committing a felony or engaging in an illegal occupation.
- **Infant Formula.**
- **Infertility Services.**

- **Intermediate Care.** The Health Plan does not cover care in an intermediate care facility.
- **Non-Medical Case Management.**
- **Nutritional Therapy.**
- **Personal Comfort and Convenience Items.**
- **Private Duty Nursing Services.**
- **Routine Foot Care Services.** The Health Plan does not cover routine foot care services that are not Medically Necessary.
- **Services for Members in the Custody of Law Enforcement Officers.** Health Plan does not cover Out-of-Network Provider services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers. This does not apply to services that are covered as out-of-Network Emergency Services or out-of-Network Urgent Care Services.
- **Services Not Available in our Service Area.** The Health Plan does not cover services not generally and customarily available in our Service Area. This does not apply when it is generally accepted medical practice in our Service Area to refer patients outside our Service Area for the service.
- **Services Related to a Non-Covered Service.** When a service is not covered, all services related to it are also not covered. This does not include services we would cover to treat complications as a result of the Non-Covered Service.
- **Sex change operations.** The Health Plan does not cover sex change operations, preparation for a sex change operation, complications arising from a sex change operation, or reversals of sex change operations.
- **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements. This includes, but is not limited to, those for:
  - Employment;
  - Participation in employee programs;

- Insurance;
- Disability;
- Licensing;
- School events, sports, or camp;
- Governmental agencies;
- Court order, parole, or probation;
- Travel.

- **Travel and Lodging Expenses.** The Health Plan does not cover travel and lodging expenses. We may pay certain expenses we preauthorize as part of the Health Plan's internal travel and lodging guidelines.

- **Unclassified Medical Technology Devices and Services.** This Health Plan does not cover Medical technology devices and services that are not 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 the Health Plan.

- **Weight Management Facilities.** This Health Plan does not cover services received in a weight management facility.

- **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 costs for any such services from the following sources:

  - Any source providing a Financial Benefit or from whom a Financial Benefit is due.
  - 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.

5. Rights and responsibilities

As a Member of Kaiser Permanente, you have certain rights and responsibilities. This chapter explains these rights and responsibilities. This chapter also includes legal notices that you have a right to as a Member of Kaiser Permanente.

Your rights

Kaiser Permanente CHP+ Members have these rights:

- be treated with respect for your personal dignity and the need for privacy.
- get information in a way that is easy for you to understand, like plain language, large print, another language, or through a TTY/TDY phone line.
- talk about Medically Necessary treatment options for your condition, regardless of cost or benefit coverage, with the information presented in a way that you can understand.
- be a part of deciding what is best to do for your health care.
- refuse recommended medical treatment or procedures.
- be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- get a copy of your or your minor child's(ren's) medical records and request corrections.
- obtain healthcare services in accordance with federal healthcare regulations for access and availability, care coordination, and quality.
- exercise these rights without any adverse effect on the way you are treated.

Your responsibilities

Kaiser Permanente CHP+ Members have these responsibilities:

- follow instructions and guidelines from people providing health care services.
- give your health care provider all information in order to care for you.
- keep appointments for care and to give required notice when canceling.
- pay your Copayment at the time Covered Services are rendered.
- read and understand all materials about your health care coverage and to share this information with your health care provider.
- notify us within 24 hours after receiving Emergency care without a Referral.
- treat the providers and Kaiser Permanente staff with respect and personal dignity.

Notice of Adverse Benefit Determination

Kaiser Permanente will send you a Notice of Adverse Benefit Determination (NABD) letter any time we deny, delay, terminate, or modify a request for health care services. You must file an Appeal within 60 calendar days from the date on the NABD letter you received.

If you disagree with our decision, you can always file an Appeal. See the Appeals section in Chapter 6 for important information on filing your Appeal. When we send you a NABD, it will inform you of all rights you have if you disagree with a decision we made.

Notice about changes to this Member Handbook

We, with the approval of the Department, can make changes to this Member Handbook at any time. We will let you know in writing of any changes 30 days before they happen.

