Sandia National Laboratories

NTESS
Kaiser Permanente
Benefit Summary
(Non-Represented Employees, PreMedicare Retirees, Survivors, Long Term Disability Terminees)
Revised: January 1, 2023

IMPORTANT

This Benefit Summary applies to eligible Employees and PreMedicare Retirees, Survivors, and Long Term Disability Terminees effective January 1, 2023.

For more information, refer to the NTESS Health and Welfare Benefits Plan for Active Employees Summary Plan Description or the NTESS Post-Employment Health and Welfare Benefits Plan Summary Plan Description.

The Total Health PPO Plan is maintained at the discretion of NTESS and is not intended to create a contract of employment and does not change the at will employment relationship between You and NTESS. The NTESS Board of Managers (or designated representative) reserves the right to amend(in writing) any or all provisions of the Total Health PPO Plan, and to terminate (in writing) the Total Health PPO Plan at any time without prior notice, subject to applicable collective bargaining agreements.

The Total Health PPO Plan terms cannot be modified by written or oral statements to You from human resources representatives or other NTESS personnel.

U.S. DEPARTMENT OF ENERGY

National Nuclear Security Administration

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Section 1: Introduction

This summary highlights healthcare benefits of the Total Health PPO Plan ("the Program"), a component of the NTESS Health and Welfare Benefits Plan for Active Employees (the "Employee H&W Plan") (ERISA Plan 540) and the NTESS Post-Employment Health and Welfare Benefits Plan (the "Post-Employment H&W Plan") (ERISA Plan 545). This Benefit Summary is part of the Employee H&W Plan Summary Plan Description (the "Employee H&W Plan SPD") and the Post-Employment H&W Plan Summary Plan Description (the "Post-Employment H&W Plan SPD"). It contains important information about Your NTESS or "Company" healthcare benefits.

Certain capitalized words in this Benefit Summary have special meaning. These words have been defined in Section 13: Definitions.

When the words "we," "us," "our," and "the Company" are used in this document, we are referring to NTESS. When the words "You" and "Your" are used throughout this document, we are referring to people who are Covered Members as defined in Section 13: Definitions.

Many sections of this Benefit Summary are related to other sections of the Benefit Summary and to information contained in the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD. You will not have all of the information You need by reading only one section of one booklet.

Refer to the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for information about eligibility, enrollment, disenrollment, premiums, termination, coordination of benefits, subrogation and reimbursement rights, when coverage ends, continuation of coverage provisions, and Your rights under the Employee Retirement Income Security Act of 1974 (ERISA) and the Affordable Care Act (ACA).

To receive a paper copy of this Benefit Summary, other Benefit Summaries, the Employee H&W Plan SPD, or the Post-Employment H&W Plan SPD, contact HR Solutions at 505-284-4700. These documents are also available electronically at hr.sandia.gov.

Since these documents will continue to be updated, it is recommended to check back on a regular basis for the most recent version. The Company reserves the right to amend, reduce, suspend or terminate any of the terms or coverage of the Employee H&W Plan and Post-Employment H&W Plan.

Language Assistance

SPANISH (Español): Para obtener asistencia en Español, llame al 866-213-3062

TAGALOG (Tagalog): Kung kailangan 7resc ang tulong sa Tagalog tumawag sa 866-213-3062

CHINESE (**中文**): **如果需要中文的帮助**,请拨打这个号码 866-213-3062

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 866-213-3062

Section 2: Total Health PPO Plan Design

Effective Date: January 01, 2023

This is a summary of benefits for Your Total Health PPO Kaiser Permanente deductible exclusive provider network plan with out-of-network benefits.

Overall Plan Features		
Benefit Type	**In-Network**	**Out-of-Network**
Plan Accumulation Type	Calendar Year	Calendar Year
Annual Plan Deductible		
Per Employee	$750	$2,000
Employee + Spouse or Child(ren)	$1,500	$4,000
Employee + Spouse and Child(ren)	$2,250	$6,000
Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.		
Plan Deductible Accumulates to Out-of-Pocket Limit	Yes	Yes
Annual Medical Out-of-Pocket Limit		
Per Employee	$2,750	$6,500
Employee + Spouse or Child(ren)	$5,500	$13,000
Employee + Spouse and Child(ren)	$8,250	$19,500
Pocket Limit The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.		
See Outpatient Pharmacy section for separate Prescription Drug Out-of-Pocket Limit (accumulates separately from Medical Out-of-Pocket Limit above).		
Visits: If multiple visits occur on the same day, each visit counts toward the applicable benefit limit.		

ROUTINE PREVENTIVE EXAMS AND SERVICES – See Preventive Exams and Services for a comprehensive list of Preventive Services. Preventive Lab and X-ray screenings not specifically listed within the Preventive Care section are treated the same as non-preventive Lab and X-ray services. Frequency and Age Limits managed by Network Provider except where noted. See Preventive Care.

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Wellness exams – adults (including well woman)	$0	40%	No	No	Yes	Yes
Wellness exams – children	$0	40%	No	No	Yes	Yes
Preventive screenings	$0	40%	No	No	Yes	Yes
Immunizations–preventive Adults andchildren	$0	40%	No	No	Yes	Yes
Health education andself-management classes	$0	40%	No	No	Yes	Yes

OUTPATIENT SERVICES (Office or Outpatient Facility/ Clinics, any Non-Inpatient setting)
Primary Care Cost Share will be charged for family practice, general internal medicine and general pediatrics specialties. Specialty Care Cost Share will be charged for visits with all other medical specialties except mental health providers are considered to be Primary Care providers for the purposes of determining Participant cost share. Note: nurse practitioner and physician assistant may betreated as primary or specialty based on their supervising physician status.

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Office Visits						
Office visits/clinics (including House Calls)	20%	40%	Yes	Yes	Yes	Yes
Telemedicine	$0	40%	No	Yes	Yes	Yes
Referred Hospital Clinic Visits						
Provider	20%	40%	Yes	Yes	Yes	Yes
Facility clinic charges	20%	40%	Yes	Yes	Yes	Yes
Allergy (office visit cost share may apply)						
Injection	20%	40%	Yes	Yes	Yes	Yes
Testing	20%	40%	Yes	Yes	Yes	Yes
Serum only	20%	40%	Yes	Yes	Yes	Yes
Biofeedback services Medical and Mental health provider	Not covered	Not covered	N/A	N/A	N/A	N/A
Cardiac rehab	20%	40%	Yes	Yes	Yes	Yes
Chemotherapy services	20%	40%	Yes	Yes	Yes	Yes

Benefit Type	In- Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies to Medical OOP
Dialysis services	20%	40%	Yes	Yes	Yes	Yes
Home dialysis	20%	40%	Yes	Yes	Yes	Yes
Family Planning						
Reversal of prior sterilization	20%	40%	Yes	Yes	Yes	Yes
Hearing exam audiometry exam	20%	40%	Yes	Yes	Yes	Yes
Infusion Services (requires skilled or medical administration Office visit cost share may apply)						
Infusion	20%	40%	Yes	Yes	Yes	Yes
Home infusion (infusion materials, drugs, and supplies)	20%	40%	Yes	Yes	Yes	Yes
Injections and Immunizations Non-routine. Office visit cost share may apply						
Injection	20%	40%	Yes	Yes	Yes	Yes
Travel Immunizations Office visit cost share may apply						
Injection	20%	40%	Yes	Yes	Yes	Yes
Male Sterilization						
Outpatient Surgery	20%	40%	Yes	Yes	Yes	Yes
Nutritional visits	$0	40%	No	Yes	Yes	Yes
Radiation therapy	20%	40%	Yes	Yes	Yes	Yes
Respiratory/ pulmonary therapy	20%	40%	Yes	Yes	Yes	Yes
UV Light Treatment Medically Necessary Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if the equipment has been approved for you through the Plan's prior authorization process.						
UV Light Therapy (in the Office) (Office Visit Cost Share may apply)	20%	40%	Yes	Yes	Yes	Yes
UV Light Therapy Box (for Home Use)	20%	40%	Yes	Yes	Yes	Yes
Vision Refraction Exam						
Office visit cost share- adult, age 19 and greater	Not covered	Not covered	N/A	N/A	N/A	N/A
Office visit cost share- pediatric, ages 0-18	Not covered	Not covered	N/A	N/A	N/A	N/A
Note: Medical care for eye illness or injury is covered under the medical benefit by provider specialty.						
Orthoptics Treatment/Therapy	20%	40%	Yes	Yes	Yes	Yes

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
DIAGNOSTIC TESTS & PROCEDURES Includes Preventive Lab and X-ray screenings not specifically listed under Preventive Screenings. These services are treated the same as Lab and X-ray services in this section.						
Diagnostic lab & X-ray	20%	40%	Yes	Yes	Yes	Yes
High tech/advanced radiology – CT, MRI, Nuclear Medicine and PET	20%	40%	Yes	Yes	Yes	Yes
Colonoscopy						
Preventive	$0	$0	No	No	No	No
Diagnostic	20%	20%	Yes	Yes	Yes	Yes
3D Mammography						
Preventive	$0	$0	No	N/o	No	No
Diagnostic	20%	20%	Yes	Yes	Yes-	Yes
HOSPITAL/SURGERY SERVICES						
Inpatient Hospital Includes room and board for private and semiprivate rooms; ICU/CCU, acute rehab, inpatient professional services, andancillary services and supplies. Per admission.	20%	40%	Yes	Yes	Yes	Yes
Ambulance						
Emergency ground and air ambulance	20%	20%	Yes	Yes	Yes	Yes
Scheduled ground and air ambulance	20%	20%	Yes	Yes	Yes	Yes
Non-network or networkhospital to network hospital (repatriation)	20%	20%	Yes	Yes	Yes	Yes
Emergency services accident and illness	20%	20%	Yes	Yes	Yes	Yes
Urgent and after-hours care	20%	20%	Yes	Yes	Yes	Yes
Outpatient surgery Performed in outpatient hospital or ambulatory surgery center.	20%	40%	Yes	Yes	Yes	Yes
Abortion (Elective, Medically Necessary)						
Outpatient surgery	20%	40%	Yes	Yes	Yes	Yes
Inpatient hospital per admission	20%	40%	Yes	Yes	Yes	Yes

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Bariatric Surgery Office visit, outpatient surgery, inpatient hospital per admission	20%	40%	Yes	Yes	Yes	Yes
Gender Affirming Surgery (covered upper and lower body gender confirming surgeries), Outpatient Surgery, Inpatient Hospital per admission	20%	40%	Yes	Yes	Yes	Yes
Temporomandibular surgery (TMD/TMJ), office visit, outpatient surgery, inpatient hospital per admission	20%	40%	Yes	Yes	Yes	Yes
Organ Transplants Organ acquisition, diagnostic testing for donor and recipient, office visit, outpatient surgery, inpatient hospital	20%	40%	Yes	Yes	Yes	Yes
Bone marrow or stem cell donor search limits	$25,000 Benefit Lifetime Maximum					
Travel and Lodging for Organ Transplants (for recipient, care-giver and donor)						
Transportation limits, lodging limits	$10,000 per Lifetime shared between Transportation and Lodging	Not covered	N/A	N/A	N/A	N/A
Daily Expense Limits (Daily expenses include incidental expenses such as meals and does not include personal expenses).	Reimbursement up to $50 per day perperson	Not covered	N/A	N/A	N/A	N/A

MATERNITY Includes most routine pre-natal and post-partum care. Delivery charges and non-routine maternity care and routine care not included under Preventive Care would be covered at the appropriatecost share.						
Benefit Type	**In-Network**	**Out- of-Network**	**In-Network**		**Out-of-Network**	
			Applies to Medical Deductible	**Applies to Medical OOP**	**Applies to Medical Deductible**	**Applies Medical to OOP**
Routine Pre-Natal and Post-Partum Care						
Visit to confirm pregnancy	20%	40%	Yes	Yes	Yes	Yes
Pre-natal and first post-partum visit	$0	40%	No	No	Yes	Yes
Note: For pregnancy related preventive tests please see preventive list at the end of this benefit summary.						
Hospital Inpatient. Includes contracted birthing center per admission (facility includes Well baby facility fees when billed with mother)	20%	40%	Yes	Yes	Yes	Yes
Well Newborn	$0	40%	Yes	$0	Yes	Yes
Home Birth	20%	20%	Yes	Yes	Yes	Yes
FERTILITY SERVICES For fertility services include those related to or part of artificial insemination, surgery, IVF/ZIFT and fertility drugs. Services to rule out the underlying medical causes of Infertilityare part of the medical benefit. Fertility drugs see Pharmacy section. Prescription drugs obtained through the Prescription Drug Program and used for infertility treatment may require a diagnosis of infertility.						
Hospital charges, per admission	20%	40%	Yes	Yes	Yes	Yes
Office visit cost share	20%	40%	Yes	Yes	Yes	Yes
Diagnostic lab & X-ray	20%	40%	Yes	Yes	Yes	Yes
Outpatient hospital or ambulatory surgery center	20%	40%	Yes	Yes	Yes	Yes
Assisted Reproductive Technology: IVF, ZIFT (includes fertility preservation)	20%	40%	Yes	Yes	Yes	Yes
Artificial insemination	20%	40%	Yes	Yes	Yes	Yes
Acquisition of eggs and sperm	20%	20%	Yes	Yes	Yes	Yes
Embryo storage andpreservation	20%	20%	Yes	Yes	Yes	Yes
Benefit lifetime maximum-All FertilityServices	$30,000					
Benefit Lifetime Maximum - Shared with Outpatient Prescription Drug Services	No					

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medicalto OOP
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES						
Mental health – inpatient (including residential treatment services)	20%	40%	Yes	Yes	Yes	Yes
Partial hospitalization	20%	40%	Yes	Yes	Yes	Yes
Mental health – intensiveoutpatient	20%	40%	Yes	Yes	Yes	Yes
Mental Health – Outpatient/Office						
Individual visit costshare	20%	40%	Yes	Yes	Yes	Yes
Group visit cost share	20%	40%	Yes	Yes	Yes	Yes
Substance use disorder services – inpatient: detox covered under medical benefits (including residential treatment services)	20%	40%	Yes	Yes	Yes	Yes
Substance use disorder services – partial hospitalization	20%	40%	Yes	Yes	Yes	Yes
Substance use disorder services – intensive outpatient – Includes all Services provided during the day	20%	40%	Yes	Yes	Yes	Yes
Substance Use Disorder Services – Outpatient/Office						
Individual visit costshare	20%	40%	Yes	Yes	Yes	Yes
Group visit cost share	20%	40%	Yes	Yes	Yes	Yes
PHYSICAL, OCCUPATIONAL, & SPEECH THERAPIES Outpatient Cost Share for Rehabilitative and Habilitative therapies are applied as one Copay per provider per day. Visits are counted on a 'per visit' basis.						
Physical therapy	20%	40%	Yes	Yes	Yes	Yes
Visit maximum	None	None	N/A	N/A	N/A	N/A
Occupational therapy	20%	40%	Yes	Yes	Yes	Yes
Visit maximum	None	None	N/A	N/A	N/A	N/A

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Speech therapy	20%	40%	Yes	Yes	Yes	Yes
Visit maximum	None	None	N/A	N/A	N/A	N/A
SKILLED CARE						
Home health care, nurse visits (2 hours),aide visits (4 hours), therapy visits and associated supplies.	20%	40%	Yes	Yes	Yes	Yes
Visit maximum	None	None	N/A	N/A	N/A	N/A
Hospice	20%	40%	Yes	Yes	Yes	Yes
Respite care for home hospice	20%	40%	Yes	Yes	Yes	Yes
Respite care for home hospice maximum	Up to five consecutive days for each approved admission	Up to 5 consecutive days for each approved admission	N/A	N/A	N/A	N/A
Skilled nursing facility	20%	40%	Yes	Yes	Yes	Yes
Day maximum	None	None	N/A	N/A	N/A	N/A
OTHER SERVICES						
Chiropractic care (self-referred visits)	20%	40%	Yes	Yes	Yes	Yes
Benefit maximum – only spinal manipulation applies	$750 per calendar year	N/A	N/A	N/A	N/A	N/A
Acupuncture (self-referred visits)	20%	40%	Yes	Yes	Yes	Yes
Benefit maximum – X-rays do not apply	$750 per calendar year	N/A	N/A	N/A	N/A	N/A

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Dental services Provided by a DDS or DMD not covered under Medical Care. See Summary Plan Description.	20%	40%	Yes	Yes	Yes	Yes
Accidental injury to teeth - Repair of sound and natural teeth directly related to an accidental injury. Office visit, outpatient surgery, inpatient hospital. Per admission *No annual maximum, time limit is 1 year from date treatment begins	20%	40%	Yes	Yes	Yes	Yes
Autism –						
Applied behavioralanalysis	20%	40%	Yes	Yes	Yes	Yes
Physical/occupational/ speech therapy	See PT/OT/ST No visit maximum					
Durable medical equipment (includes continuous glucose monitoring). See Preventive Care	20%	40%	Yes	Yes	Yes	Yes
Glucometers, Peak Flow Meters	$0	50% up to 30 Daysupply	No	Yes	No	No
Prosthetics and Orthotics – Includes medically necessaryeyewear for diagnoses of aniridiaand aphakia; colostomy/ ostomy and urological supplies	20%	40%	Yes	Yes	Yes	Yes
Orthopedic footwear	20%	20%	Yes	Yes	Yes	Yes
Hearing aids due to illness or injury (includes test to determine appropriatemodel, fitting, counseling, adjustment, cleaning and inspection after warranty is exhausted)	20%	40%	Yes	Yes	Yes	Yes

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Benefit allowance (per aid per year)*	Unlimited		N/A	N/A	N/A	N/A
Allowance frequencylimit	every 36 months		N/A	N/A	N/A	N/A
Age limit	Dependent children under the age of 21		N/A	N/A	N/A	N/A
Medical foods Amino acid modified products	20%	40%	Yes	Yes	Yes	Yes
Optical hardware. Initial pair of contact lenses or glasses when required due tocataract surgery	20%	20%	Yes	Yes	Yes	Yes
OUTPATIENT PRESCRIPTION DRUGS Obtained from Network Pharmacies and on the KP formulary (list of approved drugs), unless otherwise specified. Note: Member will pay their copay or the full cost of the medication, whichever is less.						
Outpatient Prescription Drugs Out of Pocket Limit						
Individual	$1,500	None	N/A	N/A	N/A	N/A
Family	$5,950	None	N/A	N/A	N/A	N/A
3 Tier						
Generic	20% up to 30 days' supply. 20% up to 100 days' supply	50% up to 30 days' supply	No	Yes	No	No
Per Prescription Maximum	$5 Min/$10 Max (Min/ Max applies p/30 days, p/17prescript ionn n) rolls upto 100 days	None	No	Yes	N/A	N/A
Formulary Brand	30% up to 30 days' supply 30% up to 100 days' supply	50% up to 30 days' supply	No	Yes	No	No

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Per Prescription Maximum	$30 Min/$45 Max (Min/Max applies p/30 days, p/ prescription) rolls up to 100 days	None	No	Yes	N/A	N/A
Non-Formulary Brand	40% up to 30 days' supply 40% up to 100 days' supply	50% up to 30 days' supply	No	Yes	No	No
Per Prescription Maximum	$50 Min/$75 Max (Min/Max applies p/30 days, p/ prescription) rolls up to 100 days	None	No	Yes	N/A	N/A
Note: Certain medications may be limited to 30 days' supply						
Mail Order Drugs						
Generic	20% up to 100 days $12.50 Min/$25 Max up to 100 Days' Supply	Not covered	No	Yes	N/A	N/A
Formulary Brand	30% up to 100 days $75 Min/$112.50 Max up to 100 Days	Not covered	No	Yes	N/A	N/A
Non-Formulary Brand	40% up to 100 days $125 Min/$187.50 Max up to 100 Days	Not covered	No	Yes	N/A	N/A
Note: Certain medications may be limited to 30-day supply. Not all medications are available via Mail Order.						

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Blood Factors	$0	50% up to 30 days' supply	No	No	No	No
Diabetic Coverage (Some diabetic supplies may be covered under Durable Medical Equipment (DME))						
Oral medications and insulin	Applicable formulary generic/ brand/ non-formulary cost sharing	50%/up to 30 days' supply	No	Yes	No	No
Diabetic testing supplies (meters, test strips)	Applicable formulary generic/ brand/ non-formulary cost sharing	50%/up to 30 days' supply	No	Yes	No	No
Diabetic administration devices (syringes)	Applicable formulary generic/ brand/ non-formulary cost sharing	50%/up to 30 days' supply	No	Yes	No	No
Fertility drug coverage	Applicable formulary generic/ brand/ non-formulary cost sharing	50%/up to 30 days' supply	No	Yes	No	No
Lifetime Maximum	N/A	N/A	N/A	N/A	N/A	N/A
Fertility Preservation drugs	Generic/Brand/Non-Formulary Cost Share	50% up to 30 Day supply	No	Yes	No	No
Sexual dysfunction quantity. Limits apply	Applicable formulary generic/ brand/ non-formulary cost sharing	50%/up to 30 days' supply	No	Yes	No	No

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Weight loss	Applicable formulary generic/ brand/ non-formulary cost sharing	50%/up to 30 days' supply	No	Yes	No	No
Supplemental Preventive Drugs Includes formulary drugs for asthma, cholesterol, diabetes, hypertension, osteoporosis and stroke	Generic/Brand/Non-Formulary Cost Share	50% up to 30 Day supply	No	Yes	No	No
ACA Mandated Drugs*						
Contraceptive devices (diaphragms, cervical caps, etc.) and contraceptive drugs	Generic $0 Brand $0 Non-Formulary 40%	50%/up to 30 days' supply	No	No	No	No
Emergency contraception*	$0	50%/up to 30 days' supply	No	No	No	No
Preventive breast cancer drug	$0	50%/up to 30 days' supply	No	No	No	No
Smoking Cessation (includes Nicotrol NS nasal spray, inhaler kits 3 kits/30 days, max 360 days per lifetime). See Covered Preventive Medications	$0 (on preventive list formulary)	Not covered	No	No	No	No
Statins (cholesterol lowering agent)	$0 (on preventive list formulary)	50% up to 30 days' supply	No	No	No	No
PrEP for HIV Prevention (Covered as Preventive medication beginning 7/01/2020)	$0 (on preventive list formulary)	50% up to 30-day supply	No	No	No	No
Preventive over the counter products-covered at a network pharmacy when prescribed by Your provider for certain conditions						
Aspirin	$0	Not covered	No	No	N/A	N/A
Oral fluoride	$0	Not covered	No	No	N/A	N/A
Folic acid	$0	Not covered	No	No	N/A	N/A

Benefit Type	In-Network	Out- of-Network	In-Network		Out-of-Network	
			Applies to Medical Deductible	Applies to Medical OOP	Applies to Medical Deductible	Applies Medical to OOP
Iron supplements	$0	Not covered	No	No	N/A	N/A
Female contraceptives (spermicide, male and female condoms, and sponges)**	$0	Not covered	No	No	N/A	N/A
Bowel Prep	$0	Not covered	No	No	No	No
Generic bowel cleanser	$0	Not covered	No	No	N/A	N/A
* With prescription, no cost share. Without prescription, participant pays retail cost.						
**Except for Contraceptive foams, jellies, and ointments which are not covered.						
*** For more information, see the appropriate Summary Plan Description: Employee H&W Plan SPD or the Post-Employment H&W Plan SPD.						
+ Out-of-network care is subject to retrospective review for medical necessity. You will be responsible for any services determined to be not medically necessary.						
For items or injections dispensed by Pharmacy and requiring skilled administration in the Physician's Office (Implantable contraceptives, administered meds, etc.) Office Visit Cost Share for administration may apply.						
Note: Kaiser Permanente's EPO Provider Network will be utilized for in-network services.						

Section 3: How to Obtain Services

In-Network Services

This section describes how to access medical and behavioral healthcare under the in-network and out-of-network options, Prior Authorization and referral requirements, predetermination of benefits, accessing non-emergency services or non-Urgent Care while away from home, the Kaiser Permanente Provider Network, and other general information including the Prescription Drug Program.

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

In-Network and Out-of-Network Options

The Total Health PPO Plan provides both in-network and out-of-network benefits. You may select providers either in-network or out-of-network, however using Your in-network benefit allows You to receive the maximum available benefit.

Note: You can use the in-network or out-of-network option at any time during the year, any time You need medical care. Out-of-network care is subject to retrospective review for medical necessity. You will be responsible for any services determined to not be medically necessary.

The in-network option provides You access to physicians, facilities, and suppliers who are Kaiser Permanente Network Providers. Some procedures may require Prior Authorization or a referral.

The advantages of using the in-network option include:

- Lower Coinsurance You will pay
- Lower Out-of-Pocket Limits
- No responsibility for amounts exceeding Eligible Charges
- Certain preventive care services covered at 100%
- Generally, no claims to file

The out-of-network option offers a lower level of benefit but enables You to get Covered Services from licensed providers outside Kaiser Permanente's Network Provider. You are responsible for Deductibles, Coinsurance, and amounts exceeding Eligible Charges. You are also responsible for filing all claims not filed by the provider and must obtain Retro Authorization of Medical Necessity in order to be eligible for full out-of-network benefits.

If You are admitted to a hospital for an Emergency Medical Condition that is out-of-network and services are covered, in-network benefits will be paid until You are stabilized. Once stabilized, You must be moved to a Network Hospital to continue in-network benefits. You may elect to remain in the out-of-network hospital and receive out-of-network benefits, as long as Your Network Physician determines the treatment to be Medically Necessary.

Prior Authorization and Referral Requirements for Covered In-Network Services

IMPORTANT: Just because a service or procedure does not require Prior Authorization does not mean that it is a Covered Service.

Referrals for the In-Network Plan Level

Under the in-network Plan level, You are required to obtain a referral from Your Network Physician prior to receiving certain specialty care services under the in-network plan level. If You receive certain specialty care services for which You did not obtain a referral, You will be responsible for all of the charges associated with those services.

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

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

In-Network Self Referrals

You do not need a referral or Prior Authorization to receive care from any of thefollowing in-network Providers:

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

Although a referral or prior authorization is not required to receive care from these in-network providers, the provider may have to get Prior Authorization for certain services.

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

Northwest Region

- Cancer counseling
- Occupational health
- Ophthalmology
- Social services

Georgia Region

- Dermatology
- Ophthalmology

Colorado Region

- Denver/Boulder service area

  You may self-refer for consultation (routine office) visits to specialty-care departments within Kaiser Permanente with the exception of the anesthesia clinical pain department, laboratory, and radiology and for specialty procedures such as a CT scan, MRI, colonoscopy, or surgery.

- Northern and Southern Colorado service areas

  You may self-refer for consultation (routine office) visits to Plan Physician specialty-care providers identified as eligible to receive direct referrals in the Provider Directory www.kp.org, click *"Find a Doctor"*.

Prior Authorizations for the In-Network Plan option

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

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

For care received in a Kaiser Permanente facility or by Kaiser Permanente providers, no authorization is required. All care is managed by Your Kaiser physicians and is a component of Your physician's referral within the Kaiser system. For care received outside a Kaiser Permanente facility or by non-Kaiser Permanente providers, Your physician will request prior authorization and or referral for care.

Required Prior Authorization List for In-Network Benefits

- All inpatient and outpatient facility services (excluding emergencies)
- Office based habilitative/rehabilitation: occupational, speech, and physical therapies.
- All services provided outside a KP facility
- All services provided by non-network providers
- Drugs and Durable Medical Equipment not contained on the KP formulary

Routine Care

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

Urgent Care

You may need Urgent Care if You have an illness or injury that requires prompt medical attention but is not an Emergency Medical Condition. If You think You may need Urgent Care, call the Urgent Care or advice nurse telephone number (see Section 18: Customer Service Phone Numbers or sign on to **www.kp.org** website). Note: Urgent Care received from a Non- Network emergency department is covered under the out-of-network benefit level.

For additional information about Urgent Care outside the Service Area, please refer to Section 11: Emergency and Post-Stabilization Services, From Non-Network Providers.

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

Out-of-Area Urgent Care **http://kp.org/travel**

- You may also seek care at The Little Clinics (TLC) in CO, GA, IN, KS, KY, OH, TN, VA
- If you get care at a MinuteClinic®, Concentra, TLC or any other urgent care facility within a state where Kaiser Permanente operates, you'll be asked to pay up front for services you receive and file a claim for reimbursement. Note: Urgent Care received in Kaiser Permanente Service Areas from a Non-Network provider or emergency department is not covered.
- If you get care at MinuteClinic®, TLC or Concentra outside a state where Kaiser Permanente operates, you'll be charged your standard copay or co-insurance.

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

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

Follow-up care from a Non-Network urgent care provider is covered at the non-network benefit level, except prior authorized Durable Medical Equipment related to Urgent care You received outside the Service Area.

Advice Nurses

Sometimes it is difficult to know what type of care You need. That is why Kaiser Permanente has telephone advice nurses available to assist You. These advice nurses can help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern, tell You what to do if a Network Provider is closed, or advise You about what to do next, including making a same-day appointment for You if it is medically appropriate. To reach an advice nurse, please call the advice nurse phone number listed in Section 18: Customer Service Phone Numbers.

Your Personal Physician

Personal physicians provide primary care and coordinate Your care, including hospital stays and referrals to specialists. For the current list of physicians who are available as personal Network Physicians, and to find out how to select a personal Network Physician, please call customer service at the number listed in Section 18: Customer Service Phone Numbers. You can change Your personal physician for any reason.

Kaiser Permanente (KP) generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, KP designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Customer Service or log onto www.kp.org. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from KP or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Customer Service at the number on the back of your ID card.

Second Opinions

Upon request and subject to payment of any applicable Copayments or Coinsurance, You may obtain a second opinion from:

- A Network Physician about any proposed Covered Services, or
- A Non-Network Provider.

Telemedicine

Interactive visits between You and Your Personal Network Physician using phone, interactive video, internet messaging applications and email are intended to make it more convenient for You to receive medically appropriate Covered Telemedicine Services. When available, You may receive Covered Telemedicine Services listed under the Benefits and Cost Sharing section, subject to Section 13: General Exclusions and General Limitations. You are not required to use interactive Telemedicine Services, but if You do, Your plan deductible may apply. https://about.kaiserpermanente.org/our-story/our-care/is-telehealth-right-for-you.

Your Identification Card

Your Kaiser Permanente identification card (ID card) has a medical or health record number on it, which You will need when You call for advice, make an appointment with a Network Provider, or go to a provider for Covered Services. When You get care, please bring Your Kaiser Permanente ID card and a photo ID. Your medical or health record number is used to identify Your medical records and coverage information. If You need to replace Your Kaiser Permanente ID card, please call customer service at 877-568-0774.

Your ID card is for identification only. In order for the program to cover services, You must be a current Member or Dependent on the date You receive the services. Anyone who is not a

Member or Dependent will be billed for any services he or she receives, and the amount billed may be different from the Eligible Charges for the services.

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

Receiving Care in Other Kaiser Permanente Regions

You will probably receive most Covered Services in the Service Area of the Kaiser Permanente region where You live or work. If You are in the Service Area of another Kaiser Permanente region, You may receive Covered Services from Network Providers in that region, though services that require a referral or Prior Authorization may differ among regions. For information about Network Providers or Covered Services in another region, please call customer service forthat region at the number listed in Section 18: Customer Service Phone Numbers. For assistance before, during, or after traveling within the United States, You can also contact Kaiser Permanente at 951-268-3900. This travel line can assist in helping to fill eligible prescriptions before You leave home, help You find care in a Kaiser Permanente region, or file a claim for reimbursement when You are back.

Moving outside of the Service Area

If You move to an area not within a Kaiser Permanente Service Area You may be required to change Your health plan to one that services Your area. Please contact HR Solutions for more information.

Getting Assistance for Total Health PPO Plan (In-Network)

Kaiser Permanente wants You to be satisfied with the healthcare You receive. If You have any questions or concerns about the care You are receiving from a Network Facility, please discuss them with Your personal Network Physician or with any other Network Providers who are treating You. They want to help You with Your questions. You may also call customer service atthe number listed in Section 18: Customer Service Phone Numbers.

Interpreter Services for Total Health PPO Plan (In-Network)

If You need interpreter services when You call or when You get Covered Services, please let Kaiser Permanente know. Interpreter services are available 24 hours a day, seven days a week, atno cost to You, at Network Facilities. For more information, please call customer service at the number listed in Section 18: Customer Service Phone Numbers.

In-Network Facilities

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

- All Network Hospitals provide inpatient services and are open 24 hours a day, seven days a week
- Emergency Services are available from Network Hospital Emergency Departments (as described on kp.org for Emergency Department locations in Your area). Note: Emergency Services provided by out-of-network providers or at out-of-network facilities will be covered at in-network rates as required by the No Surprises Act
- Same day appointments are available at many locations (please refer to kp.org for Urgent Care locations in Your area)
- Many Network Facilities have evening and weekend appointments
- Many Network Facilities have a customer services department (refer to kp.org for locations in Your area)
- Additionally, Kaiser Permanente care is available at certain Target Clinics in Southern California https://kptargetclinic.org.

For current locations of Network facilities please visit www.kp.org or call Customer Service at the number listed in the Section 18: Customer Service Phone Numbers. section. To find a Kaiser Pharmacy visit www.kp.org - select *Pharmacy.*

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

Healthcare Fraud Information

Healthcare and insurance fraud results in cost increases for healthcare plans. You can help by:

- Being wary of offers to waive copays, coinsurance, and Deductibles. These costs are passed on to You eventually.
- Being wary of mobile health testing labs. Ask what Your healthcare insurance will be charged for the tests.
- Reviewing the bills from Your providers and the Explanation of Benefits (EOB) form You receive from Kaiser Permanente. Verify that services for all charges were received. If there are any discrepancies, call Kaiser Permanente Customer Service at 877-568- 0774.
- Being very cautious about giving information about Your healthcare insurance over the phone.
- If You suspect fraud, contact Kaiser Permanente at 877-568-0774.

Health Management Resources

Kaiser offers the following resources and programs to help support Your health and disease management.

- Cancer Care: You have leading experts by your side every step of the way. We treat over 500,000 cancer patients each year. This means our doctors and specialists have a wealth of experience and expertise in cancer prevention, treatment, and recovery. For more information, visit kp.org/cancer.
- Cardiac Rehabilitation Program: For members who have recently had a heart attack, stent placement, or heart surgery, Kaiser offers a program to help reduce Your chances of having another heart event.
- Diabetes Care Management: In the Diabetes Care Management Program, You'll partner with a care manager to learn the self-care skills You need to manage diabetes and stay healthy and active. For more information, visit: kp.org/mydoctor/diabetes.

Health and Wellness Resources

Kaiser offers the following programs and resources to help support Your health and wellness journey:

- Choose Healthy Program: Kaiser Permanente members can get reduced rates on a variety of fitness products and wellness services through the Choose Healthy program. For more information, visit kp.org/choosehealthy.
- Active & Fit Direct: With the Choose Healthy Program, You also have access to contracted fitness centers in the Active & Fit Direct network. The Active & Fit Direct program gives You access to a fitness center membership for just $25 a month, plus a $25 enrollment fee. Choose from 11,000+ participating fitness centers and instructor-led classes nationwide and start exercising today. For more information, visit kp.org/choosehealthy.
- CALM App: Calm is an app for daily use that uses meditation and mindfulness to help lower stress, reduce anxiety, and improve sleep quality. For more information, visit kp.org/selfcareapps.
- Class Pass: As a member, You can choose one or both of these monthly Class Pass plans:
    - Plan 1: On-demand video workouts — Get access to a vast on-demand audio and video library, which includes a wide variety of workouts and meditations ranging from 5 to 75 minutes. $0/month. No credit card required for sign-up.
    - Plan 2: Livestream & in-person workouts — Get 20% off a monthly package to reserve in-person and livestream fitness classes, plus get access to plan 1's vast on-demand library of workouts. Not sure if You want a monthly package? Plan 2 includes a 45-day trial period where You can try livestream and in-person workouts for $0. A credit card is required for sign-up, but You won't be charged anything. After the 45-day trial period, you'll automatically roll over to plan 1, the $0 on-demand video workouts. At the end of the trial period, You'll also have the option to purchase a monthly package for 20% off the retail price.
- Interactive Tools and Calculators: Take an interactive quiz or enter Your information into one of our calculators to learn more about Your health at kp.org/calculators.
- Recipes: Get inspired to prepare delicious, healthy dishes. Browse recipes by category — like vegetarian dishes, soups, or desserts — or by what's in season by visiting kp.org/foodforhealth.
- Total Health Assessment: Visit kp.org/tha to take a 10-minute online survey to get a big-picture view of Your health and personalized recommendations to help reach Your goals.
- Wellness Coaching: Working with a wellness coach can help You to reach Your goals with a personalized action plan and one-on-one support. You'll work with the same coach for Your entire program, so they can get to know You and help You discover what works for You. Wellness Coaching can help You with achieving a healthy weight,

quitting tobacco, lowering Your stress, moving more, eating healthier, or sleeping better. For more information, visit kp.org/wellnesscoach.

General Health Resources

Kaiser offers the following services and resources to help You learn more about Your health and get the care You need:

- Nurseline: Our advice nurses are available to you 24/7 to help determine what type of care You need, and how to get that care.
- Symptom Checker: Use our interactive visual aid to gauge Your symptoms at kp.org/symptoms. Click on the body part that's troubling You and learn what to do next.
- Medical Test Directory: Learn more about Your options for common tests and procedures, along with their risks and benefits, by visiting kp.org/healthdecisions.
- Find Your Words: Has everything You need to start the conversation, including what to look for, what to say, and where to find help. Access at findyouwords.org.
- Drug Encyclopedia: Look up detailed descriptions of thousands of drugs, including effects, at kp.org/medications.
- Health Encyclopedia: Explore more than 40,000 pages of in-depth information on health conditions, related symptoms, and treatment options, at kp.org/health.
- Health Education Classes: With all kinds of health classes and support groups offered at our facilities, there's something for everyone. Classes vary at each location, and some may require a fee. For more information, visit: kp.org/classes.
- Health Guides: Stay informed on popular health subjects or discover something new through our healthy living guides, available in English and Spanish. For more information, visit: kp.org/livehealthy.
- Natural Medicines Comprehensive Database: Find answers to Your questions about dietary supplements, vitamins, minerals, and other natural products by visiting kp.org/naturalmedicines.
- Videos and Podcasts: Look, listen, and learn about Your health and well-being. Watch videos or download health-related, guided meditation podcasts by visiting kp.org/video or kp.org/audio.

Additional Resources

Kaiser also offers the following additional resources to help support You:

- Life Care Planning: Life Care Planning is Kaiser Permanente's name for a process also known as advance care planning. We believe that all adults should plan in advance. For more information, visit https://healthy.kaiserpermanente.org/northern-california/health-wellness/life-care-plan.
- Minute Clinics: If You need urgent care in a state without Kaiser Permanente providers,

go to the nearest MinuteClinic or urgent care facility. For care at a MinuteClinic, You'll be charged your standard cost share. Be sure to bring your Kaiser Permanente ID card and method of payment. For more information, visit kp.org/travel.

- Thrive Local: There are many community resources available — and we're here to help You find the support You need. If you need help with food, housing, transportation, paying bills, and more, explore this directory of community-based programs and services that offer assistance in your area. For more information, visit kp.org/communityresources.
- Vision Essentials: Visit our optical centers for Your glasses and contacts. For more information, visit kp2020.org.

Section 4: Deductibles, Out-of-Pocket Limits, and Lifetime Maximums

This section summarizes the annual Deductibles and Out-of-Pocket Limits that apply to thein-network option and the out-of-network option, as well as any lifetime maximums under the Total Health PPO Plan.

Note: If You do not have access to Network Providers within a Kaiser Permanente Service Area You will be covered under the in-network level if You receive a referral to a provider outside the network. You can obtain services out-of-network without a referral, but You will be required to pay a greater amount out-of-pocket.

Deductibles

This section describes Your Deductibles. You must first pay the annual Deductible before the Total Health PPO Plan begins to pay for Covered Services. Your annual deductible begins on January 1. When You meet the full Deductible amount, the Total Health PPO Plan begins to pay for eligible, covered expenses at the applicable Coinsurance amount. Deductibles are not prorated for mid-year enrollments and reset every January.

If You retire mid-year and qualify for NTESS's Post Employment Health and Welfare Benefit Plan any amounts applied towards Your deductibles under Your active employee coverage will transfer to Your NTESS retiree coverage provided you keep the same coverage into retirement.

Amounts above Eligible Charges, charges not covered by the Total Health PPO Plan, prescription drug Coinsurance and charges incurred because of failure to obtain required Prior Authorization do not apply toward the Deductible. If You are enrolled in the Total Health PPO Plan, there is no deductible for prescription drugs and prescription drug Coinsurance amounts do not apply to the annual Deductible described in the Summary Benefits and Coverage (SBCs).

IMPORTANT: Deductibles between in-network and out-of-network do not cross-apply.

For the Total Health PPO: This Program has an embedded Deductible, which means:

- If You are the only person covered by this Plan, only the Primary Covered Member Only (also referred to as individual) Deductible applies to You.
- If You are enrolled in Primary + Spouse/Child or Primary + Spouse + Child(ren) coverage, both the individual and the Family amounts apply. The family Deductible amounts can be satisfied by any combination of family members but You could satisfy Your own individual Deductible amount before the family amount is met. You will never have to satisfy more than Your own individual Deductible amount. If You meet Your individual Deductible amount, Your other family member's claims will still accumulate towards their own individual Deductible as well as the overall family amounts. This continues until Your other family members meet their own individual Deductible or the entire family Deductible is met.

Deductibles for Admissions Spanning Two Calendar Years

If a Deductible has been met while You are an inpatient and the admission continues into a new year, no additional Deductible is applied to that admission's services. All other services received during the new year; are subject to the applicable Deductible for the new year.

Coinsurance

In addition to Your Deductible, if applicable, You pay Coinsurance of 20% of the Eligible Charges for Kaiser Permanente in-network services, and 40% of the Eligible Charge for out-of-network services. Please be aware: the difference between the Covered Eligible Charge and a provider's billed charge can be significant; an out-of-network provider can bill You for this difference.

Certain preventive care as outlined under coverage details is provided at 100% coverage when You receive the services from an in-network provider, or if You receive services out-of-network, coverage is based on 100% of the Medicare-approved amount, after the Deductible (out-of-network balance billing may apply). For information on non-covered services, refer to Section 13: General Exclusions and General Limitations.

IMPORTANT: You are responsible for any amount above the Medicare-approved amount if You receive services out-of-network (except for claims that are subject to the No Surprises Act). Some services require Prior Authorization, otherwise Youwill receive reduced benefits or, in certain cases, no benefits. For a complete listing of these services, refer to Section 3: How to Obtain Services.

Out-of-Pocket Limit

This section describes Your Out-of-Pocket Limit. Your Plan includes both a medical and pharmacy Out-of-Pocket Limit.

Note: Out-of-Pocket Limit are not pro-rated for mid-year enrollments.

If You retire and are PreMedicare, and retire mid-year, any amounts applied toward Your out-of-Pocket Limit under Your employee coverage will transfer to Your PreMedicare retiree coverage, provided you keep the same coverage into retirement.

If You change your medical carrier mid-year (e.g. You move from the Kaiser STH Program to either of these Programs), any amounts applied toward Your Out-of-Pocket Limits under your current NTESS plan will not be transferred to the new carrier and you limits start over.

For details regarding annual Out-Of-Pocket Limits please refer to the Summary of Benefits and Coverage (SBC).

The following table identifies what does and does not apply toward in-network an out-of-network Out-of-Pocket Limit.

Features	Applies to the In- Network, Out-of-Pocket Limit?	Applies to the Out-of-Network,Out-of-Pocket Limit?
Payments toward the annual Deductible	Yes	Yes
Member Coinsurance payments	Yes	Yes
Charges for Non-covered Healthcare Services	No	No
Amounts of any reductions in benefits You incur by not following Prior Authorization or Precertification requirements	No	No
Amounts You pay toward behavioral health services	Yes	Yes
Charges that exceed Covered Expenses	Not applicable	No
Prescription drugs and other items obtained through Kaiser Permanente	No	No

Prescription Drug Expenses incurred through Kaiser

	In-Network Option	Out-of-Network Option
Annual Out-of-Pocket Limit	$1,500 per person $5,950 per family	None None

IMPORTANT: The Out-of-Pocket Limits do not cross apply between in-network and out-of-network. Further, the Prescription Drug Out-of-Pocket Limits are separate from the Out-of-Pocket Limits for medical expenses and the maximums do not cross apply.

No additional Coinsurance will be required for the remainder of the calendar year for Covered in-network prescription drug purchases once a covered member has met his/her $1,500 out-of-Pocket Limit for the year.

Lifetime Maximums

The Total Health PPO Plan does not have any lifetime maximums, with the exception of the fertility benefit, Travel and Lodging benefit and Bone Marrow and Stem Cell Donor Search.

Infertility Benefit

When You reach the $30,000 lifetime maximum benefit, no additional reimbursementfor any procedures incurred to treat fertility are payable. Other covered procedures related to family planning or reproduction (excluding fertility) may be payable.

Travel and Lodging

A combined overall maximum benefit of $10,000 per covered recipient and care-giver applies for all travel and lodging expenses reimbursed. This applies to all treatments during the entire period that the recipient is covered under this medical plan.

Bone Marrow and Stem Cell Donor Search

An overall maximum benefit of $25,000 per covered recipient in-network or out-of-network combined.

Section 5: Benefits and Cost Sharing

This section describes this Program's covered services, subject to exclusions and limitations described in the following sections. Exclusions and limitations that apply only to a particular benefit are described in this section; all other exclusions and limitations are described in Section 13: General Exclusions and General Limitations and Section 14: Coordination of Benefits (COB).

The services described in this section are covered only if all the following conditions are satisfied:

- You are a Member or Dependent on the date that You receive the services,
- A Network Physician or the Claims Administrator (for claims from out-of-network providers) determines that the services are Medically Necessary,
- The services are provided, prescribed, authorized, or directed by a Network Physician or an out-of-network provider except where specifically noted to the contrary in Section 11: Emergency and Post-Stabilization Services, From Non-Network Providers and Section 3: How to Obtain Services; and
- You receive the services from Network Providers inside the Service Area or an out-of-network provider except where specifically noted to the contrary in the following sections for the following in-network services:
    - Authorized referrals as described in Section 3: How to Obtain Services.
    - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in Section 11: Emergency and Post-Stabilization Services, From Non-Network Providers.
    - Care received outside the Service Area as described in Receiving Care in Other Kaiser Permanente Regions.
    - Emergency ambulance service as described under Ambulance Services.