6. Reporting and solving problems

There are two kinds of problems that you may have with Kaiser Permanente:

- A **Complaint** (or **Grievance**) is when you have a problem with Kaiser Permanente or a provider, or with the health care or treatment you got from a provider
- An **Appeal** is when you don't agree with our decision not to cover or change your services

You have the right to file Grievances and Appeals with Kaiser Permanente to let us know about your problem. This does not take away any of your legal rights and remedies. We will not discriminate or retaliate against you for complaining to us. Letting us know about your problem will help us improve care for all Members. You should always contact Kaiser Permanente to let us know about your problem. Call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**) to tell us about your problem.

Complaints

A Complaint (or Grievance) is when you have a problem or are unhappy with the services you are receiving from Kaiser Permanente or a provider. There is no time limit to file a Complaint.

You can file a Complaint with us any time by phone, in writing, in person, or online.

- **By phone:** Call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY 711). Give us your medical record number, your name, and the reason for your Complaint.
- **By mail:** Call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY 711) and ask to have a form sent to you. Also, your doctor's office

will have Complaint forms available. When you get the form, fill it out. Be sure to include your name, medical record number and the reason for your Complaint. Tell us what happened and how we can help you. Mail the form to **Customer Experience Department, Kaiser Foundation Health Plan of Colorado, 2500 South Havana Street, Aurora, CO 80014**

- **In person:** Request to meet with a Member Services staff member at a Kaiser Permanente Administrative office
- **Online:** Use the online form on our website at **kp.org**

Within 2 days of making your Complaint, we will send you a letter letting you know we are working on it. Within 15 days, we will send you another letter to tell you how we resolved your problem.

You can ask for more time to resolve your problem and we can ask for more time, up to 14 days, if more information is needed. We will send you a letter within 2 days if we need more time to solve your problem and will send you another letter when the problem is resolved.

If you need help filing your Complaint, we can help you. We can give you no-cost language services. For any questions, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**).

Appeals

An Appeal is different from a Complaint. An Appeal is a request for Kaiser Permanente to review and change a decision we made about coverage for a requested service. If we sent you a Notice of Adverse Benefit Determination (“NABD”) letter telling you we are continuing, denying, delaying, changing or ending a service, and you do not agree with our decision, you can file an Appeal. Your PCP or other provider can also file an Appeal for you with your written permission.

You must file an Appeal within 60 calendar days from the date on the NABD letter you received.

You can Appeal any of the following items:

- When we deny or limit a type or level of service you requested.

- When we reduce, suspend or stop a service that was previously approved.
- When we deny payment for any part of a service.
- When we do not provide or authorize (approve) services in a timely manner required by the state.
- When we do not act within timelines required by the state to resolve complaints and appeals, and provide notifications to you.
- When we deny your request to dispute your financial liability (your Copayment)

You can file an Appeal by phone, in writing, in person, or online:

- **By phone:** Call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**). Give your medical record number, your name, and the service you are appealing
- **By mail:** Call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**) and ask to have a form sent to you. Also, your doctor's office will have Appeal forms available. When you get the form, fill it out. Be sure to include your name, medical record number and the service you are Appealing. Mail the form to **Member Appeals Program, Kaiser Foundation Health Plan of Colorado, P.O. Box 378066 Denver Colorado 80237-8066**
- **In person:** Request to meet with a Member Services staff member at a Kaiser Permanente Administrative office
- **Online**: Use the online form on our website at **kp.org**

If you need help filing your Appeal, we can help you. We can give you no-cost language services. Call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**).

Within 2 days of getting your Appeal, we will send you a letter letting you know we got it. Within 10 days, we will send you the NABD letter with our decision. You can ask for more time for a decision on your Appeal and we can ask for more time, up to 14 days, if more information is needed. We will send you a letter within 2 days if we need more time to decide. We will resolve your Appeal before the extra time ends.

If you want or your doctor wants us to make a fast decision because the time it takes to resolve your Appeal would put your life, health, or ability to function in danger, you can ask for an expedited (fast) review. To ask for an expedited review, call Member Services at **303-338-3800** or toll-free **1-800-632-9700** (TTY **711**). We will make a decision within 72 hours of receiving your Appeal.

If you do not agree with a decision related to our decision on your Appeal, you have the right to request a State Review.

State Review

You have the right to ask for a State Review if you are not happy with our decision on your Appeal. The request for a State Review must be in writing after you receive your NABD letter with our decision on your Appeal.

A State Review means that a State Administrative Law Judge (ALJ) will review the decision on your Appeal.

You can have a representative help you with this process. You do not have to pay for a State Review hearing.