Cost Sharing

The Schedule of Benefits describes the cost sharing You must pay for covered services. Cost sharing may be due at the time You receive services. For items ordered in advance, You pay the cost sharing in effect on the order date (although the item will not be covered unless You still have coverage for it on the date You receive it). Copayments are applied per provider per day. Unless specified otherwise, when services can be provided in different settings, the cost sharing is applied according to the place of service in which the care is delivered and according to the type of provider providing the service. For example: if the service is provided during a hospital admission, the hospital inpatient services cost share is applied. If the same service is performed in an office setting by a specialist, the specialty care office visit cost share is applied. If services are provided in a hospital clinic setting, separate cost shares may apply to the hospital clinic charges and the physician charges; both hospital clinic and physician charges will be subject to applicable deductibles and cost share.

Section 6: Health Reimbursement Account (HRA)

Health Reimbursement Account Administrator

To be eligible for HRA funding, You must be enrolled in the Total Health PPO Plan. Kaiser Permanente will administer the HRA. All of Your Kaiser Permanente services will be available on kp.org. Once You log in, click: My Plan and Coverage, then click: Health PaymentServices. Kaiser Health Payment Services customer service can be reached at 877-750-3399.

Health Reimbursement Account (HRA) Amounts

The HRA is an arrangement that will allow You to determine how some of Your healthcare dollars are spent. To be eligible for HRA funding, You must be enrolled in the Total Health PPO Plan. NTESS will allocate an amount to the account that is based on:

- Your coverage and enrollment status (active, PreMedicare/single, family, etc.),
- Whether or not You and Your covered Spouse have completed a Health Assessment through the Virgin Pulse Program Website, and
- Whether or not You and Your covered Spouse have participated in the Virgin Pulse Incentive Program.
- Whether or not You and Your covered Spouse have participated in a Health Action Plan.

Annual Allocation of HRA Contributions

The HRA is entirely funded by NTESS and not taxable to You. You are not permitted to make any contribution to Your HRA, whether on a pre-tax or after-tax basis. Your HRA is an "unfunded" account, and benefit dollars are payable solely from NTESS general assets.

Both the primary covered member and covered Spouse are responsible for completing the health assessment to receive the full HRA contribution. Other covered Dependents are not required to complete a health assessment.

Note: In order to receive HRA funding for each calendar year, **Employees and their Spouses** must complete their Health Assessments by **October 31st** at 9:59PM MST of the current year and remain covered on the Total Health PPO plan as of January 1 of the next year. Employees who switch from the Total Health PPO Plan to the Health Savings Plan as part of the annual open enrollment will have all earned Virgin Pulse incentives deposited into their HSA for the following year provided their HSA is active as of the date of transfer.

If an employee retires on or after February 1st, the Retiree will receive their previous years Virgin Pulse earnings.

Coverage Category / Tier	Virgin Pulse Activity Completion	Health Action Plan Completion	Health Assessment is Taken	Health Assessment is NOT Taken	Total Possible HRA allocation
Employee only	Max $300	$100	$100	$0	Up to $500
Employee + Spouse	Max $600 ($300 max*)	Max $200 ($100 each*)	Max $200 ($100 each*)	$0	Up to $1,000
Employee + child(ren)[1]	Max $300	$100	$100 (Employee completes)	$250	Up to $750
Employee + Spouse +child(ren)[1] (family)	Max $600 ($300 max each*)	Max $200 ($100 each*)	Max $200 ($100 each*)	$250	Up to $1,250

* Amount earned each for Employee and Spouse. Note that if children are on the plan, Your HRA is auto-funded $250.

[1]This is the only amount that will be placed in Your HRA during the calendar year and may be used for any combination of eligible in-network and out-of-network Covered Health services, including eligible prescription drugs.

If You don't spend all Your HRA dollars in a calendar year, and You remain enrolled in the Total Health PPO Plan for the following year, any remaining HRA balance remains in the HRA for the next calendar year. The maximum balance in an HRA is capped at:

- $1,500 for Primary Covered Member only coverage
- $3,000 for Primary Covered Member plus Spouse or plus Child(ren)
- $4,500 for family coverage

Events Resulting in Loss of HRA Funds

The maximum balance in an HRA is capped at the amounts shown above. If You have an event which forces You to change coverage, Your HRA balance will be adjusted accordingly, at the beginning of the next calendar year. Example: You are enrolled as Primary Covered Member + Spouse and get divorced. At the time of the divorce You have $2,500 in Your HRA. You may keep the HRA funds through the end of the calendar year, however the HRA balance will be reduced to $1,500 after the rollover period of the following calendar year, as that is the maximum balance for Primary Covered Member only coverage.

Note: Expenses incurred in the previous plan year cannot be paid with HRA funds that were earned for the current plan year.

If You terminate employment or lose coverage, You have 90 days to file claims for expenses incurred while You were covered under Total Health PPO Plan Administered by Kaiser Permanente. If You do not use Your HRA funds and do not elect COBRA coverage, You forfeit any remaining HRA funds. Refer to Employee H&W Plan SPD for information on continuing coverage under COBRA.

If You are a PreMedicare Retiree, and You become Medicare-eligible, You have up to 90 days from date of Medicare eligibility to file claims for expenses incurred while You were under the Total Health PPO Plan. Any HRA funds remaining after 90days will be forfeited.

Note: If You are new to this plan at the start of the plan year and were previously enrolled in a different medical carrier under the Total Health PPO Plan, any HRA funds will not rollover until 90 days after the end of the previous calendar year. This ensures that Your current carrier has access to Your prior year HRA funds to pay for claims for medical services received in the previous year but processed during this 90-day window.

New Hires

NTESS will automatically make the full applicable Health Assessment portion of the HRA contribution (see Annual Allocation of HRA Contributions) for the calendar year in which You hire. To receive the Health Assessment portion of the HRA contribution for the next calendar year, You and Your covered Spouse must complete the Health Assessment by October 31st by 9:59PM MST to receive funds for the new calendar year.

Eligible Mid-Year Election Change Events

NTESS will automatically make the applicable HRA contribution for any Employees and/or their Dependents who enroll in Total Health PPO Plan during the calendar year as a result of an eligible mid-year election change event. Examples include:

- If You have waived coverage because You have coverage elsewhere, and You lose that coverage and enroll in the Total Health PPO Plan within 31 calendar days of the of coverage, NTESS will contribute the applicable HRA contribution.
- If You get married mid-year, NTESS will contribute the applicable additional HRA contribution ($100 to include Spouse coverage or $250 for children) if You enroll Your new eligible family members within 31 calendar days of marriage.

Open Enrollment Changes for Dual Sandians

If You change Primary Covered Members during Open Enrollment, the total HRA will be assigned to the new Primary Covered Member in the month of April up to the allowed maximum.

If You have Primary Covered Member + Spouse or Primary Covered Member + Family coverage and change to Primary Covered Member only coverage, the HRA funds will remain with the original Primary Covered Member. HRA funding will follow the coverage election.

Dual Sandians who split coverage will result in the HRA funds remaining with the original Primary Covered Member.

What Healthcare Expenses Are Eligible for HRA Reimbursement

Your Health Reimbursement Account may only be used for all qualified 213(d) expenses, which include eligible medical, dental, vision, and prescription expenses. For example, if You receive elective cosmetic surgery that is not eligible under the Total Health PPO Plan, these claims are not eligible for payment by the HRA.

How the HRA Works

Your HRA dollars can be used to pay for eligible IRS 213(d) expenses, including eligible prescription drugs purchased through a Kaiser Permanente Pharmacy, up to the amount allocated to Your HRA. HRA funds are available for use by any Covered Member and are not apportioned on a per person basis. For example, if there is $750 in available HRA funds and a claim is submitted for one member in the amount of $1,000, and the member has a $750 Deductible, the full HRA funds of $750 will be pulled to cover the Deductible portion of the claim.

Plan year begins on January 1 of each year and ends December 31.

1. Usually, in January newly earned funds are deposited into the HRA. For example, incentives earned in 2023 will be deposited in January 2024.
2. You can start to use these funds once they have been deposited for current year claims.
3. Unused HRA funds from the previous year can be rolled over up, to the maximum allowed into the next year.
4. At the beginning of each new plan year, you have a 90-day runout period to submit claims incurred in the previous year, for reimbursement, before the balance rolls over to the new plan year.
5. The debit card issues by the carrier for HRA expenses can only be used for current year expenses. All claims submitted during the runout period for previous years services, must be filed manually online directly with the carrier.
6. Once the previous year's funds have rolled over into the new plan year, you can no longer submit claims for the previous year.

Note: If you change carriers mid-year or at open enrollment, you may have the opportunity to transfer your unused HRA funds to the new carrier provided the new plan chosen offers an HRA. Please contact HR Solutions at 505-284-4700 for more information on how this may apply to you.

Claims Processing with an HRA

In general, if the covered medical service is rendered at a Kaiser Permanente facility in Northern California, and You have HCFSA/HRA funds available, the amounts owed for qualified medical expenses will be deducted from Your account(s) and paid directly to Your Kaiser Permanente provider. Any payments exceeding Your HCFSA/HRA balance will be the patient responsibility subject to deductible, coinsurance, and out-of-pocket limits.

For Kaiser Permanente Members, a debit card will be issued for Your HRA. This debit card can be used for paying eligible IRS 213 (d) expenses at the point of service.

IMPORTANT: You can use Your Kaiser Permanente Health Payment Card at the point of service. Your portion (if any) will be paid first from Your HCFSA (if You are enrolled), second from Your HRA, and third by You.

If You are using a non-Network Provider, they may require payment at the time of service. In this case You may want to use Your debit card to make the payment. Remember that only the amount available in the HCFSA and HRA will be paid.

The Healthcare Flexible Spending Account (HCFSA) and Health Reimbursement Account will only pay if You have funds available through election for the HCFSA or allocation for the HRA.

Medical Expenses

When You or Your covered dependent seeks eligible healthcare services, You must present Your Kaiser Permanente medical identification card if You see an in-network provider, and if the service requires payment, You can use Your debit card to pay Your portion of the cost sharing for medical services. If You do, Kaiser Permanente will pay Your share of the cost of the service from Your HCFSA and/or HRA. If You have funds in Your HCFSA, it will pay first, and then Your HRA will pay once the HCFSA is depleted.

If You see an out-of-network provider, and if the service requires payment, You can use Your debit card to pay Your portion of the cost sharing for medical services. If You have funds in YourHCFSA, it will pay first, and then Your HRA will pay once the HCFSA is depleted.

Managing Your HRA Claim Submissions

There are several convenient ways to access and use Your HRA funds to pay for eligible healthcare expenses:

- HRA debit card;
- Submit a manual claim to Kaiser Health Payment Services for reimbursement.

When using a debit card to pay for claims, there are certain claims which are not automatically substantiated at the point of sale and require additional documentation (receipts that indicate the date of service, the vendor, the nature of the service and cost). For unsubstantiated claims identified by our administrator, You will receive three notifications requesting additional documentation. Following the second notice, debit cards will be inactivated until claim receipt documentation is received.

IMPORTANT: For any unsubstantiated HCFSA claims remaining after the third notice, the full amount of the claim(s) will be added to Your W2 income and taxed accordingly. For any unsubstantiated HRA claims remaining after the third notice, the full amount of the unsubstantiated claim will be garnished from Your paycheck. Please remember to save all claim receipts. Remember: You are responsible for managing Your HRA funds and confirming with Kaiser that all claims have been fully substantiated within the plan year and/or rollover period.

Prescription Drugs

When You or Your covered dependent needs to purchase a prescription through a pharmacy, You must first present Your Kaiser Permanente medical identification card then if you have HRA or HCFSA funds available, you can pay to patient portion of the pharmacy benefits by using your debit card or by filing a manual claim. You are responsible for filing the claim with Kaiser for processing. Eligible 213(d) expenses will be paid first from Your HCFSA (if elected) until depleted and then the HRA will pay.

If You receive in-network services and You use Your debit card to pay Your applicable Coinsurance, Your HCFSA (if You have enrolled in one and have funds available) will be used first. HRA funds will be used second. If no funds are available in either the HCFSA or HRA You will need to pay Your Coinsurance through another method.

Note: www.kp.org is designed to provide You with the necessary information and tools You needto manage Your Flexible Spending and Health Reimbursement Accounts. To learn more about Your HCFSA and HRA log-on to www.kp.org. Once You log into www.kp.org click: **My Plan & Coverage**, then click: **Health Payment Services**. You can keep track of the dollars in Your HCFSA and HRA by going online to www.kp.org or by calling the toll-free number on the back of Your Kaiser Health Payment card.

Health Assessment and Biometric Screenings

A Health Assessment is a confidential online questionnaire that asks You about Your health history, lifestyle behaviors (such as smoking and exercise habits) and Your willingness to make changes. You will receive a personalized report of Your health status and any health risks You may have now or possibly down the road, and how You can take steps to prevent or manage those risks. If You have no health risks, the report will make suggestions for improving or better managing Your health and well-being.

Biometric Screenings Process

Employees can obtain these screenings either through the Sandia Onsite Clinic (at no cost) or through their primary care physician. To obtain the screenings through the onsite medical clinic, You can schedule an appointment calling HR Solutions at 505-284-4700.

When You get a biometric screening, a trained technician takes Your blood pressure, measurements, and draws blood for analysis. You may be asked if You want fasting or non-fasting lab tests. Fasting lab test results will typically include Total cholesterol, HDL, LDL, Triglycerides, and Glucose. Non-fasting tests report only Total Cholesterol and HDL. Fasting labs yield the most comprehensive lab test results, but either option will provide what is needed for the health assessment.

Health Assessment Process for Employees

You will need to go to app.member.virginpulse.com and register. Go to Programs and select the Wellsource Health Assessment.

Virgin Pulse Incentive Management Program

NTESS will reward You for getting and staying healthy. You can earn up to an additional $100 towards Your Health Reimbursement Account for next year through this program. Visit hr.sandia.gov for more details or contact HR Solutions at 505-284-4700.

With Virgin Pulse, Employees and their covered Spouses may participate in healthy activities andget rewarded - with better health and with points. Participants simply track their activities with a GoZone pedometer. Visit app.member.virginpulse.com for more details.

Retirees, Surviving Spouses, and Long-Term Disability Terminees, and their Dependents, are not eligible for the Virgin Pulse Program. If You participated in the Virgin Pulse Program, as an Employee, and retired at the beginning of a calendar year, You will **not** receive any HRA funds in the subsequent calendar year. However, if You participated as an Employee and retire on or after February 1 of the subsequent calendar year, any Virgin Pulse points that You earned in the previous year will be transferred if there is an applicable balance to your employee account (as long as You have no break in coverage) and You will be eligible to keep those funds or the funds will be rolled over to the retiree PreMedicare HRA.

For Spouses who need to complete the Health Action Plan visit the site for Kaiser Permanente at www.kp.org. Child dependents are not required to complete a health action plan or health assessment.

Tools and Resources to Become a Wiser Consumer

In addition to the many resources listed in this Benefit Summary, You can also access important tools and resources from Kaiser Permanente at www.kp.org.

Once You have registered at www.kp.org You can:

- Learn about health conditions, treatments, and procedures
- Search for in-network Kaiser Permanente facilities in Northern California
- Access health and wellness topics
- Access Nurse Advice services, 24 hours a day, seven days a week
- Access to telemedicine interactive video visits
- Access the provider fee list to estimate the costs of various procedures in Your geographical area
- Make real-time inquiries into the status and history of Your claims
- View eligibility and benefit information
    - View and print EOB statements online
    - Update dependent coordination of benefits status

Note: If You have not already registered as a www.kp.org subscriber, go to www.kp.org and click on Sign On. Have Your Kaiser Permanente ID card ready.

Prescription

You can obtain the following prescription information at www.kp.org:

- Locate local Network Pharmacies
- Price prescription drugs at Network Pharmacies and mail service
- Refill prescriptions online
- Find out what drugs are covered under the Program

Section 7: Healthcare Flexible Spending Account (HCFSA)

The content in this section is applicable to Kaiser Permanente Health Payment Services process. For detailed Healthcare Flexible Spending Account (HCFSA) benefit and plan information, pleaserefer to the Cafeteria Plan. .

Kaiser Health Payment Services will administer the HCFSA and Health Reimbursement Account (HRA) for participants enrolled in Kaiser Permanente Total Health PPO Plan.

Claims Filing Process

After You incur an eligible expense and don't use Your debit card, You have the option of submitting a claim online at www.kp.org/healthpayment or completing a paper claim form and mailing or faxing it along with itemized documentation to Health Payment Services. Claims may be submitted anytime.

If You have established a HCFSA, Your total annual contribution amount is available immediately. You can use Your Kaiser Health Payment Card or request reimbursement for eligible expenses up to Your annual contribution amount as soon as such eligible expenses have been incurred.

Claims Filing Process with a Healthcare FSA and/or HRA

Refer to Section 6: Health Reimbursement Account (HRA) for detailed information about the HRA.

In general, if the covered medical service is rendered at a Kaiser Permanente facility in Northern California, and You have HCFSA/HRA funds available, the amounts owed for qualified medical expenses will be deducted from Your account(s) and paid directly to Your Kaiser Permanente provider. Any payments exceeding Your HCFSA/HRA balance will be the patient responsibility subject to deductible, coinsurance, and out-of-Pocket Limits.

If You are using an out-of-network provider they may require payment at the time of service. In this case You may want to use Your Kaiser Health Payment Card to make the payment.
Remember that only the amount available in the HCFSA and HRA may be paid with Your Kaiser Health Payment Card.

The HCFSA and HRA will only pay if You have funds available.

You can keep track of the dollars in Your HCFSA and HRA by going to www.kp.org/healthpayment or by calling 877-750-3399.

IMPORTANT: You cannot be reimbursed from more than one tax-advantaged plan (e.g. HCFSA and HRA) for any single expense.

Special Note regarding Orthodontia Claims Processing

Orthodontia claims require an itemized statement/paid receipt, the orthodontist's contract/payment agreement, or monthly payment coupons. Reimbursements can be made in one lump sum, or as the services are provided over the expected treatment period.

- Coupon Payment Option – You can submit an itemized statement of Your orthodontia expenses as the service is provided. Submit this documentation with a completed claim form for reimbursement.
- Monthly Payment Option – You can obtain a contract agreement from the orthodontist showing the patient name, the date of service begins and the length of service, charges for the initial banding work and the dollar amount charged each month. Submit this with Your first claim form and we can automatically reimburse You each month, according to the contract. This eliminates the need for You to send a claim form each month. You do need to send a new claim form with Your contract agreement at the beginning of the nextplan year if You wish to continue.
- Total Payment Option – If You paid the entire amount of treatment when the service began, attach to the claim form a copy of Your paid receipt, along with an itemized statement showing the provider name, patient name, date treatment started, dollar amount and amount insurance will pay. Under this option, You can only file this expense once. You cannot submit this expense again in future plan years.

Options for Reimbursement

- Submitting on-line at www.kp.org/healthpayment.
- Fax in a claim form with the itemized receipts to 877-535-0821.
- Mail in a claim form with the itemized receipts to:

  Kaiser Permanente – Health Account Services
  PO Box 1540
  Fargo, ND 58107-1540

Kaiser Health Payment Card

You will be provided with a Kaiser Health Payment Card that may be used to pay for certain eligible expenses directly from Your HCFSA or HRA. The Kaiser Health Payment Card allows for direct payment to qualified merchant locations where Visa® is accepted. Use of the Kaiser Health Payment Card is voluntary.

IMPORTANT: You should familiarize Yourself with the specific products and services that are eligible for card use based on this Plan.

Receiving Your Kaiser Health Payment Card

Your Kaiser Health Payment Card will be mailed directly to Your home address and will arrive ina plain white envelope, so please do not confuse it with junk mail. Read the terms and

conditions found on the card insert and sign the back of Your card. You may call the customer service number listed on the back of the card to order additional cards.

Activating Your Kaiser Health Payment Card

New members to the Kaiser HRA will need to activate their debit card upon arrival. Just follow the instructions on the debit card carrier to active Your new card.

Using the Kaiser Health Payment Card

The Kaiser Health Payment Card is to be used for qualified healthcare expenses. When You use the card for purchasing healthcare related items, Your healthcare account is automatically debitedto pay for eligible expenses.

The Kaiser Health Payment Card allows You to pay for eligible expenses at the point of service. Participants using the Kaiser Health Payment Card take advantage of five key benefits:

- Immediate payment of Your expenses from Your healthcare account
- Auto-substantiated claims when used at a Kaiser Permanente facility/hospital
- Increases Your personal cash flow
- Reduces paper claim filing
- Ease of use of Your pre-tax funds

Note: It is important that You keep all itemized documentation for the entire plan year in the event the purchase substantiation information is requested by Kaiser Permanente to comply with IRS regulations.

How does the Kaiser Health Payment Card work?

As You incur eligible healthcare expenses, You present Your Kaiser Health Payment Card for payment. If You are purchasing services or items from a healthcare-related merchant or one that has implemented an inventory information approval system, Your transaction will be automatically validated at the point of sale. You should always retain documentation of Your expenses in the event that You need to provide to the IRS. Documentation includes an itemized receipt listing the merchant name, name of the item/product, date of purchase and amount.

The card is valid for a three-year period and will contain information regarding Your current planyear election. Each year when You re-enroll, the card will reflect that plan year election amount(s). The card can only be used for expenses incurred during the plan year.

Retailers with Inventory Information Approval System (IIAS)

The Kaiser Health Payment Card is accepted at all healthcare-related merchants, such as physician and dentist offices, hospitals, pharmacies, hearing and vision care providers. The card will also work at discount stores and grocery stores that have implemented an inventory information approval system (IIAS). The IIAS only allows eligible expenses to be purchased at these merchants.

Overpayment Procedures

It is possible, although not common, to have a negative balance in Your HCFSA account. The transaction information for the Kaiser Health Payment Card is updated daily. However, there could be an instance when the card is used on the same day a manual/auto-rollover claim is received and the total amount of both services results in a negative balance in the account. If this occurs, You should notify Kaiser Health Payment Services at 877-750-3399. Kaiser Health Payment Services will advise You of the overpayment procedures to begin the recoupment process.

Contacting Kaiser Health Payment Services

Kaiser Permanente Health Account ServicesPO Box 1540
Fargo, ND 58107-1540
Phone: 877-750-3399
Fax: 877-535-0821
Email: kp@healthaccountservices.com7:00 am – 9:00 pm CST, M-F

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, You may call Kaiser Health Payment Services before requesting a formal appeal Kaiser Health Payment Services will try to resolve the issue over the phone; however, if You are not satisfied, You have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If You wish to appeal a denied claim, You must submit Your appeal in writing within 180 days ofreceiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of service;
- the reason You think Your claim should be paid; and
- any documentation or other written information to support Your request.

You or Your Dependent may send a written request for an appeal to:

Kaiser Permanente Health Account Services
Attention: Appeals
PO Box 1540
Fargo, ND 58107-1540

Review of an Appeal

Kaiser Health Payment Services will conduct a full and fair review of Your appeal. The appeal may be reviewed by an appropriate individual(s) who did not make the initial benefit determination. Once the review is complete, if Kaiser Health Payment Services upholds the denial, You will receive a written explanation of the reasons and facts relating to the denial.