You need to ask for a State Review within 120 calendar days from the date you received the NABD letter with our decision on your Appeal. We may require you to pay for the cost of services if the final decision is not in your favor.

You can ask for a State Review by phone or mail.

- **By phone:** Call the Office of Administrative Courts at **303-866-2000**
- **By mail**: Fill out the form provided with your Appeals resolution notice. Send it to the address below:

  Office of Administrative Courts
  1525 Sherman Street, 4th Floor
  Denver, CO 80203
- **By fax:** Fax to the Office of Administrative Courts at **303-866-5909**

The Office of Administrative Courts will send you a letter that explains the State Review process and will set a date for your hearing. You can talk for yourself at a State Review

or you can have your representative talk for you. The ALJ will review our decision on your Appeal. Then the ALJ will make a decision. It could take up to 90 days for the judge to decide your case. We must follow what the judge decides.

If you want the Office of Administrative Courts to make a fast decision because the time it takes to have a State Review would put your life, health or ability to function fully in danger, you or your representative can contact the Office of Administrative Courts and ask for an expedited (fast) State Review. The Office of Administrative Courts must make a decision no later than 72 hours after it receives your request.

If you need help asking for a State Review, we can help you. We can give you no-cost language services. Call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Fraud, waste and abuse

If you suspect that a provider or a person who gets CHP+ has committed Fraud, waste or abuse, it is your responsibility to report it by calling Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Provider Fraud, waste and abuse includes:

- Falsifying medical records
- Prescribing more medication than is Medically Necessary
- Giving more health care services than Medically Necessary
- Billing for services that were not given
- Billing for professional services when the professional did not perform the service
- Offering free or discounted items and services to Members in an effort to influence which provider is selected by the Member
- Changing Member's Primary Care Provider without the knowledge of the Member

Fraud, waste and abuse by a person who gets benefits includes:

- Lending, selling, or giving a Health Plan ID card to someone else
- Getting similar or the same treatments or medicines from more than one provider
- Going to an emergency room when it is not an emergency
- Using someone else's Social Security number or Health Plan ID card or number

To report Fraud, waste and abuse, write down the name, address and ID number of the person who committed the Fraud, waste or abuse. Give as much information as you can about the person, such as the phone number or the specialty if it is a provider. Give the dates of the events and a summary of exactly what happened.

If you notice potential signs of misconduct, contact Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**.

7. General policy provisions

Access Plan

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

Access to services for foreign language speakers

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

Coordination of benefits

Being eligible for **CHP+** means you do not have any other health insurance. If you are covered by any other valid insurance, you will no longer be eligible for **CHP+**.

If you get any other health insurance, please call **Member Services** and the Department. If you are found to have other health insurance, your coverage will be

terminated (ended). The exceptions to have double coverage are Medicare and dental insurance.

Notice about third party liability

Someone other than you may be responsible for the cost of covered services that you received from us related to an injury or illness.

You must help if we discover another payer may be responsible. Please call **1-800-632-9700** (TTY **711**) if you have questions about third party liability.

If a third party is responsible for your injury or illness, we will still provide you covered services. We have the right to collect from a third party in your name and be repaid the cost for providing you covered services.

If a third party is responsible to make payments for any covered services, then the following must occur:

- You must repay the amount of benefits paid by the Health Plan in any settlement with the third party or the third party's insurance carrier.
- You must notify the Health Plan, in writing, of your claim against the third party.

You must follow any rules of a liable third party payer prior to receiving non-Emergency Services.

Contracts with Network Providers

Network Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee-for-service; and incentive payments. No financial incentives exist that encourage denials of coverage or service that result in decreased use of services. If you would like more information about the way Network Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

Our contracts with Network 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 Out-of-Network Providers. If our contract with any Network 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 Copayments, until we make arrangements for the Services to be provided by another Network Provider and so notify you.

Limitations

There may be events that cause a delay or cancellation of your Covered Services. Some examples include: major disaster; epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Network Facility; complete or partial destruction of facilities; and labor disputes not involving the Health Plan or Colorado Permanente Medical Group. We will use our best efforts to provide Covered Services or make an arrangement for you to receive the Covered Services.

In these instances, the Health Plan and Colorado Permanente Medical Group will not have any liability for any delay or failure in providing Covered Services. In the case of a labor dispute involving the Health Plan or Colorado Permanente Medical Group, we may postpone your care until the dispute is resolved if delaying your care is safe and will not be harmful to your health.