IMPORTANT: Unsubstantiated FSA claims balance(s) will be added to Your W2 income and taxed accordingly. Unsubstantiated HRA claims balance(s) will result in the full amount of the claim(s) being garnished from Your paycheck.

Section 8: Benefits

The Total Health PPO Plan provides a wide range of medical care services for You and Your family. This section outlines the benefits available under the Total Health PPO Plan.For detailed explanations of what is covered under each benefit, refer to the information in the table. For information on Your prescription drug benefits, refer to Section 10: Prescription Drug Program section.

The following information provides detailed descriptions of services.

IMPORTANT: Services are those health services and supplies that are:

- Provided for preventing, diagnosing, or treating sickness, injury, mental illness, substance use, or their symptoms
- Included in this section (subject to limitations and conditions and exclusions as stated in this Benefit Summary)
- Provided to You, if You meet the eligibility requirements as described in the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD.
- Medically appropriate

If a health service is not listed in this section as a service, or in Section 13: General Exclusions and General Limitations as a specific exclusion, it may or may not be covered. Contact Kaiser Permanente's Customer Service at 877-568-0774 for information.

Acupuncture Services

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

- X-rays and other Medically Necessary services provided by a Network Physician, a licensed acupuncturist or doctor of oriental medicine, either in- or out-of-network.
- A maximum paid benefit of $750 per calendar year for Covered Services by a Network Physician, a licensed acupuncturist or doctor of oriental medicine per calendar year, per Covered Member. This maximum applies to in- and out-of- network acupuncture benefits combined. X-rays do not apply to the maximum benefit.

For Acupuncture Services Contact:

California regions: American Specialty Health Plans of California, https://www.ashlink.com/ASH/public/applications/NetworkSearch/NetworkSearch.aspx 800-678-9133.

Auditory Integration Training

The Program recommends the following guidelines for auditory integration training service:

- A difference of 20dB or more between the most sensitive and least sensitive frequencies;
- The presence of at least one peak of processes, or an air-bone gap of more than 15 dB; or
- Less than 6/11 frequencies perceived at the same intensity level.

Allergy Services

Services related to allergies are covered as follows:

- Office visits
- Allergy testing
- Allergy injections (including serum)
- Allergy injections only (administration and materials)

Ambulance Services

Ambulance services provided by a licensed ambulance service are covered as follows. Note that You are required to contact customer service as soon as reasonably possible.

Ground Ambulance Services

- For emergency transportation to the nearest hospital where emergency health services can be performed is paid at the in-network level of benefit.
- Transportation from one facility to another is considered an emergency when ordered bythe treating physician.
- If there is documentation from the ambulance service provider that it does not differentiate between advanced life support and basic life support, the Program willcover the services as billed.
- If provided through the 911 emergency response system, ambulance services are covered if You reasonably believed that a medical emergency existed even if You are not transported to a hospital.

Air Ambulance Services

- Air ambulance is covered only when ground transportation is impossible or would put lifeor health in serious jeopardy.
- Transport by air ambulance to a contracted facility nearest to Your established home is a Covered Service if Your condition precludes his/her ability to travel by a nonmedical transport.

- If You are in line for a transplant and the transplant has been approved by the Program and there are no commercial flights to the city in which the organ is available, the Program will cover in-network medical transport of the patient via air ambulance or jet (whichever is less expensive).

The following destinations are covered when medically necessary:

- Home to hospital and return
- Home to skilled nursing facility
- Hospital to skilled nursing facility
- Skilled nursing facility to hospital
- Skilled nursing facility to home
- Home to doctor's office
- Hospital to hospital
- Skilled nursing facility to dialysis center and return

Exclusion: Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered, even if it is the only way to travel to an in-network facility.

Cancer Services

Oncology services are covered as follows:

- Office visits
- Professional fees for surgical and medical services
- Inpatient services
- Outpatient surgical services

For oncology services and supplies to be considered services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer.

Clinical Trials

In-Network and referred Non-Network Services for an Approved Clinical Trial are covered for Qualified Individuals. Services associated with cancer clinical trials are covered if all of the following requirements are met:

"Qualified Individual" means an enrollee who is eligible to participate in an Approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined inone of the following ways:

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

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

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

Exclusions:

- Non-approved clinical trials.
- Investigational items or services.
- Items and services that are provided solely for data collection and analysis and that are notused in the direct clinical management of the patient.
- Services which are clearly inconsistent with widely accepted and established standards of care for the patient's diagnosis.

Chiropractic Services

Chiropractic services are covered as follows:

- X-rays and other services provided by a licensed chiropractor, doctor of oriental medicine, medical doctor, doctor of osteopathy, licensed acupuncturist, or physical therapist either in- or out-of-network, with no referral required.
- A maximum paid benefit of $750 annually for spinal manipulation treatment per calendar year, per Member. This maximum applies to in- and out-of-network benefits combined. All other chiropractic services are not covered.

For Chiropractic Services Contact:

California Regions, American Specialty Health Plans of California, https://www.ashlink.com/ASH/public/applications/NetworkSearch/NetworkSearch.aspx# 800-678-9133.

Dental Care Covered Under In-Network and Out-of-Network Medical

IMPORTANT: Prior Authorization is required before receiving dental services. If Prior Authorization is not received, benefits may be reduced by $300.

Dental Services

The Total Health PPO Plan covers dental services due to sickness or injury when providedby a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD) as a result of accidental injury to sound, natural teeth and the jaw

Dental Anesthesia

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

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

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

Dental Services pursuant to Transplants

Dental Services for potential transplant recipients who require pre-transplant dental evaluation and ‘clearance’ before being placed on the transplant wait list. Services include those necessary to ensure the oral cavity is clear of infection, such as evaluation, relevant x-rays, clearing, fluoride treatment, and extractions.

Dental Services for Radiation Treatment

Dental evaluation, X-rays, and extractions necessary to prepare Your jaw for radiation therapy of cancer in Your head or neck are covered.

Other Dental Services

- Orthognathic surgery limited to documented skeletal Class II and Class III conditions as determined by cephalometric diagnosis, provided the condition is:
    - Both functional and aesthetic
    - Not adequately treatable by conventional orthodontic therapy
- Initiation of immunosuppressive therapy
- Direct treatment of cancer or cleft palate
- As a result of tooth or bone loss, due to a medical condition (e.g., osteoporosis, radiationto the mouth, etc.)
- Dental implants, implant related surgery, and associated crowns or prosthetics arecovered in situations where:
    - Permanent teeth are congenitally missing (anodontia), the result of anodontia is impaired function (e.g., chewing/eating), and the implants are not done solely for cosmetic reasons
    - Tooth loss occurs as a result of accidental injury
    - Tooth loss occurs due to a medical condition such as osteoporosis or radiation of the mouth

IMPORTANT: If You receive coverage under the Total Health PPO Plan for implants, or crowns or other prostheses required as a result of implants, You cannot submit any remaining portion to the Dental Care Program for coordination of benefits. If You receive coverage under the Dental Care Program for implants, crowns or other prostheses required as a result of implants, You cannot submit any remaining portion to the Total Health PPO Plan. For more information, reference the Dental Care Program Summary on hr.sandia.gov.

For Services that are provided as a result of an accident, initial treatment must have been started within one year of Injury regardless of whether You were covered under a NTESS medical plan or another employer plan.

Diagnostic Tests

Medically Necessary diagnostic tests are covered as follows:

- Laboratory and radiology
- Computerized Tomography (CT) scans

- Position Emission Tomography (PET) scans
- Magnetic Resonance Imaging (MRI)
- Nuclear medicine
- Echocardiograms
- Electroencephalograms
- Sleep studies
- Other diagnostic tests

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

To be covered by the Plan, in-network DME must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary, which can be found at www.kp.org. A formulary is a list ofDME, external prosthetics and orthotics covered by Kaiser Permanente. Examples of covered items include wheelchairs, hospital beds, and oxygen.

Medical supplies of an expendable nature, such as oxygen tubing, are covered if they are required for the effective use of the DME. Drugs purchased at the pharmacy for use in DME equipment are covered under the Outpatient Prescription Drugs benefit and not this benefit. In order to have coverage You must meet Kaiser Permanente's criteria for use of any equipment andobtain items from a Network Provider. Coverage is limited to the standard item of equipment that adequately meets Your medical needs. Kaiser Permanente will decide whether to rent or purchase the covered equipment for Your use. You will have to pay for non-covered equipment. Coverage includes fitting and adjustment. When the item continues to be Medically Necessary, coverage includes repair and replacement of the standard item in cases of, irreparable damage, wear or replacement required because of a change in Your medical condition. You mustreturn the equipment or pay the fair market price of the equipment when it is no longer covered.

The formulary guidelines allow You to obtain non-formulary DME (those not listed on the formulary for Your condition) if they would otherwise be covered if KP criteria are met. To request a formulary exception contact Kaiser Customer Service.

If the purchased/owned DME is lost or stolen, the Total Health PPO Plan will not pay for replacement. The Total Health PPO Plan will not pay to replace leased/rented DME; however, some rental agreements may cover it if lost or stolen.

Replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed the new purchase price, if the DME breaks or is otherwise irreparable as a result of normal use, or when a change in Your medical condition occurs. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc. for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time.

External Prosthetics

External Prosthetics must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered. Examples of external Prosthetic covered items include:

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

Internally Implanted Devices

Prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseo integrated hearing devices, and hip joints, must be implanted during an approved surgery.

Orthotics

Orthotics must be on Kaiser Permanente's DME, External Prosthetic and Orthotic formulary to be covered.

Education and Training for Self-Management

Health education and training for self-management is covered when provided by a Network Physician or a qualified network non-physician (example: health educator or dietician) using a standardized curriculum to teach You how to self-manage Your disease or condition.
Education and training may be provided in group or individual sessions. Sample conditions include:

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

Emergency Services

Emergency services include professional, facility and ancillary services such as laboratory, X-ray or imaging services necessary to diagnose and stabilize Your condition in an Emergency Department. See Section 11: Emergency and Post-Stabilization Services, From Non-Network Providers for more information.

Eye/Vision Services

Eye Exam / Eyeglasses / Contact Lenses
The Total Health PPO Plan covers routine eye exams for non-refractive care due to sickness or injury of the eye such as conjunctivitis, diabetic retinopathy, glaucoma, and cataracts, and refractions. An initial pair of contact lenses or glasses when required due to theloss of a natural lens or cataract surgery available out-of-network only, covered at the in- network level is allowed.

Vision Therapy
The Program covers eye exercise therapy, optometric visual (or vision) therapy, vision training, orthoptic training and pleoptic training when:
- The services are performed by a Physician or a licensed therapy provider; and
- The services are determined to be proven

Family Planning

The following types of services and supplies are covered as described under separateheadings in this section**.**

- Sterilization procedures such as vasectomies and tubal ligations.
- Medically Necessary ultrasounds and laparoscopies.
- Family planning devices that are implanted or injected by the physician such as IUDs, Norplant, or Depo-Provera.
- Reversals of prior sterilizations available. Performed out-of-network only but covered as in-network and paid at 80% after deductible has been met. See In-Network and Out-of-Network Options section for cost sharing information.
- Surgical, nonsurgical, or drug-induced pregnancy termination.
- Health services and associated expenses for elective and therapeutic abortion. Diaphragms and any other birth control obtained at a pharmacy are eligible forcoverage.

Gender Affirming Surgery

When authorized by Kaiser Permanente, the Total Health PPO Plan covers gender affirming surgery as follows:

- **Below waist surgery:**
  - **Assigned at birth male** - clitoroplasty, labiaplasty, penile skin inversion, vagina construction, bilateral orchiectomy, penile amputation, urethromeatoplasy,plastic repair of intoitus, vaginoplasty
  - **Assigned at birth female** - hysterectomy, salpingo oopherectomy, colpectomy, vaginectomy, phalloplasty, urethroplasty and extension, scrotoplasty, plastic glans formation, insertion of penile and testicular prosthesis

- **Above waist surgery:**
  - **Assigned at birth male** - Tracheal shave and facial hair removal, medically necessary breast augmentation if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment is not sufficient for comfort in the social role and medically necessary gender confirming facial reconstruction.
  - **Assigned at birth female**- mastectomy with chest reconstruction and nipple/areolarreconstruction
- Voice therapy lessons

Refer to Section 13: General Exclusions and General Limitations for information on what is excluded under Gender Affirming Surgery.

Genetic Testing

The Total Health PPO Plan covers medically necessary genetic testing. Examples of covered genetic tests include testing related to breast and ovarian cancer. Genetic testing for breast cancer is covered under Preventive Care. Prior authorization and genetic counseling is required for all medically necessary genetic testing

Hearing Aids

NTESS will cover one hearing aid per hearing-impaired ear every thirty-six months for Dependent Children and disabled dependents under the age of 21. The benefit is unlimited in-network and out-of-network, as follows:

In-Network

- The Member must satisfy $750 annual deductible, before co-insurance payments begin.
- Once the $750 annual deductible is met, the Plan pays 80% coinsurance and the Member pays 20% coinsurance.
- The Member's annual out of Pocket Limit is $2,750 (includes $750 deductible).

Out-of-Network

- Member must satisfy $2,000 annual deductible, before co-insurance payments begin.
- Once the $2,000 annual deductible is met, the Plan pays 60% coinsurance and the Member pays 40% coinsurance.

The Member's annual out of Pocket Limit is $6,500 (includes $2,000 deductible).In addition, this coverage shall include fitting and dispensing services, including providing earmolds as necessary to maintain optimal fit, provided by a licensed audiologist, a hearing aid dispenser or a physician. See Section 13: General Exclusions and General Limitations for additional details.

Home Health Services

Skilled, part-time or intermittent home health Services are covered when you are confined to your home. Skilled home health Services are those Services provided by nurses, medical social workers, and physical, occupational and speech therapists. Medical supplies used during a covered home health visit are also covered. The Services are covered only if a Network Physician determines that you require skilled care and it is feasible to maintain effective supervision and control of your care in your home. Home health aide Services are covered only when you are also getting covered home health care from one of the licensed providers mentioned previously.

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

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

Home Infusion Services

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

- Administration
- Professional pharmacy services
- Care coordination
- All necessary supplies and equipment, including delivery and removal of supplies and equipment
- Drugs and biologicals
- Nursing visits related to infusion

Hospice

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

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

- Network Physician and nursing care
- Counseling and bereavement Services
- Physical, occupational, speech or respiratory therapy for purposes of symptom control or to enable you to maintain activities of daily living.
- Medical social Services
- Home health aide and homemaker Services
- Durable Medical Equipment and Medical supplies
- Palliative drugs, in accordance with Kaiser Permanente's drug formulary guidelines
- Short-term (no more than 5 days at a time) inpatient care, limited to respite care and care for pain control, and acute and chronic symptom management.
- Dietary counseling
- Respite care

Benefits are available only when Hospice care is received from a licensed Hospice agency or hospital.

Fertility Services

Inpatient and outpatient fertility Services include any necessary procedures, laboratory and radiology Services and drugs administered by medical personnel. Fertility Services include correcting underlying medical conditions causing infertility and artificial insemination. Additional eligible services included advanced reproductive technologies such as in vitro fertilization (IVF); zygote intrafallopian transfer (ZIFT) and variations of these procedures (includes fertility preservation (Iatrogenic) services of egg or ovarian tissue retrieval and short-term cryopreservation). Services to rule out the underlying medical causes of Infertility are part of the medical benefit.

A maximum lifetime benefit of $30,000 per Covered Member is allowed for fertility treatments. This maximum is accumulated from any expenses, except prescription drugs, related to fertility treatment paid following a confirmed diagnosis of fertility. There are limitations to eligible

procedures (refer to Section 13: General Exclusions and General Limitations). The maximum lifetime benefit does not include expenses related to diagnosing infertility, testing relating to determining the cause of infertility, or the diagnosis and treatment of an underlying medical condition (e.g., endometriosis) that causes infertility.

Fertility Preservation (Iatrogenic)

When planned cancer or other medical treatment is likely to produce infertility/sterility, the plan covers the collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of oocyte (egg), oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation.

Prescription Drugs for Fertility Treatments

Prescription drugs related to infertility are covered under the Prescription Drug Program. The cost of these drugs is not applied to the $30,000 fertility maximum if received through the Prescription Drug Program.

If the prescription drug or device is provided by the physician and billed through the provider's office or facility charges, the Program will determine eligibility for reimbursement. If categorized as a fertility treatment, the charges will be applied to the $30,000 maximum. These charges may also be applied to the appropriate Deductibles and Out-of-Pocket Limits. Coverage for prescriptions for donors is not covered.

Injections in Physician's Office

Injections in a physician's office are covered as follows:

- In-network:
  - Allergy shots – 20% Coinsurance of Eligible Charges**,** after the Deductible
  - Immunizations/vaccines – no cost to You as outlined under the Preventive Care benefit in this section
  - All other injections (e.g., cortisone, etc.) – 20% of Eligible Charges**,** after the Deductible
- For out-of-network services, You pay 40% of Eligible Charges, after theDeductible

Inpatient Care

Inpatient Covered Services in a hospital are as follows:

- Acute inpatient rehabilitation including physical, occupational, and speech therapy
- Anesthesia
- Bariatric surgery when you meet certain medical criteria
- Blood and blood products and their administration

- Diagnostic x-rays and lab tests, and other diagnostic tests such as EEGs EKGs and endoscopic procedures
- Dialysis
- Dressings and medical supplies used or applied during an inpatient hospital admission
- Drugs that require administration or observation by medical personnel
- Network Physician Services, including consultation and treatment by specialists
- General nursing care
- Medical social Services
- Medically necessary surgical or non-surgical treatment of TMJ.
- Maternity care and delivery (including cesarean section and newborn care)
- Operating and recovery room including FDA approved internally implanted Prosthetic devices such as pacemakers or artificial hips
- Respiratory therapy
- Room and board, including a private room, if Medically Necessary
- Specialized care and critical care units

Benefits for an inpatient stay in the hospital are available only when the inpatient stay is Medically Necessary to prevent, diagnose, or treat a sickness or injury.

If You are admitted to a hospital for an Emergency Medical Condition that is not in the network and services are covered, in-network benefits will be paid until You are stabilized. Once stabilized, You must be moved to a network hospital to continue in-network benefits. You may elect to remain in the out-of-network hospital and receive out-of-network benefits, as long as a network physician confirms the treatment to be Medically Necessary.

Surgeries (resulting in an inpatient stay) performed outside the United States will be covered at the out-of-network level of benefits if they are considered a covered procedure.

Maternity Services

IMPORTANT: Newborn and Mother's Health Protection Act: Under federal law, mothers and their newborns that are covered under group health plans are guaranteed a stay in the hospital of not less than 48 hours following a normal delivery or not less than 96 hours following a cesarean section.

See the Preventive Care section for information on Prenatal Services covered at zero cost share.

The Plan covers physician charges for maternity care, delivery and postnatal care. Also covered are hospital services (including network birthing centers) and newborn care.

Notes:

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

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

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

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

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

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

Note: Applicable to medical claims only. Pharmacy claims processing always requires active eligibility in the claims system.

Benefits for birthing services rendered in the home will be paid at the in-network cost sharing.

Refer to the Employee H&W Plan SPD or the Post-Employment H&W Plan SPD for continued coverage for new dependents. This coverage does not apply to third generation dependents.

Mental (Behavioral) Health Services

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

Inpatient

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

Outpatient Therapy

The following outpatient mental healthcare is covered:

- Partial Hospitalization, sometimes known as day-night treatment programs.
- Intensive outpatient programs.
- Individual and group visits for diagnostic evaluation and psychiatric treatment.
- Other services:
  - Psychological testing.
  - Electroconvulsive therapy (ECT).
  - Visits for the purpose of monitoring drug therapy.

Bariatric Surgery

Bariatric Surgery is provided under the direction of a physician and will be covered provided all of the following are true:

- You have a Body Mass Index (BMI) greater than 40
- BMI 35-40 with a serious obesity related health problem (ex: type 2 diabetes,coronary heart disease or severe sleep apnea)
- Expectable operative risks per ACC guidelines
- An ability to participate in treatment and long-term follow-up
- Ability to exercise
- Able to demonstrate an understanding of the operation, risk and benefits, and long term lifestyle changes.

Office Visits - Outpatient Services

The following Services provided in the physician's office are covered as follows:

- Consultations
- Second opinions

- Post-operative follow-up
- Services after hours and Emergency office visits (allowed separately)
- Office surgery
- Health education
- Supplies dispensed by the provider
- Diagnostic tests
- Radiology services
- Chemotherapy
- Radiation therapy
- Dialysis
- Hearing exams

Other Outpatient Services

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

- House calls by a Network Physician when care can best be provided in Your home
- Infusion services provided in an outpatient setting

Transplant Services

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

- Bone Marrow transplant/stem cell rescue
- Cornea
- Heart
- Heart & lung
- Liver
- Lung
- Kidney; Simultaneous kidney & pancreas
- Pancreas; Pancreas after kidney alone
- Small bowel; Small bowel & liver

The Services are covered if:

- KPIC has determined that you meet certain medical criteria for patients needing transplants; and
- KPIC provides a written referral to an approved transplant facility. The facility may be located outside the Service Area. Transplants are covered only at a facility approved by KPIC, even if another facility within the Service Area could perform the transplant.

Covered Services include:

- Reasonable transportation and lodging expenses outside of the Service Area when approved in advance by Kaiser Permanente. Coverage will include the transplant recipient plus, one parent or guardian if the transplant recipient is a minor or one other person if the transplant recipient is an adult.
- Reasonable medical and hospital expenses of an organ/tissue donor which are directly related to a covered transplant are covered only if such expenses are incurred for Services within the United States or Canada. Coverage of expenses for these Services is subject to Living Donor Guidelines on www.kp.org.
- Per diem reimbursement up to approved limits for daily expenses (includes meals, ground transportation, and any other expenses). The allowance will be paid for all days that Kaiser Permanente determines the Member Recipient must be at the facility and alldays that Kaiser Permanente determines are reasonably required for travel to or from the facility. The Participant recipient will not receive an allowance while an inpatient. Other than the allowance, Kaiser Permanente will not pay for any personal expenses, such as phone calls. Reimbursement will be retrospective.

Limitations and Exclusions:

- Lifetime in-network limit maximum for transportation and lodging is $10,000.
- The search for bone marrow/stem cells from a donor who is not biologically related to thepatient is a service. If a separate charge is made for a bone marrow/stem cell search, the Program will pay up to $25,000 for all charges made in connection with the search.
- The per diem reimbursement for daily expenses is $50 per eligible person (transplant recipient plus, one parent or guardian if the transplant recipient is a minor or one other person if the transplant recipient is an adult), maximum $100 per day.
- Kaiser Permanente does not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.
- Organ/tissue transplants which are experimental or investigational are not covered.

Outpatient Dialysis

Outpatient dialysis services related to acute renal failure and end-stage renal disease are covered if You satisfy all medical criteria developed by medical group and by the facility providing the dialysis.

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

Outpatient Surgical Services

Outpatient Surgery and related services are covered as follows:

- Facility charge
- Anesthesia
- Supplies related to the surgery
- Equipment related to the surgery

Surgeries performed outside the United States will be covered at the out-of-network level of benefits if they are considered a covered procedure.