Surrogacy

Surrogacy is when a woman agrees to become pregnant and to give the baby to another person or couple who intend to raise the child. In a case where you receive payment to act as a surrogate, the Health Plan will seek repayment for Covered Services you receive. This includes the Services in connection with the conception, pregnancy, and/or delivery of the child. This amount would not exceed the payment you receive to act as a surrogate.

Evaluation of new and existing technologies

Kaiser Permanente has a rigorous process for monitoring and evaluating the clinical evidence for new medical technologies that are treatments and tests.

Governing law

This EOC will be governed by Colorado and federal law, and may be changed as those laws may require.

Nondiscrimination

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

Notices

Our notices to you will be sent to the most recent address we have for you. You are 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.

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 generally may access and receive copies of your PHI, update or amend your PHI, and ask us for an accounting of certain disclosures of your PHI. You also may request to receive confidential information at a different address or by another method.

We may use or disclose your PHI for treatment, payment and health care operations purposes. This includes quality improvement. Sometimes we may be required by law to give PHI to government agencies or in legal actions. We will not use or disclose your PHI for any other purpose without your (or your representative's) permission, except as described in our *Notice of Privacy Practices* (see below). Giving us permission is your choice.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy

practices and your rights regarding your PHI, is available and will be given to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Kaiser Permanente medical office building or on our website, kp.org.

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:

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

8. Important numbers and words to know

Important phone numbers

- Kaiser Permanente Member Services:
  - ♦ English **303-338-3800** or toll-free **1-800-632-9700** (and more than 150 languages using interpreter services)
  - ♦ TTY **711**
- Kaiser Permanente Appointments and Advice **303-338-4545** or **1-800-218-1059** (TTY **711**)
- Kaiser Permanente Utilization Management **1-877-895-2705**
- Kaiser Permanente Transplant Offices **303-636-3131**
- Health First Colorado Enrollment **303-839-2120** or toll-free **1-888-367-6557**
- CHP+ Customer Service **1-800-359-1991**

Important websites

- Kaiser Permanente CHP+ website

  kp.org/Colorado-CHP

- CHP+ website

  hcpf.colorado.gov/child-health-plan-plus

- PEAK is a quick and easy way for people in Colorado to get answers to questions about eligibility

  Colorado.gov/peak

Words to know

American Indian: An individual, defined at title 25 of the U.S.C. sections 1603(c), 1603(f). 1679(b) or who has been determined eligible, as an Indian, pursuant to 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, to receive health care services from Indian health care providers (IHS, an Indian Tribe, Tribal Organization, or Urban Indian Organization–I/T/U) or through referral under Contract Health Services.

Appeal: A Member's request for Kaiser Permanente to review and change a decision made about coverage for a requested service.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Capitation: When providers are paid a set amount of money every month for each Member. This is called a Capitation payment.

CHP+ Provider Network (Network): A group of doctors, clinics, hospitals, and other providers contracted with Kaiser Permanente to provide care.

Complaint: A Member's verbal or written expression of dissatisfaction about Kaiser Permanente, a provider, or the quality of care or quality of services provided. A Complaint is the same as a Grievance.

Continuity of Care: The ability of a CHP+ Health Plan Member to keep getting services from their existing provider under certain situations without a break in service, if the provider and Health Plan agree.

Copayment (Copay): The dollar amount you must pay for a Covered Service, as listed in the CHP+ covered benefits summary.

Covered Services: The health care services provided to Members of Kaiser Permanente, subject to the terms, conditions, limitations and Exclusions of the CHP+ contract and Health Plan and as listed in this Member Handbook and any amendments.

Durable Medical Equipment ("DME"): Equipment that is Medically Necessary and ordered by your doctor or other provider. We decide whether to rent or buy DME. Rental costs must not be more than the cost to buy.

Early and periodic screening, diagnostic and treatment ("EPSDT"): EPSDT services are a benefit for CHP+ Members under the age of 21 to help keep you healthy. Members must get the right health check-ups for their age and appropriate screenings to find health problems and treat illnesses early.

Emergency Medical Condition: A medical or mental health condition with such severe symptoms, such as active labor or severe pain, that someone with a prudent layperson's knowledge of health and medicine could reasonably believe that not getting immediate medical care could:

- Place your health or the health of your unborn baby in serious danger
- Cause impairment to a body function
- Cause a body part or organ to not work right

Emergency Medical Transportation: Transportation in an ambulance or emergency vehicle to an emergency room to get emergency medical care.

Emergency Services: Care provided by a doctor (or staff under direction of a doctor as allowed by law) to find out if an Emergency Medical Condition exists, and that is a Medically Necessary service to make you clinically stable within the capabilities of the facility.

Excluded Services (Exclusions): Services not covered by Kaiser Permanente or by the Colorado CHP+ program; Non-Covered Services.

Family Planning: Medically Necessary services for Family Planning, like services to prevent or delay pregnancy.

Federally Qualified Health Center ("FQHC"): A health center in an area that does not have many health care providers. You can get primary and preventive care at an FQHC.

Formulary: A list of drugs or items that meet certain criteria and are approved for CHP+ Health Plan Members.

Fraud: An intentional act to deceive or misrepresent by a person who knows the deception could result in some unauthorized benefit for the person or someone else.

Grievance: A Member's verbal or written expression of dissatisfaction about Kaiser Permanente, a provider, or the quality of care or services provided. A Complaint is the same as a Grievance.

Habilitation Services: Health care services that help you keep, learn or improve skills and functioning for daily living.

HCPF: The Colorado Department of Health Care Policy and Financing (the Department). This is the State office that oversees the CHP+ program.

Health Insurance: Insurance coverage that pays for medical and surgical expenses by repaying the insured for expenses from illness or injury or paying the care provider directly.

Home Health Care: Skilled nursing care and other services given at home.

Hospice Care: Care to reduce physical, emotional, social, and spiritual discomforts for a Member with a terminal illness (not expected to live for more than 6 months).

Hospital Inpatient Care (Hospitalization): When you have to stay the night in a hospital or other place for the medical care you need.

Indian Health Care Provider ("IHCP"): A health care provider or program operated by the Indian Health Service (HIS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization.

Indian Health Service: A federal agency within the U.S. Department of Health and Human Services that is responsible for providing health services to American Indians and Alaska Natives

Kaiser Permanente: Kaiser Foundation Health Plan, Inc., and Colorado Permanente Medical Group. Kaiser Permanente is a health plan for CHP+.

Kaiser Permanente CHP+ Health Plan (Health Plan): Kaiser Foundation Health Plan, Inc. is a Colorado nonprofit corporation. In this Member Handbook, "we," "us," or "our" means Kaiser Foundation Health Plan, Inc.

Medically Necessary (or **Medical Necessity):** A service is Medically Necessary if:

- It is consistent with the symptoms, diagnosis, and treatment of a Member's medical condition.
- It is consistent with accepted standards of medical practice.
- It is not experimental, investigational, unproven, unusual, or not customary.
- It is not solely for cosmetic purposes.
- It is not solely for the convenience of the Member, physician, or other provider.

- It is the most appropriate level of care that can be safely provided to the Member.
- Failure to provide the Covered Service would adversely affect the Member's health.
- When applied to inpatient care, Medically Necessary further means that Covered Services cannot be safely provided in an ambulatory setting.

The fact that a provider may prescribe, order, recommend, or approve a service does not of itself make the service Medically Necessary.

Member: Any eligible CHP+ beneficiary enrolled with Kaiser Permanente who is entitled to receive Covered Services. In this Member Handbook, "you" means a Member.

Network Facility: Any facility listed in our Provider Directory that is part of our Network. This does not include facilities with whom we contract only to provide Referral services. Network Facilities are subject to change at any time without notice. For the current locations of Network Facilities, please call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**) or find the Provider Directory online at **kp.org/Colorado-CHP** under CHP+ Resources. If you need a printed Provider Directory, call Member Services at **303-338-3800** or toll-free at **1-800-632-9700** (TTY **711**).

Network Provider: A doctor or other licensed health care professional who is contracted with Health Plan to offer Covered Services to Members at the time a Member receives care. This does not include providers who contract only to provide Referral services. Network Providers may change during the year.

Non-Covered Service: A service that Kaiser Permanente does not cover.

Notice of Adverse Benefit Determination: If Health Plan does not approve a request for services, we will send you a Notice of Adverse Benefit Determination ("NABD") letter. This letter will tell you how to file an Appeal if you do not agree with the decision.