Medical Foods

Medical foods are foods that are prescribed by a Network Provider and used in the treatment of certain medical conditions, such as phenylketonuria (PKU) and other inherited diseases of amino acids and organic acids caused by genetic defects that can lead to life threatening abnormalities in body chemistry. Medical foods are not foods that are generally available in retail grocery stores. Medical foods are not used with feeding tubes. For coverage of nutritionalformulas delivered via a feeding tube, see Durable Medical Equipment (DME), External Prosthetics and Orthotics DME section.

Preventive Care

The Total Health PPO Plan will not cover all carethat is preventive in nature but will cover certain services under the preventive care benefit as required by the Patient Protection Affordable Care Act.

Preventive services may change according to federal guidelines and Your benefits will be updated to include these changes as they are made throughout the Plan year.

For a complete list of current preventive services required under the Patient Protection Affordable Care Act for which cost share does not apply, please call the customer servicenumber on the back of Your ID card or visit: www.healthcare.gov/center/regulations/prevention.html.

The following preventive care benefits guidelines are based on the recommendations of the U.S. Preventive Services Task Force (USPSTF) although other preventive care services may be covered

as well. Your physician may recommend additional services based on Your family or medical history. The Total Health PPO Plan will not cover all care that is preventive in nature but will cover certain services under the preventive care benefit.

Preventive care refers to measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care:

- protects against disease such as in the use of immunizations,
- promotes health, such as counseling on healthy lifestyles and
- detects disease in its earliest stages before noticeable symptoms develop such asscreening for breast cancer.

IMPORTANT: In order to receive the preventive care benefit, the service must be submitted with a preventive ICD diagnostic code. If it is submitted with a non-preventive ICD diagnostic code, the service will be reimbursed at the applicable benefit level. Routine annual physical exams will be covered under the preventive benefit, even if billed with a non-preventive IDC-9 diagnostic code, so long as a preventive ICD diagnostic code is also billed. It is solely up to the provider as to whether the service is coded as preventive or diagnostic. Neither NTESS nor the Claims Administrator can direct the provider to bill a service in any particular way. The issue asto how it is billed is between You and Your provider.

KP complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Age, sex, and frequency guidelines will be determined by KP providers.

Preventive Services for adults
Abdominal aortic aneurysm—one-time screening by ultrasonography in men age 65 to 75 who have ever smoked
Age-appropriate preventive medical examination
Annual lung cancer screening with low-dose computed tomography and counseling in adults 55 to 80 who are at high risk based on their current or past smoking history
Blood pressure screening
Colon cancer screening for adults including bowel preparations medications prescribed prior to a screening colonoscopy, pathology exam on a polyp biopsy, performed in connection with colon cancer screening, and pre-consultation visit associated with colon cancer screening.
Depression screening
Diabetes screening (type 2) for adults with abnormal blood glucose
Discussion with primary care physician about alcohol misuse screening and counseling
Discussion with primary care physician about diet if at higher risk for chronic disease
Discussion with primary care physician about low-dose aspirin if at high risk of cardiovascular disease or colorectal cancer
Discussion with primary care physician about obesity and weight management, including intensive behavioral counseling for overweight adults at risk of cardiovascular disease
Discussion with primary care physician about sexually transmitted infections prevention

Discussion with primary care physician about tobacco use cessation and counseling

FDA-approved medications for tobacco cessation, including over-the-counter medications, when prescribed by a Plan provider

FDA-approved preexposure prophylaxis (PrEP) with effective antiretroviral therapy to persons at high risk of HIV acquisition, (when prescribed by a Plan provider), including the following baseline and monitoring services for the use of PrEP:

- HIV testing
- Hepatitis B and C testing
- Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR)
- Pregnancy testing
- Sexually transmitted infection (STI) screening and counseling
- Adherence counseling

Hemoglobin A1C testing for the chronic condition of diabetes

Hepatitis B screening for adults at higher risk

Hepatitis C screening for adults 18 to 79 years

Immunizations for adults (doses, recommended ages, and recommended populations vary):

- Hepatitis A
- Hepatitis B
- Herpes zoster
- Human papillomavirus
- Influenza
- Measles, mumps, rubella
- Meningococcal (meningitis)
- Pneumococcal
- Tetanus, diphtheria, pertussis
- Varicella
- Zoster/Shingles

International normalized (INR) testing for the chronic condition of liver disease and/or bleeding disorders

Low-density lipoprotein (LDL) testing for the chronic condition of heart disease

Latent tuberculosis infection screening

Over-the-counter drugs when prescribed by your doctor for preventive purposes:

- Low-dose aspirin to prevent colorectal cancer
- Low-dose aspirin to reduce the risk of heart

Physical therapy to prevent falls in community-dwelling adults age 65 and older who are at increased risk of falling

Retinopathy screening for the chronic condition of diabetes

Routine Physical exam

Sexually transmitted infection screening for adults at higher risk:

- Chlamydia

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

who are capable or planning pregnancy to reduce the risk of birth defects when prescribed by a doctor for preventive purposes)
Pap Test (as needed)
Preeclampsia screening for pregnant women with blood pressure measurements during pregnancy
Prescribed, FDA-approved medications for breast cancer prevention if at higher risk, 35 and older with no prior history of breast cancer
Rh incompatibility screening (for pregnant women) and follow-up testing (for those at higher risk)
Routine Physical exam
Routine prenatal care visits
Screening for diabetes mellitus after pregnancy
Screening for urinary incontinence in women
Syphilis screening for all pregnant women
Urinary tract or other infection screening for pregnant women
Group B strep (between weeks 35 and 37)
Preventive Services for children
Age-appropriate preventive medical examination
Autism screening by primary care physician at 18 months and 24 months
Behavioral assessments by primary care provider throughout development
Blood pressure screening for adolescents
Cervical dysplasia screening for sexually active females
Congenital hypothyroidism screening for newborns
Depression screening for adolescents 12 to 18 years
Developmental screening (under 3 years) and surveillance (throughout childhood) by primary care physician
Discussion with primary care physician about Alcohol and drug use counseling for adolescents
Discussion with primary care physician about Fluoride supplements for children who have no fluoride in their water source
Discussion with primary care physician about Iron supplements for children 6 months to 12 months who are at risk for anemia
Discussion with primary care physician about obesity screening and counseling
Discussion with primary care physician about Sexually transmitted infection prevention counseling for adolescents at higher risk
Discussion with primary care physician about Skin cancer counseling for young adults, adolescents, children and parents of young children about minimizing exposure to ultraviolet (UV) radiation for person 6 months to 24 years with fair skin types to reduce their risk of skin cancer
Discussion with primary care provider about tobacco use cessation and counseling
Dyslipidemia screening for children at higher risk of lipid disorders
FDA-approved medications for tobacco cessation, including over-the-counter medications, when prescribed by a Plan provider
Gonorrhea prevention medication for the eyes of newborns

Hearing screening for newborns Height, weight, and body mass index (BMI) measurements throughout development Hematocrit or hemoglobin screening Hemoglobinopathies or sickle cell screening for newborns Hepatitis B screening for adolescents at higher risk HIV screening for adolescents at higher risk Immunizations from birth to 18 years (doses, recommended ages, and recommended populations vary): - Diphtheria, tetanus, pertussis - Hemophilus influenzae type B - Hepatitis A - Hepatitis B - Human papillomavirus - Inactivated poliovirus - Influenza - Measles, mumps, rubella - Meningococcal (meningitis) - Pneumococcal - Rotavirus - Varicella Lead screening for children at risk of exposure Medical history throughout development Oral health risk assessment by primary care physician - Fluoride supplementation starting at 6 months for children who have no fluoride in their water source - Fluoride varnish for the primary teeth of all infants and children starting at the age of primary tooth eruption Over-the-counter drugs when prescribed by a physician for preventive purposes: - Iron supplements for children to reduce the risk of anemia - Oral fluoride for children to reduce the risk of tooth decay Phenylketonuria (PKU) screening in newborns Routine physical exam Tuberculin testing for children at higher risk of tuberculosis Vision screening
Additional Preventive Services
Prostate Cancer Screening
Plan Sponsor Preventive Services not on the list above
Chlamydia Infection Screening: Sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk. Gonorrhea Screening: Sexually active women, including pregnant women, if they are at increased risk for infection.

Hearing Loss
Sickle Cell Disease, Screening: Newborns
HRSA Recommendation for Preventive Pediatric Health Care based on age (newborn to 21 years):
Physical Examination Procedures - Newborn Metabolic/Hemoglobin Screening:
Well Woman Exam (HRSA)
Breastfeeding, Primary Care Interventions to Promote: Interventions during pregnancy and after birth to promote and support breastfeeding. (Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the post-partum period, and cost for renting breast feeding equipment). Personal double electric breast pumps / supplies at no cost form a network doctor or an approved DME provider. Hospital grade breast pumps / supplies (rental only) covered at deductible/coinsurance.
Hepatitis C virus screening for persons at high risk of infection and one-time screening for adults
HIV
HIV PrEP
Mammogram Screening - Baseline allowable between the ages of 35 and 39, and annual visits allowable age 40 and older. For those patients identified as high risk, annual visits age 25 and older
Osteoporosis Screening every 3 years at age 50 or older
Pregnancy Related Preventive Services
Multiple marker screen (between weeks 15 and 18)
Serum alpha-fetoprotein (between weeks 16 and 18)
Chorionic villus sampling before week 13 or Amniocentesis (between weeks 15 and 18)
Hemoglobinopathy screen
Preventive Labs
Lab work ordered in connection with a preventive check-up will be covered as preventive provided the lab draws (excluding lab work performed in an Emergency Room setting) occur within 7 calendar days of a preventive Wellness Examination. This is regardless of diagnosis or if the lab service would normally fail under the preventive care guidelines as outlined in the benefit document.
Blood count, complete, with differential, which includes: white blood count, red blood count, hemoglobin, hematocrit, platelet, mcv, mchc, rdw. Differential includes neutrophils, lymphocytes, monosite, eosinophil, basophile, absolute neutrophil, absolute lymphocyte, absolute monocyte, absolute eosinophile, absolute basophile, diff type, platelet estimate, red blood cell morphology
Urinalysis, complete, which includes: source, color, appearance, specific gravity, urine PH, protein, urine glucose, urine ketones, urine bilirubin, blood, nitrate, urobilinogen, leukocyte estrase, red blood count, white blood count, squamous epithelial, calcium oxalate
Metabolic profile, complete (Includes sodium, potassium, chloride, CO2, anion, glucose, bun, creatinine, calcium, total protein, albumin, globulin, bilirubin total, alkphos, asp, alt)
Thyroid screen (Includes free T4 and TSH)
Cancer Screening
Fecal occult blood test
Additional information about preventive Services

Preventive and other Services provided during the same visit

There are some additional things to keep in mind about coverage for mandated preventive Services that are provided along with other Services during the same visit. The following Cost Share rules apply when a mandated preventive Service is provided during an office visit:

If the preventive Service is billed separately (or is tracked as individual encounter data separately) from the office visit, then cost sharing may apply to the office visit.

If the preventive Service is not billed separately (or is not tracked as individual encounter data separately) from the office visit, then:

- o If the primary purpose of the office visit is the delivery of the preventive service, then no cost sharing may apply to the office visit.
- o If the primary purpose of the office visit is not the delivery of the preventive service, then cost sharing may apply to the office visit.

Note: The Preventive List is subject to changes based on new Federal recommendations (and clinical interpretations) issued after the date of this document

Professional Fees for Surgical Procedures

The Total Health PPO Plan pays professional fees for surgical procedures and othermedical care received from a physician in a hospital, in-network or out-of-network skillednursing facility, inpatient rehabilitation facility, or outpatient surgery facility.

This Program will pay the following surgical expenses:

- A surgeon will not be paid as both a co-surgeon and an assistant surgeon.
- Expenses for certified first assistants are allowed.
- Incidental procedures are those services carried out at the same time as a more complex, primary procedure. The incidental procedure may be a part of the primary procedure and require little or very little additional time and resources; therefore, they are usually not covered.
- A surgical procedure that is performed and not considered incidental to the primary procedure will be reimbursed at half of the allowable. For example: when bilateral surgical procedures are performed by one or two surgeons, the Total Health PPO Plan will consider the first procedure at the full allowed amount, and the secondprocedure will be considered at half of the allowed amount of the listed surgical unitvalue.
- Foot surgery – for a single surgical field/incision or two surgical fields/incisions on the same foot, the Program will allow the full amount for the procedure commanding the greatest value; half of the full amount for the second procedure; half of the full amount for the third procedure; and a quarter of the full amount for each subsequent procedure.

Prosthetic Devices/Appliances

The Total Health PPO Plan covers prosthetic devices and appliances that replace a limb orbody part or help an impaired limb or body part work. Examples include:

- Artificial limbs
- Artificial eyes
- Breast prosthesis following a mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras (see Durable Medical Equipment (DME), External Prosthetics and Orthotics DME section) and lymphedema stockings. There are no limitations on the number of prostheses and no time limitationsfrom the date of the mastectomy. Refer to Reconstructive Procedures section for more information.

If more than one prosthetic device can meet Your functional needs, benefits are available only forthe most cost-effective prosthetic device. The device must be ordered or provided either by a physician, or under a physician's direction.

Benefits are provided for the replacement of each type of prosthetic device. Prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement, if the device or appliance breaks, or is otherwise irreparable. Replacement of artificial limbs or any part of such devices may be covered when the condition

of the device or part requires repairs that cost more than the cost of a replacement device or part. If the appliance is lost or stolen, the Total Health PPO Plan may not pay for replacement unless the device or appliance is at least five years old.

Reconstructive Procedures

The Total Health PPO Plan covers certain Reconstructive Procedures where a physical impairment exists, and the expected outcome is a restored or improved physiological function foran organ or body part.

Improving or restoring physiological function means that the organ or body part is made to work better. The fact that You may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored. There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Upper eyelid surgery, for example, is sometimes performed to improve vision, which is considered a Reconstructive Procedure, but in other cases, improvement in appearance is the primary intended purpose, which is considered a cosmetic procedure and is not covered.

Correction of congenital hemangioma (known as port wine stain) is limited to hemangiomas of the face and neck for children aged 18 years and Younger.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy. Coverage is provided for all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Replacement of an existing breast implant is covered if the initial breast implant followed mastectomy.

Rehabilitation and Habilitative Services

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

Rehabilitation and habilitative services for the following types of therapy are covered:

- Inpatient and outpatient multidisciplinary rehabilitation in an approved organized multidisciplinary program or facility; and
- Outpatient physical, occupational, and speech therapy; and

- Outpatient pulmonary rehabilitation; and
- Outpatient cardiac rehabilitation.

Rehabilitation services must be provided by a licensed therapy provider and be under the direction of a physician. Physical, occupational, and speech therapy are subject to reimbursement with demonstrated improvement as determined by Your Network Physician.

Manual therapy techniques for lymphatic drainage, including manual traction, etc., arecovered when performed by a licensed chiropractor, physical therapist, or physician.

Skilled Nursing Facility Services

Facility services for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility are covered. Skilled inpatient services and supplies must be services customarily provided by a skilled nursing facility and must be above the level of custodial or intermediate care. Benefits include:

- Network Physician and nursing services.
- Room and board.
- Medical social services.
- Prescribed drugs.
- Respiratory therapy.
- Physical, occupational, and speech therapy.
- Medical equipment ordinarily furnished by the skilled nursing facility.
- Medical supplies.
- Imaging and laboratory services ordinarily provided by skilled nursing facilities.
- Blood, blood products and their administration.

Note: The Total Health PPO Plan will pay the difference in cost between a semiprivateroom and a private room only if a private room is Medically Necessary.

Benefits are available when skilled nursing and/or inpatient rehabilitation facility services are needed daily. Benefits are also available in a skilled nursing facility or inpatient rehabilitation facility for treatment of a sickness or injury that would have otherwise required an inpatient stay in a hospital.

The intent of skilled nursing is to provide benefits if, because of an injury or sickness, You require:

- An intensity of care less than that provided at a general acute hospital but greater than thatavailable in a home setting

- A combination of skilled nursing, rehabilitation, and facility services

The Program does not pay benefits for custodial care, even if ordered by a physician.

Substance Use Disorder Services

Inpatient:

Hospitalization (including residential treatment) is covered for medical management of withdrawal symptoms, including room and board, Network Physician services, drugs that require administration or observation by medical personnel, dependency recovery services, and counseling. Substance use disorder rehabilitation services in a licensed residential treatment Network Facility are also covered.

Outpatient:

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

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

Temporomandibular Joint (TMJ) Syndrome

The Total Health PPO Plan covers diagnostic and medical treatment of conditions affecting the temporomandibular joint, including splints, when provided by or under the direction of a physician. Coverage includes Medically Necessary treatment required because of accident, trauma, a congenital anomaly, developmental defect, or pathology.

Urgent Care Services

The Program will cover Urgent Care as follows:

- If You receive care at an in-network Urgent Care Facility within the United States, You will be reimbursed under the in-network level of benefits.
- If You receive care at an out-of-network Urgent Care Facility within the UnitedStates, You will be reimbursed under the in-network level of benefits.
- If You are traveling outside the United States, Your claim will be processed at the in-network benefit level.
- Follow-up care while traveling outside the United States will be covered at the out-of-network level of benefits.
- Follow-up care while traveling within the United States will be covered at theapplicable in-network level of benefits only if the place of care is not located within a service area of any in-network provider.

Treatment of Pervasive Development Disorders

Covered Services for pervasive developmental disorder or autism include:

- Medically Necessary Inpatient, Skilled Nursing Home and Outpatient care;
- Behavioral health treatment;
- Applied behavior analysis and evidence-based behavior intervention programs that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet all the following criteria:
  - The treatment is referred by KPIC and administered by a Network Provider. Reminder certain services require Prior-Authorization:

    Required Prior-Authorization List
    - All inpatient and outpatient facility services (excluding emergencies);
    - Office based habilitative / rehabilitative care: ABA, Occupational; Speech, and Physical therapies;
    - All services provided outside a KP facility;
    - All services provided by non-network providers; and
    - Drugs and Durable Medical Equipment not contained on the KP formulary.
  - The treatment plan has measurable goals over a specific timeline that is developed and approved by the Network Qualified Autism Service Provider;
  - The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate and the treatment plan includes:
    - the behavioral health impairments to be treated;
    - an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the progress is evaluated and reported;
    - utilizes evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism; and
    - discontinues intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate.
  - The treatment plan is not used for either of the following:
    - for purposes of providing (or for the reimbursement of) respite care, day care, or educational services; or
    - to reimburse a parent for participating in the treatment program.

Exclusions:

- Services not identified in an approved treatment plan;
- Teaching manners and etiquette;

- Teaching and support services to develop planning skills such as daily activity planning and project or task planning;
- Items and services for the purpose of increasing academic knowledge or skills;
- Teaching and support services to increase intelligence;
- Academic coaching or tutoring for skills such as grammar, math, and time management;
- Teaching you how to read, whether or not you have dyslexia;
- Educational testing;
- Teaching skills for employment or vocational purposes;
- Professional growth courses; and
- Training for a specific job or employment counseling.

Section 9: In-Network Services that Require Prior Authorization

Services not available from Network Providers require Prior Authorization in order to be paid at the in-network level. If Your Network Physician decides that You require Covered Services not available from Network Providers, he or she will recommend to the medical group that You be referred to a Non–Network Provider inside or outside the Service Area. The appropriate Medical Group designee will authorize the services if he or she determines that they are Medically Necessary and are not available from a Network Provider. Referrals to Non–Network Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask Your network physician what services have been authorized.

Required Prior Authorization List for In-Network Benefits

- All inpatient and outpatient facility services (excluding emergencies)
- Office based habilitative/rehabilitation: occupational; speech, and physicaltherapies
- All services provided outside a KP facility
- All services provided by non-network providers
- All Dental Services
- Drugs and Durable Medical Equipment not contained on the KP formulary

For more information about the Kaiser Permanente’s DME formulary, please refer to Durable Medical Equipment (DME), External Prosthetics and Orthotics DME section.

- Ostomy and urological supplies. If Your Network Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Network Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered, and the item is listed on the Kaiser Permanente’s soft goods formulary for Your condition. If the item doesn't appear to meet the Kaiser Permanente’s soft goods formulary guidelines, then the coordinator will contact the Network Physician for additional information. If the request still doesn't appear to meet the Kaiser Permanente’s soft goods formulary guidelines, it will be submitted to the Medical Group's designee Network Physician, who will authorize the item if he or she determines that it is Medically Necessary.
- Transplants. If Your Network Physician makes a written referral for a transplant, the medical group's regional transplant advisory committee or board (if one exists) will authorize the services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer You to

physician(s) at a transplant center, and the Medical Group will authorize the services if the transplant center's physician(s) determine that they are Medically Necessary.

Note: A Network Physician may provide or authorize a corneal transplant without using this medical group transplant authorization procedure.

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For more information about utilization review, a copy of the complete utilization review criteria approved by the Program for a specific condition, or to talk to a utilization review staff person, please contact customer service. Please refer to the customer service numbers for Your home Region in Section 18: Customer Service Phone Numbers.

Authorizations for services may be revoked or amended if You have not yet received the services if Your participation terminates or Your coverage changes, or You lose Your Eligibility. For care received in a Kaiser Permanente facility or by Kaiser Permanente providers, no authorization is required. All care is managed by Your Kaiser physicians and is a component of Your physician's referral within the Kaiser system. For care received outside a Kaiser Permanente facility or by non-Kaiser Permanente providers, Your physician will request prior authorization and or referralfor care.

Section 10: Prescription Drug Program

Some Kaiser Permanente Pharmacies may not be able to fill or refill a prescription from an out-of-network provider.

Outpatient Prescription Drugs

Outpatient drugs, supplies, and supplements are covered when all of the followingrequirements are met:

- The item is prescribed by a Network Provider or an out-of-network provider authorized to prescribe drugs or by one of the following Non-Network Providers:
    - A dentist
    - A Non-Network Provider
    - A Non-Network Provider if You got the prescription in conjunction with Covered Services
    - A Community Pharmacy in a Service Area outside of California; or
    - The first refill of a prescription originally filled prior to enrollment in the Plan.
- The item is prescribed in accordance with Kaiser Permanente drug formularyguidelines.
- You get the item from a Network Pharmacy or the Kaiser Permanente mail order Service, except that you can get the item from a Non-Network Pharmacy if you obtain the prescription in conjunction with covered Urgent Care or Emergency Service outside the Service Area and it is not possible for you to get the item from a Network Pharmacy. Please refer to www.kp.org for the locations of Network Pharmacies in your area.
- The item is one of the following:
    - Drugs that require a prescription by law including:
        - Contraceptive drugs including the emergency contraceptive pill and devices, such as diaphragms and cervical caps and over the counter contraceptives when prescribed by a Network physician;
        - Fertility drugs;
        - Drugs for the treatment of sexual dysfunction;
        - Smoking Cessation products; or
        - Drugs used in the treatment of weight control.
- Drugs that do not require a prescription but are listed on KaiserPermanente's drug formulary.
- Diabetic supplies such as insulin, syringes, pen delivery devices, blood glucose

monitors, test strips and tablets. Other diabetic supplies may be covered under Durable Medical Equipment.

- Specialty drugs – high-cost drugs contained on the KP specialty drug list. To obtain a list of specialty drugs on the KP formulary, or to find out if a non-formulary drug is on the specialty drug list, please call Customer Service.

Kaiser Permanente uses a formulary, which is a list of drugs that have been approved for coverage by the Pharmacy and Therapeutics Committee. The drug formulary guidelines allow You to obtain non-formulary prescription drugs (those not listed on the drug formulary for Your condition) if they would otherwise be covered if pharmacy criteria are met. Prescriptions written by dentists are not eligible for non-formulary exceptions.

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the formulary includes a pre-determined amount of an item that constitutes a Medically Necessary day's supply. The pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (the pharmacy can tell You if a drug You take is one of these drugs).

Note: episodic drugs prescribed for the treatment of sexual dysfunction disorders may be limited by number of doses within a 30-day period.

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

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

Refills may be ordered from Kaiser Pharmacies, the mail-order program, or online at www.kp.org. A Kaiser Pharmacy can provide more information about obtaining refills.

To locate a Network Pharmacy, view the formulary, learn more about mail order or print a claim form, sign on to www.kp.org, click Pharmacy or call OptumRx 866-427-7701.

For outpatient prescription drugs and/or items covered under this Outpatient-Prescription Drug section and obtained at a pharmacy owned and operated by Kaiser Permanente, you may use certain manufacturer coupons you have procured, when allowed by law (i.e., on HSA plans you must satisfy your deductible prior using a coupon) and approved by Kaiser Permanente, as payment of your Cost Sharing. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Sharing for your prescription. If the coupon is for an amount greater than the Cost Sharing amount you owe for your prescription, no credit, cash or other refund will be given for the excess amount. When a coupon is accepted toward satisfaction of your Cost Sharing, an amount equal to the coupon value and, if applicable, any

additional amount that you pay, will accumulate to Out-of-Pocket Limit. Kaiser Permanente reserves the right to change the terms and conditions of its coupon program, including but not limited to the types and amounts of coupons that will be accepted at any time without prior notice. You may obtain information regarding the Kaiser Permanente coupon program at www.kp.org and search on the term "coupons". Acceptance of your coupon does not relieve you of your responsibility regarding Cost Sharing if the drug manufacturer does not honor the coupon in whole or in part or if Kaiser Permanente later determines that the coupon was not allowed. www.kp.org/rxcoupons

Covered Preventive Medications

The Total Health PPO Plan will pay 100% of the cost at a retail network pharmacy for the following medications:

- Aspirin
- Oral fluoride
- Folic acid
- Iron supplements
- Female contraceptives
- PrEP for HIV Prevention
- Tobacco cessation products

The following chart summarizes Your Coinsurance responsibility as well as coverage for purchases under the Mail-Order Program and the Kaiser network and out-of-network retail pharmacies.

<table>
<tr><th>Kaiser Permanente Mail-Order Program (For maintenance prescription drugs)</th><th>Kaiser Network Retail Pharmacies</th><th>Out-of-Network Retail Pharmacies</th></tr>
<tr><td>Coinsurance of 20% of mail order price with a $12.50 minimum and $25 maximum for generic prescription drugs</td><td>Coinsurance of 20% of retail discount price with a $5 minimum and $10 maximum for generic prescription drugs</td><td>50% reimbursement</td></tr>
<tr><td>Coinsurance of 30% of mail order price with a $75 minimum and $112.50 maximum for preferred brand name prescription drugs</td><td>Coinsurance of 30% of retail discount price with a $35 minimum and $45 maximum for preferred brand name prescription drugs</td><td>50% reimbursement</td></tr>
<tr><td>Coinsurance of 40% of mail order price with a $125 and $187.50 maximum for non-preferred brand name prescription drugs</td><td>Coinsurance of 40% of retail discount price with a $50 minimum and $75 maximum for non-preferred brand name prescription drugs</td><td>50% reimbursement</td></tr>
<tr><td>No charge for mail order preventive tier prescription drugs</td><td>No charge for preventive tier prescription drugs from a retail pharmacy</td><td>Retail cost share</td></tr>
<tr><td>Maximum of 100-day supply</td><td>Maximum of 30-day supply</td><td>Maximum of 30-day supply</td></tr>
<tr><td colspan="2">Out-of-Pocket Limit is $1,500 per person per year and $5,950 family. Refer to Section 5: Deductibles, Out-of-Pocket Limits, and Lifetime Maximums section for more information.</td><td>Out-of-Pocket Limit doesnot apply</td></tr>
<tr><td colspan="3">Coinsurance does not apply to the Total Health PPO Plan medical deductible or out-of-Pocket Limit. Reimbursement for prescriptions purchased outside the United States willbe reimbursed at the applicable retail Coinsurance, limited to a maximum of a 30-day supply.</td></tr>
</table>

Section 11: Emergency and Post-Stabilization Services, FromNon-Network Providers

This section explains certain protections against balance billing and out-of-network cost sharing under the No Surprises Act (NSA) and how to obtain covered emergency and post-stabilization from non–Network Providers.

If You have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need Prior Authorization for Emergency Services. When You have an Emergency Medical Condition, we cover Emergency Services You receive from Network Providers or Non-Network Providers anywhere in the world, as long as the services would have been covered under the Section 9: Benefits.

Emergency Services are available from hospital emergency departments 24 hours a day, seven days a week.

For ease and continuity of care, you are encouraged to go to a Network Hospital emergency department if you are inside the Service Area, but only if it is reasonable to do so, considering your condition or symptoms.

No Surprises Act Requirements

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes certain requirements relating to surprise billing claims under the NSA. This section explains the requirements and Your rights under the NSA.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the NSA requirements (as applicable to each type of claim listed below):

- Emergency Services provided by out-of-network providers;
- Covered services provided by an out-of-network provider at an in-network facility; and
- Out-of-network air ambulance services.

Emergency Services

Emergency Services (i.e., services relating to an emergency medical condition in an emergency department of a hospital or in an independent freestanding emergency department) are covered without the need for prior authorization and regardless of whether the services are received from an in-network provider or an out-of-network provider. If Emergency Services are received from an out-of-network provider, the following NSA protections will also apply:

- Any applicable administrative requirements or coverage limitations will not be more

restrictive than the requirements or limitations that apply to Emergency Services received from in-network providers and in-network emergency facilities.

- Your cost-sharing payments will count toward any in-network deductible or out-of-Pocket Limits under Your medical plan, and the in-network deductible or out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider or facility.

- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider or in-network emergency facility.

Additionally, Your out-of-network provider may not balance bill You for Emergency Services, meaning the out-of-network provider may not charge You for any difference between the maximum allowable amount payable under Your medical plan and the out-of-network provider's billed charges.

Post-Stabilization Services

Post-Stabilization Services are services covered under the Program that are provided by an out-of-network provider or out-of-network emergency facility after You have received Emergency Services and are stabilized. Post-Stabilization Services are subject to the same NSA protections as Emergency Services unless excepted under the Notice and Consent Exception (see "Notice and Consent Exception for Certain Services" section below for specific requirements). The Notice and Consent Exception requires that the out-network provider supply You with proper notice of the Post-Stabilization Services and that You provide informed consent to receive such services. The out-of-network provider must also determine that You are:

- stable;

- able to travel to an in-network facility by non-medical or non-emergency transport;

- in a condition to receive the information and provide informed consent.

If the out-of-network provider meets the Notice and Consent Exception requirements and You continue to receive services from the out-of-network provider after You are stabilized, You will be responsible for the out-of-network provider cost-shares, and the out-of-network provider will also be able to balance bill You (i.e., charge You any difference between the maximum allowable amount payable under Your medical plan and the out-of-network provider's billed charges). However, there are certain services that cannot be excepted under the notice and consent exception even if the out-of-network provider meets all the requirements (refer to Ancillary Services in the "Notice and Consent Exception for Certain Services" section below).

Non-Emergency Services from an Out-of-Network Provider at an In-Network Facility

If You receive non-Emergency Services covered under the Program from an out-of-network provider at an in-network facility, the following NSA protections will apply:

- Any applicable administrative requirements or coverage limitations will not be more restrictive than the requirements or limitations that apply to non-Emergency Services

received from an in-network provider.

- Your cost-sharing payments will count toward any in-network deductible or out-of-Pocket Limits under Your medical plan, and the in-network deductible or out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider.

- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider.

Additionally, Your out-of-network provider may not balance bill You for the non-Emergency Services (i.e., charge You any difference between the maximum allowable amount payable under the Program and the out-of-network provider's billed charges).

However, the NSA protections will not apply if the Notice and Consent Exception applies (see "Notice and Consent Exception for Certain Services" section below for specific requirements). Under the Notice and Consent Exception, the out-of-network provider must provide You with proper notice of the non-Emergency Services and You must provide informed consent to receive such services. However, there are certain services that cannot be excepted under the notice and consent exception even if the out-of-network provider meets all the requirements (refer to Ancillary Services in the "Notice and Consent Exception for Certain Services" section below).

Notice and Consent Exception for Certain Services

For certain Post-Stabilization Services and certain non-Emergency Services, applicable NSA protections will not apply if the out-of-network provider provides You with proper notice and You provide written informed consent to such services that meet the requirements discussed below. The provider's notice is required to inform You about Your NSA protections from unexpected medical charges, give You the option to give up those protections and potentially pay more for out-of-network care, and provide an estimate of what Your out-of-network care might cost.

"Proper notice" from a provider requires that at least 72 hours before the day of the appointment, or 3 hours in advance of services rendered in the case of a same-day appointment, the provider supplies You with a written notice disclosing:

- the provider is an out-of-network provider with respect to the Program;

- the good faith estimated charges for Your covered services;

- any advance limitations that Your medical plan may put on Your treatment (e.g., any prior authorization requirements, etc.); and

- You may elect to seek care from an available in-network provider instead.

Note: If the notice relates to Post-Stabilization Services (see "Post-Stabilization Services" section above), the notice must also include a list of the names of any in-network providers at the facility who are able to treat You and a statement that You may elect to be referred to one of the in-network providers.

"Informed consent" requires that You give the provider written consent to any charges disclosed in the provider's notice, acknowledging that You understand that continued treatment by the out-of-network provider may result in greater cost to You. This means You will be responsible for out-of-network provider cost-shares for those services and the out-of-network provider can also balance bill You for such services (i.e., charge You any difference between the maximum allowable amount under Your medical plan and the out-of-network provider's billed charges).

The notice and consent exception does not apply to the following services, which are always covered by the NSA protections:

- Ancillary Services, which means:
    - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
    - Items and services provided by assistant surgeons, hospitalists, and intensivists;
    - Diagnostic services, including radiology and laboratory services; and
    - Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished.

How Cost-Shares Are Calculated

Your cost-shares for NSA-protected Emergency Services or covered non-Emergency Services received by an out-of-network provider at an in-network facility are calculated using the median in-network contract rate that the medical plan applies to in-network providers for the geographic area where the covered service is provided. Any out-of-pocket cost-shares You pay to an out-of-network provider for either Emergency Services or covered non-Emergency Services provided by the out-of-network provider at an in-network facility will be applied to Your in-network out-of-pocket limit and Your in-network deductible in the same manner as if such cost-sharing payment was made with respect to items and services furnished by an in-network provider or facility.

Coverage of Air Ambulance Services

If You receive Air Ambulance Services (i.e., medical transport by helicopter or airplane for patients) from an out-of-network provider, and such services would have been covered under the medical if provided by an in-network provider, then the medical plan will cover the services as follows:

- Your cost-sharing payments will be counted toward any in-network deductible or out-of-Pocket Limits under the medical plan, and the in-network deductible or out-of-Pocket Limits will be applied in the same manner as if Your cost-sharing payments were made for services by an in-network provider.

- Your cost-sharing will be no more than the cost-sharing that would apply if the services were provided by an in-network provider.
- Cost-sharing will be calculated based on the lesser of the qualifying payment amount (i.e., the median in-network contract rate the medical plan applies to in-network providers for the geographic area where the covered service is provided) or the out-of-network provider's billed amount.
- Not later than 30 calendar days after all information necessary to decide Your claim for the services has been received, Kaiser will send the provider an initial payment or a notice of denial of payment.

Appeals and External Reviews

If You have a claim that is denied and You believe the claim is protected by the surprise billing and cost-sharing protections under the NSA, You have the right to appeal Your claim under the Program's internal claims and appeals process.

If You have exhausted, or are deemed to have exhausted, the Program's internal claims and appeals process or You have requested an expedited external review, You may request external review for any adverse determination involving consideration of whether the Program is complying with the surprise billing and cost-sharing protections under the NSA.

Examples of NSA Adverse Benefit Determinations Eligible for External Review

- Patient cost-sharing and surprise billing for emergency services;
- Patient cost-sharing and surprise billing protections related to care provided by nonparticipating providers at participating facilities;
- Whether patients are in a condition to receive notice and provide informed consent to waive NSA protections; and
- Whether a claim for care received is coded correctly and accurately reflects the treatments received, and the associated NSA protections related to patient cost-sharing and surprise billing.

Refer to Section 16: Claims and Appeals for information regarding the Program's claims and appeals process and external review procedures.

Continuity of Care

If You are a continuing care patient, and the contract with Your in-network provider or facility terminates:

- You will be notified in a timely manner of the contract termination and of Your right to elect continued transitional care from the provider or facility; and
- You will be allowed up to 90 days of continued coverage at in-network cost-sharing to allow for a transition of care to an in-network provider.

The term "Continuing Care Patient" means an individual who, with respect to a provider or facility:

- is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
- is undergoing a course of institutional or inpatient care from the provider or facility;
- is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

The term "Serious and Complex Condition" means, with respect to a participant under the plan, one of the following:

- in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
- in the case of a chronic illness or condition, a condition that is—
    - is life-threatening, degenerative, potentially disabling, or congenital; and
    - requires specialized medical care over a prolonged period of time.

Note: the right to elect continued transitional care described in this section does not apply if the contract with an in-network provider or facility is terminated for failure to meet applicable quality standards or for fraud.

Refer to Section 2: ("Transition of Care/Special Circumstances") of this Benefit Summary for additional information regarding continuity of care.

Transparency

The following information is publicly available at hr.sandia.gov (search "Plan Documents"). The following information is also provided on each explanation of benefits for any item or service You receive that is covered by the NSA:

- Protections with respect to Surprise Billing Claims by providers;
- Estimates on what out-of-network providers may charge for a particular service;
- Information on contacting state and federal agencies in case You believe a provider has violated the No Surprises Act's requirements.

You may obtain the following information through hr.sandia.gov (under "Publicly Available Files"):

- Cost sharing information that You would be responsible for, for a service from a specific in-network provider;
- Cost sharing information on an out-of-network provider's services based on the medical plan's reasonable estimate based on what the medical plan would pay an out-of-network provider for the service;
- A list of all in-network providers (refer to "Finding Network Providers" above for additional information).

In addition, You may access the following information online at hr.sandia.gov (under "Publicly Available Files"):

- In-network negotiated rates;
- Historical out-of-network rates; and
- Drug pricing information.

Section 12: Definitions

Please note that certain capitalized words in this Benefit Summary have special meanings. These words have been defined in this section. You can refer to this section as You read this document to have a clearer understanding of Your benefits.

In this Summary, Members and Dependents may be referred to as "You" or "Your."

Term	Definition
Adverse Benefit Determination	• A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of Your, or Your beneficiary's, eligibility to participate in the Plan. • A denial, reduction, or termination of a benefit by the Plan, or a failure of the Plan to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review; and a failure of the Plan to cover an item or service for which benefits are otherwise provided because such item or service is determined to be experimental or investigational or not Medically Necessary or appropriate. • The Plan's determination that a participant or beneficiary is not entitled to a reasonable alternative standard for reward under a wellness program. • The Plan's determination as to whether the Plan is not complying with the non-quantitative treatment limitation parity provision of the Mental Health Parity and Addiction Equity Act. • Plan determinations that involve plan compliance with surprise billing and cost-sharing protections under the Federal No Surprises Act.
Allowable Amount	• The amount the provider has contracted to accept for services rendered. This amount is based on a case rate for bundled professional and facility services, a contract rate or a network fee schedule. In the case of pharmaceuticals, the Allowable Amount is an amount based on the average wholesale price plus a dispensing fee. • For Non-network providers, In situations where there is no contracted amount the Allowable Amount is the Usual and Customary Rate (UCR) or billed charges.
Allowance	A dollar amount the Program will pay for benefits for a service during a specified period of time. Amounts in excess of the Allowance, are Your responsibility to pay and do not apply toward Your Out-of-Pocket Limit.
Claims Administrator	KPIC is the self-funded claims administrator. You can find the Claims Administrator's address in Section 18: Customer Service Phone Numbers and on Your Kaiser Permanente ID card.

Term	Definition
Ancillary Service	Services that are: Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner Items and services provided by assistant surgeons, hospitalists, and intensivists Diagnostic services, including radiology and laboratory services Items and services provided by a nonparticipating provider if there is no Network provider who can furnish such item or service at such facility Items or services furnished because of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Network Provider satisfies the notice and consent requirements under federal law.
Claims Administrator	The Kaiser Permanente Insurance Company (KPIC) self-funded claims administrator. You can find the Claims Administrator's address in the **Error! Reference source not found.** section and on your Kaiser Permanente ID card.
Clinically Stable	You are considered Clinically Stable when Your treating physician believes, within a reasonable medical probability and in accord with recognized medical standards, that You are safe for discharge or transferand that Your condition is not expected to get materially worse during, or as a result of, the discharge or transfer.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985.
Coinsurance	The percentage of a service which the Program pays after You have met the Deductible.
Community Pharmacy	A retail pharmacy under contract with Kaiser Permanente.
Copayment	A specified dollar amount that You must pay for certain CoveredServices.
Cost Sharing	Copayments, Coinsurance and Deductibles.
Covered Service	Services that meet the requirements for coverage described in this Benefit Summary.
Custodial Care	Any service, procedure or supply that is provided primarily: • For ongoing maintenance of a person's condition, not for therapeutic value, in the treatment of an illness or injury • To assist a person in meeting activities of daily living for example, assistance in walking, bathing, dressing, eating and preparation of special diets and supervision over self-administration of medication not requiring the constant attention of trained medical personnel Such services and supplies are regarded as custodial without regard to the following: • Who prescribes the service and supplies • Who recommends the service and supplies

	• Who performs the service or the method in which such services are performed
Deductible	Eligible Charges incurred during a calendar year that You must pay in full before the Total Health PPO Plan pays benefits. Does not apply to outpatient prescription drugs purchased through Kaiser Permanente.
Dental Services	Items and services provided in connection with the care, treatment, filling or removal, or replacement of teeth or structures directly supporting the teeth. (Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.)
Dependent	A person who is enrolled in the Program if the person's relationship to the Member is the basis for eligibility (i.e., Your eligible Child(ren) and Spouse as described in the Employee H&W Plan SPD and Post-Employment H&W Plan SPD).
Durable Medical Equipment (DME)	Durable Medical Equipment (DME) is a device or instrument of a durable nature that meets all of the following requirements: • It can withstand repeated use; • It is primarily and customarily used to serve a medical purpose; • It is generally not useful to a person in the absence of illness or injury; and • It is appropriate for use in Your home.
Eligible Charges Network Providers	• For services provided by Kaiser Permanente, the charge in the relevant Kaiser Foundation Health Plan's schedule of Kaiser Permanente charges for services provided to participants. • For services that Network Providers (other than Kaiser Permanente) provide under a contract with Kaiser Permanente, the amount that the provider has agreed to accept as payment in full under that contract. For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge You for the item if Your benefits did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs and other items, the direct and indirect costs of providing Kaiser

Term	Definition
	• Permanente pharmacy services, and the pharmacy program's contribution to the net revenue requirements of the relevant KaiserFoundation Health Plan). • For all other services, the amounts that the Plan pays for the services or, ifthe Plan subtracts Cost Sharing from its payment, the amount the Plan would have paid if it did not subtract Cost Sharing.
Eligible Charges Non-Network Providers	• For Emergency Services and scheduled services at a Network Hospital or ambulatory surgical center rendered by Non-Network Providers, the plan's Qualifying Payment Amount (QPA) – which is the median contracted rate (the middle amount in an ascending or descending list of contracted rates), adjusted for market consumer price index in urban areas (CPIU). The Cost Share will be based on the Recognized Amount (RA) which is lower of the QPA or the provider billed charges for a given service. The QPA is based on contracted rates for the same or similar insurance market (individual, large group, small group, self-insured employer); geography, based on MSAs (Metropolitan Statistical Area - a geographical region with a relatively high population density at its core and close economic ties throughout the area) and the non-MSA areas in a state; and service provided in the same or similar specialty or type of facility. The contracted rates must reflect the total provider reimbursement amount contractually agreed, including cost-sharing, whether it's under a direct or indirect contract with the plan. • To determine the QPA when there is no contracted rate KPIC will use the lower of an underlying fee schedule or the derived amount from Kaiser claims history. • In the alternative KPIC may attempt to contract with the provider on a patient-by-patient basis. • Should a provider dispute the QPA they may enter into an Independent Dispute Resolution (IDR) process after a 30-day negotiation period. A certified IDR entity will select between the provider and KPIC's offer of payment. The non-prevailing party will pay all fees charged by the IDR entity.
Emergency Medical Condition	A medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: • Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; • Serious impairment to bodily functions; or • Serious dysfunction of any bodily organ or part.

	A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true: • The person is an immediate danger to himself or herself or to others • The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder
Emergency Services	All of the following with respect to an Emergency Medical Condition: a. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate an Emergency Medical Condition; b. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and c. Post stabilization services which are additional services covered under the Plan that are furnished by a Non-Participating Provider or Non-Participating emergency facility (regardless of the department of the hospital in which such items or services are furnished) after a patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay, with respect to the visit in which the services described in subsections a. and b. are provided, until: (1) The provider or facility determines that the participant or dependent is (i) stable; (ii) able to travel using nonmedical transportation or nonemergency medical transportation to an available Participating Provider or Participating Facility within a reasonable travel distance, taking into account the individual's medical condition; and (iii) in a condition to receive the information and provide informed consent, as described herein; (2) The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Participating Provider with respect to the Plan, of the estimated charges for the treatment and any advance limitations that the Plan may put on such treatment, of the names of any Participating Providers at the facility who are able to provide such treatment, and that the participant or dependent may elect to be referred to one of the Participating Providers listed; and (3) The participant or dependent gives informed consent to continued treatment by the Non-Participating Provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Participating Provider may result in greater cost to the participant or dependent.