Orthotic Device: A device used as a support or brace affixed externally to the body to support or correct an acutely injured or diseased body part and that is Medically Necessary for the medical recovery of the Member.

Out-of-Network Facility: A facility that is not part of the CHP+ Provider Network.

Out-of-Network Provider: A provider who is not part of the CHP+ Provider Network.

Outpatient Care: When you do not have to stay the night in a hospital or other place for the medical care you need.

Outpatient Mental Health Services: Outpatient services for Members with mental health conditions including:

- Individual or group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication therapy
- Psychiatric consultation
- Outpatient laboratory services

Palliative Care: Care to reduce physical, emotional, social, and spiritual discomforts for a Member with a serious illness.

Physician Services: Services given by a person licensed under state law to practice medicine or osteopathy, not including services offered by doctors while you are admitted in a hospital.

Post-Stabilization Care Services: Covered Services related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 C.F.R. § 438.114(e), to improve or resolve the Member's condition.

Pre-Approval (or Prior Authorization): Your PCP must get approval from Health Plan before you get certain services. Health Plan will approve only the services you need. We will not approve services by Out-of-Network Providers or Out-of-Network Facilities if we believe you can get comparable or more appropriate services through Network Providers. A Referral is not an approval. You must get Prior Authorization from Health

Plan for certain services. A Prior Authorization is limited to a specific Service, treatment or series of treatments, and period of time.

Prescription Drug: A drug that legally requires an order from a licensed provider to be dispensed, unlike an over-the-counter ("OTC") drug that does not require a prescription.

Primary Care Provider ("PCP"): A physician, a physician group practice, or an appropriately licensed health care professional, who has entered into a professional service agreement to serve the Members of Kaiser Permanente, and has been designated by Kaiser Permanente, and selected by the Member as the provider who will attend to the Member's routine medical care and supervise and/or coordinate the delivery of all Medically Necessary Covered Services to the Member.

Prosthetic Device: An artificial device attached to the body to replace a missing body part.

Provider Directory: A list of physicians, hospitals, pharmacies, physician assistants, certified nurse practitioners, or other licensed, certified, or registered health care professionals or facilities that have entered into a professional service agreement with us to provide Covered Services for our CHP+ Health Plan Members.

Reconstructive Surgery: Surgery to correct or repair abnormal structures of the body to improve function or create a normal appearance to the extent possible. Abnormal structures of the body are those caused by a congenital defect, developmental abnormalities, trauma, infection, tumors, or disease.

Referral: A document from a provider that recommends or provides permission for a Member to receive additional services. When your PCP says you need Covered Services not available from us, they can request that you get care from another provider. Some Covered Services require a Referral and a Pre-Approval. The Referral needs to be approved by Health Plan. Not all Referrals are approved. If you do not get a written approval, you may need to pay for the services you receive. See Chapter 3 ("How to get care") for more about services that require Referrals or Pre-Approval.

Rehabilitation Services: Services and devices to help people with injuries, disabilities, or chronic conditions to gain or recover mental and physical skills.

Routine Care: Services and preventive care, well child visits, or care such as routine follow-up care. The goal of Routine Care is to prevent health problems.

Service Area: The geographic area for the Kaiser Permanente CHP+ Health Plan: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, and Jefferson County. You must live within this area to enroll and stay enrolled in the Kaiser Permanente CHP+ Health Plan.

Skilled Nursing Facility: A place that gives 24-hour-a-day nursing care that only trained health professionals may give.

Specialist: A doctor who treats certain types of health care problems. For example, an orthopedic surgeon treats broken bones; an allergist treats allergies; and a cardiologist treats heart problems. In most cases, you will need a Referral from your PCP to see a Specialist.

Urgent Care Services: Services provided to treat a non-emergency illness, injury or condition that requires medical care. You can get Urgent Care from a Network Facility or Out-of-Network Facility.

Urgent Medical Condition: A medical condition that has the potential to become an Emergency Medical Condition in the absence of treatment.

KAISER PERMANENTE®

Surprise Billing -- Know your rights

Beginning January 1, 2020, Colorado state law protects you from "surprise billing". This is sometimes called "balance billing" and it may happen when you receive covered services, other than ambulance services, from an out-of-network provider in Colorado. **This law does not apply to all health plans and may not apply to out-of-network providers located outside of Colorado. Check to see if you have a "CO-DOI" on your ID card; if not, this law may not apply to your health plan.**

What is surprise/balance billing and when does it happen?