Term	Definition
EMTALA	The Emergency Medical Treatment and Labor Act (EMTALA) is a United States Congressional Act passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.
ERISA	The Employee Retirement Income Security Act of 1974, as amended.
Experimental and Investigational	• Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients); • It requires government approval that has not been obtained when Service is to be provided; • It cannot be legally performed or marketed in the United States without FDA approval; • It is the subject of a current new drug or device application on file with the FDA; • It has not been approved or granted by the U.S. Food and Drug Administration (FDA) excluding off-label use of FDA approved drugs and devices • It is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; • It is subject to approval or review of an Institutional Review Board or other body that approves or reviews research; • It is provided pursuant to informed consent documents that describe the Services as experimental or investigational, or indicate that the Services are being evaluated for their safety, toxicity or efficacy; or • The prevailing opinion among experts is that use of the Services should be substantially confined to research settings or further research is necessary to determine the safety, toxicity or efficacy of the Service; • It is provided for Non-referred Services in connection to an approved clinical trial and/or Services in connection with a non-approved clinical trial; Services related to Clinical Trials are considered Experimental and Investigational when; • Items and Services are provided solely to satisfy data collection and analytical needs of a clinical trial and are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan); • Items and Services customarily provided by the research sponsors free of charge for any enrollee in the trial; and

	Items or Services needed for reasonable and necessary care arising from the provision of an investigational item or Service--in particular, for the diagnosis or treatment of complications.
Family	A Member and all his or her Dependents.
Hearing Aid	An electronic device you wear for amplifying sound and assisting the physiologic process of hearing, including an ear mold if necessary
HIPAA	The Health Insurance Portability and Accountability Act, as amended.
Hospice	A specialized form of interdisciplinary healthcare designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts You may experience during the last phases of life due to a terminal illness. It also provides support to Your primary caregiver and Your family.
Independent Freestanding Emergency Department	A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.
Term	**Definition**
Kaiser Permanente/Kaiser	A Network of Providers that operate through Regions, each of which has a Service Area. For each Kaiser Permanente Region, Kaiser Permanente consists of Kaiser Foundation Hospitals (a California nonprofit corporation) and the Medical Group for that Region: • Kaiser Foundation Health Plan, Inc., for the Northern California Region the Southern California Region, and the Hawaii Region • Kaiser Foundation Health Plan of Colorado for the Colorado Region • Kaiser Foundation Health Plan of Georgia, Inc., for the Georgia Region • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., for the Mid-Atlantic States Region • Kaiser Foundation Health Plan of the Northwest for the Northwest Region • Kaiser Foundation Health Plan of Washington for the Washington Region
KPIC	Kaiser Permanente Insurance Company, which provides claims administrative services.

Material Modification	Per section 102 of the Employee Retirement Income Security Act of 1974 (ERISA), a material modification includes: • Any coverage modification that alone or combined with other changes made at the same time would be considered by "an average participant" to be "an important change in covered benefits or other terms of coverage under the plan or policy." • An enhancement of covered benefits, services or other more general, plan or policy terms. For example, coverage of previously excluded benefits or reduced cost-sharing. • A "material reduction in covered services or benefits" or more strict requirements for "receipt of benefits," including: o Changes or modifications that reduce or eliminate benefits o Increases in cost-sharing Imposing a new referral requirement
Medically Necessary	A Service is Medically Necessary if, in the judgment of Kaiser Permanente it meets all of the following requirements: • It is required for the prevention, diagnosis, or treatment of Yourmedical condition • Omission of the Service would adversely affect Your condition • It is provided in the least costly medically appropriate setting; and • It is in accord with generally accepted professional standards of practicethat is consistent with a standard of care in the medical community.
Medicare	A federal health insurance program for people age 65 and older, certain people with disabilities or end-stage renal disease (ESRD).
Term	**Definition**
Member	A person who is enrolled in the Program if that person is eligible in his own right and not because of his or her relationship to someone else. ThisSummary sometimes refers to a Dependent or Member as "You."
Network Ancillary Providers	Non-MD providers such as Psychologists, MFCCs, LCSWs, Optometrists, Physical, Speech, and Occupational Therapy. Such providers will be subject to the primary care Cost share, however, verify referral requirements in Section 3: How to Obtain Services.
Network Primary Care Provider	Family Practice, Internal Medicine, Pediatrics, and Obstetrics/Gynecology. Note: Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based the supervising physicians' provider status.

Network Provider	An in-network hospital, physician, pharmacy, skilled nursing facility, medical group, or any other healthcare provider under contract with Kaiser Permanente to provide Covered Services. Network Providers are subject to change at any time without notice. For current locations of Network facilities please call Customer Service at the number listed in Section 18: Customer Service Phone Numbers. To find a Kaiser Pharmacy visit www.kp.org – select the Locate Our Services tab, select Your region, and then select the Facilities tab. *Network Facility:* Any facility listed on www.kp.org. *Network Hospital:* A licensed hospital owned and operated by Kaiser Foundation Hospitals or another hospital which contracts with Kaiser Foundation Hospitals to provide Covered Services. *Network Pharmacy:* A pharmacy owned and operated by Kaiser Permanente, or another pharmacy that Kaiser Permanente designates. *Network Physician:* A licensed physician who is a partner, shareholder, or employee of the Medical Group, or another licensed physician who contracts with the Medical Group to provide Covered Services. • Medical Group: The following medical group is available for Northern California members: ○ The Permanente Medical Group for the Northern California Region • The Southern California Permanente Medical Group for the Southern California Region • Colorado Permanente Medical Group, P.C., for the Colorado Region • The Southeast Permanente Medical Group, Inc., for the Georgia Region • Hawaii Permanente Medical Group, Inc., for the Hawaii Region

Term	Definition
Network Provider, cont.	• Mid-Atlantic Permanente Medical Group, P.C., for the Mid-Atlantic States Region • Northwest Permanente, P.C., Physicians & Surgeons, for the Northwest Region *Network skilled nursing facility:* A licensed facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services that contracts with Kaiser Permanente to provide Covered Services. The facility's primary business is the provision of 24-hour-a-day skilled nursing care. The term "skilled nursing facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "skilled nursing facility" may also be a unit or section within another facility as long as it continues to meet the definition.
Network Specialist	Medical Doctor with a specialty not considered primary care. Note: Physician Assistants and Nurse Practitioners may be treated as Primary Care Providers or Specialists based the supervising physicians' provider status.
Non-Network Provider or Out-of-Network Provider	Any licensed provider that is not a Network Provider who provides Covered Services.
Out-of-Pocket Limit	Your financial responsibility for covered medical expenses before the Program reimburses additional Eligible Charges at 100%, with no Deductible, for the remaining portion of that calendar year.
Plan Administrator	NTESS
Plan Sponsor	NTESS
Post-Stabilization Care	Means Medically Necessary Services related to your Emergency Medical Condition you receive after your treating physician determines your Emergency Medical Condition is Stabilized. Post-Stabilization Care is covered only when (1) it is considered to be Emergency Services under federal law (without Prior Authorization) or, (2) KPIC determines such Services are Medically Necessary pursuant to a request for Prior Authorization for the Service.
Primary Care	Care provided by a Network Provider who specializes in internal medicine, pediatrics or family practice services.
Prior Authorization	Medical Necessity approval obtained in advance which is required for certain services to be Covered Services under the Program. Authorization is not a guarantee of payment and will not result in payment for services that do not meet the conditions for payment by the Program.
Program	The Kaiser Permanente Total Health PPO Plan

Term	Definition
Prosthetics and Orthotics	An external prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Internally implanted prosthetic devices are devices placed inside the body through a surgical incision which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part Orthotics are rigid or semi-rigid external devices that are used for the purpose of supportinga weak or deformed body part, improving the function of moveable parts or for restricting or eliminating motion in a diseased or injured part of the body.
Quantity Limit	Quantity Limit is a limitation on the number (or amount) of a prescription medication covered within a certain time period.
Reconstructive Surgery	Surgery is to improve function and under certain conditions, to restore normal appearance after significant disfigurement.
Region	A geographic area serviced by Kaiser Permanente. See “Kaiser Permanente” in this “Definitions” section.
Services	Healthcare, including mental healthcare, services and items.
Service Area	A smaller geographic area of a Kaiser Permanente Region.
SPD (Summary Plan Description)	An ERISA required document which conveys the plan information in an understandable summary.
Specialty Care	Care provided by a Network Provider or Non-Network Provider who provides services other than Primary Care services.
Stabilize	To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), “stabilize” means to deliver (including the placenta).
State of Emergency	During a national or regional state of emergency patient care may be handled in a variety of new and unusual locations (i.e., Drive up testing in parking lots, overflow inpatient care in convention centers, floating military hospitals and reopened previously closed facilities). Reimbursement for Services rendered by licensed providers will be based on provider licensure rather than place of service.
Surprise Billing	Unexpected billing by a Non-Network provider (except when you have consented) for 1)Emergency Services,2) certain other Services performed by a Non-Network provider at a Network facility and 3) air ambulance services from a Non-Network provider that is prohibited under federal law. When Surprise Billing occurs, you are only required to pay the Network cost-sharing amount. Your Cost-Sharing amount is calculated based upon the ‘Recognized Amount’ for a Non-Network

	provider/facility, and for Emergency Services and Ancillary Services, the Recognized Amount is the All Payer Model Agreement amount, if applicable, or the amount calculated pursuant to a specified state law if applicable, or the Qualifying Payment Amount (QPA).
Urgent Care	Treatment of an unexpected sickness or injury that is not life threatening but requires Outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering such as high fever, a skin rash, or an ear infection, but is not an Emergency Medical Condition.
UCR (Usual, Customary & Reasonable)	The amount paid for a medical service in geographic area based on what providers in the area usually charge for the same or similar medical service.

Section 13: General Exclusions and General Limitations

Although the Total Health PPO Plan provides benefits for a wide range of Covered Health services, there are specific conditions or circumstances for which the Total Health PPO Plan will not provide benefit payments. In general, any expense that is primarily for Your convenience or comfort or that of Your family, caretaker, physician, or other medical provider will not be covered. For additional limitations under the Prescription Drug Program, refer to Section 10: Prescription Drug Program.

You should be aware of these exclusions that include, but are not limited to, items in the following table**.**

IMPORTANT: The Plan will pay for out-of-network medical services based on a percentage of UCR (Usual, Customary & Reasonable) charges. Standard: 80% of Fair Health. Charges in excess of the UCR will not be covered by the Plan.

Exclusions	Examples
Administrative fees, penalties, and limits	Charges that exceed what the Claims Administrator determines are Eligible Expenses Insurance filing fees, attorney fees, physician charges for information released to claims administrator, and other service charges and finance or interest charges Amount You pay as a result of failure to contact Kaiser Permanente for Prior Authorization or Precertification, including unauthorized care Charges incurred for services rendered that are not within the scope of a provider's licensure Charges for missed appointments
Ambulance	Non-emergency ambulance services (e.g., home to physician for an office visit)
Behavioral Health Services	Behavioral/conduct problems - Therapies and services delivered in a non-clinical setting such as educational therapies and programs for behavioral/conduct problems. Religious, personal growth counseling or marriage counseling including Services and treatment related to religious, personal growth counseling or marriage counseling unless the primary patient has a mental health diagnosis. Educational, vocational, and/or recreational services as Outpatient procedures. Biofeedback for treatment of diagnosed medical conditions Treatment for insomnia, other sleep disorders, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer), dementia, neurological disorders, and other disorders with a known physical basis (certain treatments may be covered under medical portion of the Program) Court-ordered placements when such orders are inconsistent with the recommendations for treatment of a Kaiser Permanente participating provider for mental health or Kaiser Permanente services to treat conditions that are identified

Exclusions	Examples
	by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders as not being attributable to a Mental Disorder Any services or supplies that are not Medically Necessary Custodial care Pastoral counseling Treatment for caffeine or tobacco addictions, withdrawal, or dependence Services, treatments, or supplies provided as a result of a Worker's Compensationlaw or similar legislation, or obtained through, or required by, any government agency or program, whether federal, state, or any subdivision, or caused by the conduct or omission of a third party for which You have a claim for damages or relief, unless You provide Kaiser Permanente with a lien against the claim for damages or relief in a form and manner satisfactory to Kaiser Permanente Services or supplies that: • Are considered Investigational, Experimental, or Unproven drugs, devices, treatments, or procedures • Result from or relate to the application of such Investigational, Experimental, or Unproven drugs, devices, treatments, or procedures Education - Services other than Health Education or Self-Management of a medical condition as determined by the Plan to be primarily educational in nature, recreational, diversional and play activities.
Biofeedback	Biofeedback is not a Covered Health Service
Dental Procedures	Dental procedures are not covered under this Program except for injuries to sound, natural teeth, the jawbone, or surrounding tissue, or birth defects. Treatment must be initiated within one year of injury. Dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not covered.
Drugs	In addition to the clinical guideline limitation imposed by Kaiser Permanente (see Section 10: Prescription Drug Program), the Program excludes coverage for certain drugs, supplies, and treatments, which include, but are not limited to, the following: Over-the-counter medications unless specifically included Fluoride preparations (other than for ages 6 months to 5 years) and dental rinses Contraceptive foams, jellies, and ointments Drugs labeled "Caution: Limited by Federal Law to Investigational use or Experimental drugs" Experimental drugs are defined as "a therapy that has not been or is not scientifically validated with respect to safety and efficacy." Investigational drugs are defined as "those substances in any of the clinical stages of evaluation which have not been released by the Food and Drug

Exclusions	Examples
	Administration (FDA) for general use or cleared for sale in interstate commerce. It also includes those drugs that are in any of the clinical stages of
	evaluation (Phase I, II, and III) which have not been released by the FDA for general use or cleared for sale in interstate commerce." Glucose tablets Drugs used for cosmetic purposes Prescription drugs that may be properly received without charge under local, state, or federal programs, including Workers Compensation Refills of prescriptions in excess of the number specified by the physician Refills dispensed after one year from the date of order by the physician Prescription drugs purchased for those who are ineligible for coverage under the Total Health PPO Plan Prescription drugs taken by a donor who is not insured under the Total Health PPO Plan Medicine not Medically Necessary for the treatment of a disease or an injury The following are excluded by the Prescription Drug Program but may be covered by Kaiser Permanente if Medically Necessary: Ostomy supplies Blood glucose meters Implantable birth control devices such IUDs (Covered under Family Planning) Allergy serum External Insulin pumps and supplies Continuous glucose monitoring systems and supplies Medication that is dispensed and/or administered by a licensed facility or provider such as a hospital, home healthcare agency, or physician's office, and the charges are included in the facility or provider bill to Kaiser Permanente
Equipment	Exercise equipment (e.g., exercycles, weights, etc.) Hearing aids for hearing loss for members and dependents age 21 and over (see benefit under hearing aids for Sickness and Injury coverage) Braces prescribed to prevent injuries while You are participating in athletic activities Household items, including, but not limited to Air cleaners and/or humidifiers Bathing apparatus Scales or calorie counters Blood pressure kits Water beds Personal items, including, but not limited to Support hose, except Medically Necessary surgical or compression stockings Foam cushions Pajamas Equipment rental fees above the purchase price, with the exception of oxygen equipment

Exclusions	Examples
Fertility, Reproductive, and Family Planning -	Services related to or provided to anonymous donors, Services provided by a doula (labor aide), Storing and preserving sperm beyond two (2) years, Donor expenses related to donating eggs/sperm (including prescription drugs); however, charges to extract the eggs from a covered Employee for a donor are allowed, Expenses incurred by surrogate mothers (including members as surrogates), Artificial reproductive treatments done solely for genetic or eugenic (selective breeding) purposes unless medically necessary, Over-the-counter medications for birth control/prevention unless notated otherwise, Non-KP Network Parenting, pre-natal, or birthing classes
Gender Affirming Surgery	Gender Surgery related services listed below: The following services may be covered if medically necessary as part of gender Surgery treatment: • Face Lifts • Voice modification surgery • Blepharoplasty • Rhinoplasty • Abdominoplasty • Cosmetic Surgery Sperm procurement and storage in anticipation of future Fertility, unless covered under Fertility Services Benefit Gamete preservation and storage in anticipation of future Fertility, unless covered under Fertility Services Benefit Cryopreservation of fertilized embryos in anticipation of future Fertility, unless covered under Fertility Services Benefit Other electrolysis or laser hair removal not specified as covered Vaniqa Other surgeries which have no medically necessary role in gender identification and are considered cosmetic in nature Referral outside US
Genetic Testing/ Counseling	Investigational, Experimental, or Unproven genetic testing and related genetic counseling is not covered Refer to Genetic Testing/Counseling and Preventive Care for covered services.
Government Obligations	Any disease or injury resulting from a war, declared or not, any military duty, or any release of nuclear energy for which the federal government has primary responsibility for payment. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.
Hospital Fees	Expenses incurred in any federal hospital unless You are legally obligated to pay hospital room and board charges in excess of the semi-private room rate unless medically necessary and approved by Kaiser Permanente. In-hospital charges (e.g., telephone, barber, TV service, toothbrushes, slippers)
Hypnotherapy	Hypnotherapy is not a Covered Health Service

Exclusions	Examples
Investigational, Experimental, or Unproven treatment	Investigational, Experimental, or Unproven services, unless the Total Health PPO Plan has agreed to cover them in Section 14, Coverages/Limitations. **Note:** This exclusion applies even if experimental or investigational services or unproven services, treatments, devices, or pharmacological regimens are the only available treatment option for Your condition. **Note:** This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which benefits are provided as described under clinical trials.
Legal Prohibition	Charges prohibited by any law of the jurisdiction in which the Participant resides at the time the expense is incurred.
Licensed Provider	Charges for a Provider acting outside the scope of his license.
Miscellaneous	Eye exams Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training. Modifications to vehicles and houses for wheelchair access Health club memberships and programs or spa treatments Treatment or services Incurred when the patient was not covered under this Program even if the medical condition being treated began before the date Your coverage under the Program ends For Sickness or Injury resulting from Your intentional acts of aggression, including armed aggression, except for injuries inflicted on an innocent bystander (e.g., You did not start the act of aggression) For job-incurred Injury or illness for which payments are payable under any Workers Compensation Act, Occupational Disease Law, or similar law While on active military duty That are reimbursable through any public program other than Medicare or through no-fault automobile insurance Charges for blood or blood plasma that is replaced by or for the patient Conditions resulting from insurrection, except for injuries inflicted on an innocent bystander who is covered under this Program Christian Science practitioners and facilities Food of any kind (except for Medical Foods which would be covered) Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk (except for Medical Foods which would be covered) Foods to control weight, treat obesity (including liquid diets), lower cholesterol, or control diabetes Oral vitamins and minerals (with the exception of certain prescription vitamins) as outlined in Section 7: Healthcare Flexible Spending Account (HCFSA). Herbs and over-the-counter medications except as specifically allowed under the Program Charges prohibited by federal anti-kickback or self-referral statutes Chelation therapy, except to treat heavy metal poisoning Diagnostic tests that are: Delivered in other than a physician’s office or healthcare facility

Exclusions	Examples
	Self-administered home-diagnostic tests, including, but not limited to, HIV and pregnancy tests Domiciliary care Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for ten seconds or longer). Appliances for snoring are always excluded. Physical, psychiatric, or psychological exams, testing, vaccinations, immunizations, or treatments when: Required solely for purposes of career, education, camp, employment, insurance, marriage or adoption; or as a result of incarceration Conducted for purposes of medical research Related to judicial or administrative proceedings or orders or Required to obtain or maintain a license of any type Private duty nursing received on an inpatient basis Respite care (with the exception of hospice related respite care) Rest cures Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace). Storage of blood, umbilical cord, or other material for use in a Covered Health Service, except if needed for an imminent surgery
Not a Covered Health Service and/ or not Medically Necessary	Health services, including services and supplies which are: Not provided for the purpose of preventing, diagnosing or treating Sickness, Injury, mental illness, substance use or their symptoms; Not Medically Necessary; Not consistent with nationally recognized scientific evidence, as available, and prevailing medical standards and clinical guidelines; For the convenience of the covered person, physician, facility or any other person; Included in Section 13: General Exclusions and General Limitations Provided to a covered person who does not meets the Program's eligibility requirements; and Identified in general program exclusions.
Old claims	Claims received one year after the date charges are incurred
Physical Appearance	Breast reduction/augmentation surgery that is determined to be a Cosmetic Procedure. This exclusion does not apply to breast reduction surgery which the claims administrator determines is requested to treat a physiologic functional impairment or coverage required by the Women's Health and Cancer Right's Act of 1998. Cosmetic Services - Except for medically necessary reconstructive surgery and related services. Any loss, expense, or charge that results from cosmetic or reconstructive surgery, except after breast cancer. Exceptions to this exclusion include: • Repair of defects that result from surgery for which You were paid benefits underthe policy Reconstructive (not cosmetic) repair of a congenital defect that materiallycorrects a bodily malfunction. Liposuction

Exclusions	Examples
	Pharmacological regimens Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures) Replacement of an existing intact breast implant unless there is documented evidence of silicon leakage Physical conditioning programs, such as athletic training, body building, exercise, fitness, flexibility, and diversion or general motivation Weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity Wigs regardless of the reason for hair loss Treatments for hair loss
Providers	Services that are: • Performed by a provider who is a family member by birth or marriage, including Your Spouse, brother, sister, parent, or child • A provider may perform on himself or herself • Performed by a provider with Your same legal residence • Provided at a diagnostic facility (hospital or otherwise) without a written order from a provider Ordered by a provider affiliated with a diagnostic facility (hospital or otherwise) when that provider is not actively involved in Your medical care prior to ordering the service or after the service is received This exclusion does not apply to mammography testing. Excluded Providers: Services, supplies, equipment or prescriptions provided by OIG (Office of the Inspector General) excluded providers.
Services, supplies, therapy, or treatments	Charges that are: Custodial in nature Otherwise free of charge to You Furnished under an alternative medical program provided by NTESS For aromatherapy or rolfing (holistic tissue massage) For Developmental Care after a maintenance level of care has been reached For Maintenance care For massage therapy unless performed by a licensed chiropractor, physical therapist, or physician as a manual therapy technique for lymphatic drainage Educational therapy when not Medically Necessary Educational testing Paid Smoking-cessation programs. Note: Except for services described within the Preventive Care section.
Services, supplies, therapy, or treatments, cont.	Services, other than Emergency Services, received outside the United States whether or not the services are available in the United States Services, supplies, equipment or prescriptions provided by OIG (Office of the Inspector General) excluded providers. Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia, and astigmatism, including but not limited to procedures such as laser and other refractive eye surgery and radial keratotomy

Exclusions	Examples
Surgical and nonsurgical treatment for obesity	Treatment for over-the-counter appetite control, food addictions, or eating disorders that are not documented cases of bulimia or anorexia meeting standard diagnostic criteria as determined by Kaiser Permanente The following treatments for obesity: Non-surgical treatment, even if for morbid obesity (except for nutrition treatments), and Surgical operations for the correction of morbid obesity determined by Kaiser Permanente not to be Medically Necessary to preserve the life or health of the member
Third Generation Dependents	Services Related to third generation dependents, unless covered as a Dependent.
Transplants	Health services for organ and tissue transplants except as identified under Organ Transplants in Section 7, Benefits, unless Kaiser Permanente determines the transplant to be appropriate according to Kaiser Permanente transplant guidelines. Determined by Kaiser Permanente not to be Unproven procedures for the involved diagnoses Not consistent with the diagnosis of the condition Donor costs for organ or tissue transplantation to another person unless the recipient is covered under this Program
Transportation	Non-emergency ambulance services that are not medically necessary Transportation, except ground ambulance and air ambulance services as outlined in Section 13: General Exclusions and General Limitations
Travel	Travel or transportation expenses, even if ordered by a physician, except as identified under Travel and Lodging Lifetime Maximum section.
Services Provided Outside the United States	Services, other than Emergency Services, received outside the United States whether or not the services are available in the United States
Shoes	Shoe inserts, orthotics (except for care of the diabetic foot), and orthopedic shoes (except when an orthopedic shoe is joined to a brace).
Vision	Orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) or visual training. Medical benefits for low vision aids, eyeglasses, contact lenses and follow-up care thereof, except that Covered Services and expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows cataract surgery or loss of lens due to eye disease for aphakia or aniridia.
Vision- Hardware	Eyeglasses, lenses, contact lenses as prescribed to correct visual acuity

Section 14: Coordination of Benefits (COB)

Coordination of Benefits (COB) is the provision that allows families with different employer group health plan coverage to receive up to 100% coverage for services. Under COB Your health plan as the Employee provides primary coverage for You and Your Spouse's health plan through his or her employer provides primary coverage for him or her.