You are responsible for the cost-sharing amounts required by your health plan, including copayments, deductibles, and/or coinsurance. If you are seen by a provider or use services in a hospital or other type of facility that are **not** in your health plan's network, you may have to pay additional costs associated with that care. These providers or services at hospitals and other facilities are sometimes referred to as "out-of-network".

Out-of-network hospitals, facilities, or providers often bill you the difference between what Kaiser Permanente decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

When you CANNOT be balance-billed:

Emergency Services

When you receive services for emergency medical care, usually the most you can be billed for emergency services is your plan's in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be balance-billed for any other amount. This includes both the emergency facility and any providers you may see for emergency care.

Non-emergency Services at an In-Network or Out-of-Network Facility

The hospital or facility must tell you if you are at an out-of-network location or at an in-network location that is using out-of-network providers. It must also tell you what types of services may be provided by any out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is not available. When this happens, the most you can be billed for **covered** services is your in-network cost-sharing amount (copayments, deductibles, and/or coinsurance). These providers cannot balance bill you.

Additional Protections

- Kaiser Permanente will pay out-of-network providers and facilities directly. Again, you are responsible only for paying your in-network cost-sharing for covered services.
- Kaiser Permanente will count any amount you pay for emergency services or certain out-of-network services (described above) toward your **in-network** deductible and out-of-pocket limit.
- Your provider, hospital, or facility must refund any amount you overpay within 60 days of your reporting the overpayment to them.
- A provider, hospital, or other type of facility cannot ask you to limit or give up these rights.

If you receive services from an out-of-network provider, hospital, or facility in any OTHER situation, you may still be balance-billed, or you may be responsible for the entire bill. If you intentionally receive non-emergency services from an out-of-network provider or facility, you may also be balance-billed.

If you do receive a bill for amounts other than your copayments, deductibles, and/or coinsurance, please contact us at the number on your ID card, or the Division of Insurance at **303-894-7490** or **1-800-930-3745 (TTY 711)**.

Ambulance Information: You may be balance-billed for emergency ambulance services you receive if the ambulance service provider is a publicly funded fire agency, but state law against balance billing does apply to private companies that are not publicly funded fire agencies. Non-emergency ambulance services, such as ambulance transport between hospitals, are not subject to the state law against balance billing, so if you receive such services and they are not a service covered by Kaiser Permanente, you may receive a balance bill.

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

If you need these services, call **1-800-632-9700** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 2500 S. Havana St., Aurora, CO 80014, or by phone at Member Services: **1-800-632-9700**.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov**, or by mail or phone at:
U.S. Department of
Health and Human Services,
200 Independence Ave. SW, Room 509F,
HHH Building,
Washington, DC 20201,
1-800-368-1019, **1-800-537-7697** (TDD).
Complaint forms are available at **hhs.gov/ocr/filing-with-oc**

HELP IN YOUR LANGUAGE

Attention: If you speak English, language assistance services, free of charge, are available to you.
Call **1-800-632-9700** (TTY **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ
1-800-632-9700 (TTY **711**).

ملحوظة: (Arabic) العربية
إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية
تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY **711**)

Bǎsɔ́ ɔ̀ Wù ɖù (Bassa) Dè ɖɛ nià kɛ dyéɖé gbo:
Ɔ jǔ ké mɛ̀Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn mgbo kpáa. Đá **1-800-632-9700** (TTY **711**)

中文 (Chinese) 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-800-632-9700
(TTY **711**) 。

فارسی (Farsi) توجه:
اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.با
1-800-632-9700 (TTY **711**) تماس بگیرید.

Français (French) ATTENTION:
Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **711**).**日本語 (Japanese) 注意事項**: 日本語を話さる場合、無料の言語支援をご利用いただけます。**1-800-632-9700** (TTY **711**) まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용 하실 수 있습니다.
1-800-632-9700
(TTY **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę́', t'áá jiik'eh, éí ná hól ọ́, koj ị' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस् : तपा ंले नेपाली बोल्नुहुन्छ भने तपा को ननमतत भाषा सहायता सेवाह न शुल्क पमा उपलब्ध छ । **1-800-632-9700** (TTY **711**) फोन गनहोस ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA:
Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama.
Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ:
если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN:
si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al
1-800-632-9700 (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).