Refer to the Employee H&W Plan SPD_or the Post-Employment H&W Plan SPD for more information on COB policy and rules for determining which plan provides primary coverage.

This medical Total Health PPO Plan contains a COB provision so that the benefits paid or provided by all employer group plans are not more than the total allowable expenses under this medical Total Health PPO Plan. The medical Total Health PPO Plan will not pay more than 100% of the cost of the medical treatment, nor will it pay for treatment or services not covered under this medical Total Health PPO Plan.

"Covered Services" means a healthcare expense, including Deductibles, Coinsurance, and Copayments, that is covered at least in part by any of the group health plans covering the person. An expense or an expense for a Service that is not covered by any of the group health plans is nota Covered Health Expense. In addition, any expense that a provider by law or in accordance witha contractual agreement is prohibited from charging a covered person is not a Covered Health Expense. The following are additional examples of expenses or services that are not Covered Health Expenses:

- If a covered person is confined in a private hospital room, the difference between the cost of a semi-private hospital room and the private room (unless the patient's stay in a private hospital room is medically necessary in terms of generally accepted medical practice, or one of the group health plans routinely provides coverage for hospital private rooms) is not a Covered Health Expense.
- If a person is covered by two or more group health plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount inexcess of the highest of the usual and customary fees (or other reimbursement amount) for a specific benefit is not a Covered Health Expense.
- If a person is covered by two or more group health plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not a Covered Health Expense.

  If a person is covered by one group health plan that calculates its benefits or services on the basis of usual and customary fees and another group health plan that provides its benefits orservices on the basis of negotiated fees, the primary plan's payment arrangements shall be the Covered Health Expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or Service for a payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Covered Health Expense used by the secondary plan to determine its benefits.

- The amount a benefit is reduced by the primary plan because a covered person does not comply with the plan provisions is not a Covered Health Expense. Examples of these provisions are second surgical opinions, precertification of admissions, etc.

Refer to Section 3 of the Employee H&W Plan SPD for more information on "Medicare-Eligible Participants" and "End-Stage Renal Disease." Refer to Section 4 of the for more information on "Medicare-Eligible Participants" and "Provision for Covered Members with End-Stage Renal Disease."

Beginning January 1 of every year or if You are a new enrollee, You are required to provide an update to Kaiser Permanente on whether any of Your covered family members have other insurance. This notification is also required if Your family member enrolls in another medical plan during the year. If You do not provide this information to Kaiser Permanente, Your covered family members' claims may be denied. You may update Your other insurance information by calling Kaiser Permanente at 877-568-0774.

Refer to Section 10: Prescription Drug Program for information on eligibility to use the Prescription Drug Program, as well as how COB works, if Your covered family member has other insurance coverage.

Section 15: Binding Arbitration

Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region

This section applies only to Members and Dependents who are assigned to the Kaiser Permanente Northern California Region.

For all claims subject to this section, both Claimants and Respondents give up the right to a juryor court trial and accept the use of binding arbitration.

Scope of Arbitration

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

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

As referred to in this section, "Member or Dependent Parties" include:

- A Member or Dependent
- A Member's or Dependent's heir, relative, or personal representative

Any person claiming that a duty to him or her arises from a Member's or Dependent's relationship to one or more Kaiser Permanente Parties "Kaiser Permanente Parties" include:

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

- Southern California Permanente Medical Group (SCPMG)
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any KFH, TPMG, or SCPMG physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member or Dependent Parties
- Any employee or agent of any of the foregoing

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

Initiating Arbitration

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

Serving Demand for Arbitration

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

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

  Kaiser Foundation Health Plan, Inc.
  Legal Department
  1950 Franklin St., 17th Floor
  Oakland, CA 94612

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

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

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

Filing Fee

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

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

Number of Arbitrators

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

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

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

Payment of Arbitrators' Fees and Expenses

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

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

Costs

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

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Customer Service at the telephone number listed in Section 18: Customer Service Phone Numbers.

General Provisions

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

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

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

In accord with the rule that applies under sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration for Members and Dependents Assigned to the Kaiser Permanente Northern California Region" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member or Dependent Party and a Kaiser Permanente Party involves both arbitral and non-arbitral claims or because one or more parties

to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Arbitration Agreement

All members and dependents agree to the following arbitration language:

I understand that if I am assigned to the Kaiser Permanente Northern California Region or Southern California Region, then except for Small Claims Court cases, cases subject to a Medicare appeals procedure**,** and certain benefit-related disputes, any dispute between myself, my heirs or relatives, or other associated parties on the one hand and Kaiser Permanente Parties on the other hand (Kaiser Permanente Insurance Company, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospitals, The Permanente Medical Group, the Southern California Permanente Medical Group, or other associated parties), for alleged violation of any duty relating to or arising from a relationship to any of the Kaiser Permanente Parties as a participant in this medical plan, a member, or a patient, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the delivery of services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up my right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the summary plan description.

Section 16: Claims and Appeals

To obtain payment from the Program when for services You have paid for or to obtain review of a claims payment decision, You must follow the procedures outlined in this section. You may appoint an authorized representative to help You file Your claim or appeal. A written authorization must be received from You before any information will be communicated to Your representative.

Timing of Claim Determinations

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

Program will make a determination on Your claim within the time frames indicated below based upon the type of claim: Urgent Claim, Pre-Service Claim, Post-Service Claim, or Concurrent Care Claim.

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

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

A “Post-Service Claim” is any claim for a Service that is not a Pre-Service Claim or an Urgent Care Claim.

A “Concurrent Care Claim” is any claim for services that are part of an on-going course of treatment that was previously approved by Program for a specific period of time or number of treatments.

Type of Notice or Claim Event	Urgent Care Claim	Pre-Service Care Claim	Post-Service Care Claim
The Program Notice of Failure to Follow the Proper Procedure to File a Claim	Not later than 24 hours after receiving the improper claim.	Not later than 5 days after receiving the improper claim.	Not applicable.
The Program Notice of Initial Claim Decision	If the claim when initially filed is proper and complete, a decision will be made as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receiving the initial claim. If the claim is not complete,The Program shall notify You as soon as possible, but not later than 24 hours of receipt of the claim. You shall have 48 hours to provide the information necessary to complete the claim. A decision will be made no later than 48 hours after the administrator receives the requested information, or within 48 hours after the expiration of the 48-hour deadline for submitting additional information, whichever is earlier.	If the claim when initially filed is proper and complete, a decision will be made within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control of The Program. You shall be notified within the initial 15 days if an extension will be needed by The Program. The notice shall state the reason for the extension. A decision will be made not later than 15 days after the initial claim is received, unless additional information is required from You. You will be notified during the initial 15-day period and shall have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information, or within 15 days after the expiration of the 45-day deadline for submitting additional information, which-ever is earlier.	A decision will be made within a reasonable amount of time, but not later than 30 days after the initial claim is received, unless an extension, of up to 15 days, is necessary due to matters beyond the control The Program. You shall be notified within the initial 30 days if an extension will be needed by The Program. The notice shall state the reason for the extension. A decision will be made not later than 30 days after the initial claim is received, unless additional information is required from You. You will be notified during the initial 30- day period and shall have 45 days to provide the additional information requested. A decision will be made within 15 days after receiving the additional information or, within 15 days after the expiration of the 45-day deadline for submitting additional information, whichever is earlier.

* All listed time frames are calendar days

Concurrent Care Claims

If You have a Concurrent Care Claim that is also an Urgent Care Claim to extend a previously approved on-going course of treatment provided over a period of time or number of treatments, the Program will make a determination as soon as possible, taking into account the medical exigencies, and notify You of the determination within twenty-four (24) hours after receipt of the claim, provided that the claim was made to the Program at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments previously approved. If Your request for extended treatment is not made at least twenty-four (24) hours prior to the end of the prescribed period of time or number of treatments, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If Your Concurrent Care Claim is not an Urgent Care Claim, and there is a reduction or termination of the previously approved on-going course of treatment provided over a period of time or number of treatments (other than by the Program amendment or termination) before the end of the period of time or number of treatments, You will be notified by the Program sufficiently in advance of the reduction or termination to allow You to appeal the denial and receive a determination on appeal before the reduction or termination of the benefit.

Post Service Claims

To obtain payment for services You have paid for or to obtain review of a claims payment decision, You must follow the procedures outlined in the Arbitration Agreement, above.

If You miss a deadline for filing a claim or appeal, review may be declined. Before You can file a civil action under ERISA section 502(a)(1)(B), You must meet any deadlines and exhaust the claims and appeals procedures set forth in this Benefit Summary.

How to File a Claim

Network Providers are responsible for submitting claims for their services on Your behalf and will be paid directly by the Program for the services they render. If a Network Provider bills You for a Covered Service (other than for Cost Sharing), please call customer service at the telephone number listed in Section 18: Customer Service Phone Numbers.

For services rendered by Non-Network providers, where the provider agrees to submit a claim on Your behalf, eligible claims payment to the provider will require a valid assignment of benefits. Even if the Non-Network Provider agrees to bill on Your behalf, You are responsible for making sure that the claim is received within 365 days of the date of service and that all information necessary to process the claim is received.

To receive reimbursement for services You have paid for, You must complete and mail a claim form or (or write a letter) to the Claims Administrator at the address listed in Section 18: Customer Service Phone Numbers, within 365 days after You receive services. The claim form (or letter) must explain the services, the date(s) You received services, where You received services, who provided services, and why You think the Program should pay for services. Include a copy of the bill and any supporting documents. Your claim form (or letter) and the related documents constitutes Your claim.

IMPORTANT: All claims must be submitted within one year from the date of service in order to be eligible for consideration of payment. This one-year requirement will not apply if You are legally incapacitated. If Your claim relates to an Inpatient Stay, the date of service is the date Your Inpatient Stay ends. It is recommended that claims be submitted as soon as possible after the medical or prescription expenses are incurred. If You need assistance in filing a claim, call Kaiser Member Service at 877-568-0774.

Your claim must include all the following information:

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

To obtain a medical or pharmacy claim form, visit www.kp.org, log in, and go to *Coverage and Costs*, then select *Submit a Claim*.

If the Program pays a Post-Service Claim, it will pay You directly, except that it will pay the provider if one of the following is true:

- Before the claim is processed, a written notice is received indicating You have assigned Your right to payment to the provider
- Your claim includes a written request that the Program pay the provider

If You have any questions about submitting a claim for payment for a Service from a Non-Network Provider, please call customer service at the telephone number listed on Your ID card or in Section 18: Customer Service Phone Numbers.

If a Claim Is Denied

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

- The reasons for the denial, including references to specific the Program provisions upon which the denial was based.
- If the claim was denied because You did not furnish complete information or documentation, the notice will specify the additional materials or information needed to support the claim and an explanation of why the information or materials are necessary.

- If the claim is denied based on an internal rule, guideline, protocol, or other similar criterion, the notice will either (a) state the specific rule, guideline, protocol, or other similar criterion, or (b) or include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a medical necessity or experimental treatment or a similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.
- The notice will also state how and when to request a review of the denied claim.
- The notice will also contain a statement of Your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

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

How to Appeal a Denied Claim

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

Send the written request to the Program at the address that corresponds to the region in which you received your care:

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	**Mid-Atlantic (DC, MD, VA)**
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-888-225-7202

Northwest	Washington
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 1-866-616-0047	**Kaiser Permanente Appeals** P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Phone 1-866-458-5479 Fax 206-630-1859

Or for Urgent appeals submitted over the phone

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

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

In addition, states with Consumer Assistance Programs under PHS ACT Section 279.3 may be available in Your state to assist You in filing Your appeal. A list of state Consumer Protection Agencies is available on www.kp.org (Log into My Health Manager, select Manage My Plan & Coverage, then click on Claims Summary list of the State Assistance Programs is listed under the Resources banner) or https//www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/#statelisting.

Deemed Exhaustion

If the Program does not adhere to the Federal Appeals process as described below, it will be deemed that You have exhausted the appeals process. This means that You are no longer required to stay within the mandated internal appeal process. Exception:

- Violations which do not cause and are not likely to cause prejudice or harm and,
- Can be demonstrated were for good cause or due to matters beyond the control of the Plan and,
- The violation occurred in the context of an on-going, good faith exchange of information between the Program and You.

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

Procedures on Appeal

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

Also, You may give testimony in writing or by telephone. Please send Your written testimony to the address mentioned in our acknowledgement letter, sent to You within five days after we receive Your appeal. To arrange to give testimony by telephone, You should call the phone number mentioned in our acknowledgement letter. We will add the information that You provide through testimony or other means to Your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding Your request for services.

Upon request and free of charge, You will be provided reasonable access to, and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to Your claim.

The Program will review the claim, taking into account all comments, documents, records, and other information submitted relating to the claim, without regard to whether that information was submitted or considered in the initial benefit determination.

The review shall not afford deference to the initial claim denial and shall be conducted by the Claims Fiduciary (named in the "Legal and Administrative Information" section), who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual.

In deciding an appeal that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary, the Claims Fiduciary shall consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and that healthcare professional shall not be the individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal (nor the subordinate of that individual).

Upon request, the Program will provide for the identification of any medical or vocational experts whose advice was obtained on behalf of the Program in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

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

Timing of Initial Appeal Determinations

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

Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Not later than 72 hours after receiving the appeal.	Not later than 15 days after receiving the appeal	Not later than 30 days after receiving the appeal.

* All listed time frames are calendar days

Notice of Determination on Initial Appeal

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

If Your claim is denied on review, the notice shall state:

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

How to File a Final Appeal

For Pre-Service Claims and Post-Service Claims, You may appeal the denial of Your initial appeal by submitting a written request for review to the Plan. You must make the appeal request within 180 days after the date of notice that Your appeal is denied.

Send the written request to the address that corresponds to the region in which you received your care:

California	Colorado
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	**Mid-Atlantic (DC, MD, VA)**
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-888-225-7202
Northwest	**Washington**
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 1-866-616-0047	**Kaiser Permanente Appeals** P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Phone 1-866-458-5479 Fax 206-630-1859

Or for Urgent appeals submitted over the phone

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

Timing of Final Appeal Determinations

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

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

* All listed time frames are calendar days

Notice of Determination on Final Appeal

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

If Your claim is denied on review, the notice shall state:

- The reasons for the denial, including references to specific the Program provisions upon which the denial was based.
- That You are entitled to receive, upon request and free of charge, reasonable access to,and copies of, all documents, records, and other information (other than legally or medically privileged documents) relevant to Your claim for benefits.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the notice will either (a) state the specific rule, guideline, protocol, or other similar criterion, or (b) include a statement that the rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.
- If the claim is denied based on a Medical Necessity, Experimental treatment or similar exclusion or limit, the notice will also include an explanation of the scientific or clinical judgment for the determination, applying the terms of the Program to the medical circumstances, or include a statement that this explanation will be provided free of charge upon request.
- Any voluntary appeal procedures offered by the Program and Your right to obtain the information about those procedures.
- The notice will also include a statement of Your right to bring an action under section 502(a) of ERISA following an adverse benefit determination following completion of all levels of review.

Next Steps

If after exhausting the appeals process, You are still not satisfied, Your remaining remedies include the right to bring suit in Federal Court under Section 502(a) of ERISA and voluntary dispute resolution options, such as mediation or independent External Review as described below.

External Review

If you are still dissatisfied you may have a right to request an external review by an independent third-party when our final appeal determination (1) relies on medical judgment (including but not

limited to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a benefit), (2) concludes that a treatment is experimental or investigation; (3) concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or substance use) benefits; (4) involves consideration of whether We are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130); or, (5) involves a decision related to rescission of your coverage.

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

To request an independent external review of Plan denials, complete the External Review request form on www.kp.org and send the written request the address that corresponds to the region in which you received your care:

California	**Colorado**
Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-800-788-0710	Kaiser Foundation Health Plan of Colorado Member Relations, Appeals PO Box 378066 Denver, CO 80237-8066 Fax: 1-866-466-4042 Phone: 1-855-364-3184
Georgia	**Mid-Atlantic (DC, MD, VA)**
Kaiser Foundation Health Plan of Georgia Member Relations, Appeals Nine Piedmont Center 3495 Piedmont Rd NE Atlanta, GA 30305-1736 Fax: 1-404-949-5001 Phone: 1-855-354-3185	Kaiser Permanente Member Relations, Appeals PO Box 1809 Pleasanton, CA 94566 Fax: 888-987-2252 Phone: 1-888-225-7202
Northwest	**Washington**
Kaiser Foundation Health Plan of the Northwest Member Relations, Appeals 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099 Fax: 1-855-347-7239 1-866-616-0047	**Kaiser Permanente Appeals** P.O. Box 34593 Seattle, WA 98124-1593 Attn: Appeal Coordinator Phone 1-866-458-5479 Fax 206-630-1859

Or for Urgent appeals submitted over the phone

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

Preliminary Review of External Review Request

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

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

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

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

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

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

Referral to Independent Review Organization

KPIC will assign an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or by similar nationally-recognized accrediting organization to conduct the external review. Moreover, KPIC will take action to guard against bias and to ensure independence. Accordingly, KPIC will maintain contracts with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support a denial of benefits.

Contracts between KPIC and IROs will provide for the following:

(a) The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

(b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant many submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted afterten business days.

(c) Within five business days after the date of assignment of the IRO, KPIC will provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by KPIC to timely provide the documents and information will not delay the conduct of the external review. If KPIC fails totimely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making its decision, the IRO will notify the claimant and KPIC of that decision.

(d) Upon receipt of any information submitted by the claimant, the IRO will within one business day forward the information to KPIC. Upon receipt of any such information, KPIC may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by KPIC will not delay the external review. The external review may be terminated as a result of the reconsideration only if KPIC decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, KPIC will provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO will terminate the external review uponreceipt of the notice from KPIC.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the internal claims and appeals process applicable under section 2719 of the PHS Act. In addition to the document and information provided, the assigned IRO, to the extent information or documents is available and the assigned IRO considers them appropriate, the IRO will consider the following in reaching a decision:

- The claimant's medical records;
- The attending healthcare professional's recommendation;
- Reports from appropriate healthcare professionals and other documents submitted by the Plan, claimant or the claimant's treating provider;
- The terms of the claimant's Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

- Appropriate practice guidelines, which will include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by the Plan, the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO will deliver the noticeof final external review decision to the claimant and the Plan.

The assigned IRO’s decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the healthcare provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning (if applicable), the treatment code and its corresponding meaning (if applicable), and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the documentation considered, including the specific coverage provision and evidence-based standards considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards, that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable ombudsman established under the PHS Act of 2793.

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

Reversal of Plan's Decision

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, KPIC will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim as directed by the IRO.

Expedited External Review

If after exhausting of the internal Urgent Appeal process, You are still not satisfied, You may be eligible for an expedited external appeal.

Request for Expedited External Review

KPIC will allow a claimant to make a request for an expedited external review at the time the claimant receives:

(a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare item or service for which the claimant received emergency services, but has not been discharged from a facility.

Preliminary Review

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

Referral to Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of Final External Review Decision

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

Your Claim after External Review

You may have certain additional rights if You remain dissatisfied after You have exhausted all levels of review including external review. If You are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), You may file a civil action under section 502(a) of the federal ERISA statute. You must commence any legal or equitable action for benefits within **365 days** after the date that notification is sent to the participant or beneficiary (and/or his or her authorized representative) that the adverse benefit determination has been upheld on appeal.

To understand these rights, You should check withYour benefits office or contact the Employee Benefits Security Administration (part of the U.S.Department of Labor) at 866-444-EBSA (3272). Alternatively, if Your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), You may have a right to request review in state court.

Section 17: Service Areas

Members must live or work in a Kaiser Service Area at the time of enrollment. You cannot continue enrollment as a Member if You move outside a Kaiser Permanente Service Area.

Service Areas by County for Northern California

County	City
Alameda	Alameda, Albany, Berkeley, Castro Valley, Dublin, Emeryville, Fremont, Hayward, Livermore, Newark, Oakland, Piedmont, Pleasanton, San Leandro, San Lorenzo, Sunol, Union City
Amador	Ione, Plymouth
Contra Costa	Alamo, Antioch, Bethel Island, Brentwood, Byron, Canyon, Clayton, Concord, Crockett, Danville, Diablo, Discovery Bay, El Cerrito, El Sobrante, Hercules, Knightsen, Lafayette, Martinez, Moraga, Oakley, Orinda, Pinole, Pittsburg, Pleasant Hill, Port Costa, Richmond, Rodeo, San Pablo, San Ramon, Walnut Creek
El Dorado	Coloma, Cool, Diamond Springs, El Dorado, El Dorado Hills, Garden Valley, Georgetown, Greenwood, Lotus, Pilot Hill, Placerville, Rescue, Shingle Springs
Fresno	Auberry, Biola, Burrel, Caruthers, Clovis, Del Rey, Five Points, Fowler, Fresno, Friant, Helm, Kerman, Kingsburg, Laton, Orange Cove, Parlier, Piedra, Prather, Raisin City, Reedley, Riverdale, San Joaquin, Sanger, Selma, Squaw Valley, Tollhouse, Tranquility
Kings	Hanford
Madera	Ahwahnee, Bass Lake, Coarsegold, Madera, North Fork, O'Neals, Oakhurst, Raymond, Wishon
Marin	Belvedere Tiburon, Bolinas, Corte Madera, Dillon Beach, Fairfax, Forest Knolls, Greenbrae, Inverness, Kentfield, Lagunitas, Larkspur, Marshall, Mill Valley, Nicasio, Novato, Olema, Point Reyes Station, Ross, San Anselmo, San Geronimo, San Quentin, San Rafael, Sausalito, Stinson Beach, Tomales, Woodacre
Mariposa	Fish Camp, La Grange
Merced	Gustine
Napa	American Canyon, Angwin, Calistoga, Deer Park, Napa, Oakville, Pope Valley, Rutherford, Saint Helena, Yountville
Placer	Applegate, Auburn, Granite Bay, Lincoln, Loomis, Meadow Vista, Newcastle, Penryn, Rocklin, Roseville, Sheridan, Weimar
Sacramento	Antelope, Carmichael, Citrus Heights, Courtland, Elk Grove, Elverta, Fair Oaks, Folsom, Galt, Herald, Hood, Isleton, Mather, McClellan, North Highlands, Orangevale, Rancho Cordova, Represa, Rio Linda, Ryde, Sacramento, Sloughhouse, Walnut Grove, Wilton
San Francisco	San Francisco
San Joaquin	Acampo, Clements, Escalon, Farmington, French Camp, Holt, Lathrop, Linden, Lockeford, Lodi, Manteca, Ripon, San Joaquin, Stockton, Thornton, Tracy, Victor, Woodbridge

County	City
San Mateo	Atherton, Belmont, Brisbane, Burlingame, Daly City, El Granada, Half Moon Bay, La Honda, Loma Mar, Menlo Park, Millbrae, Montara, Moss Beach, Pacifica, Pescadero, Portola Valley, Redwood City, San Bruno, San Carlos, San Francisco, San Gregorio, San Mateo, South San Francisco
Santa Clara	Alviso, Campbell, Coyote, Cupertino, Gilroy, Holy City, Los Altos, Los Gatos, Milpitas, Morgan Hill, Mount Hamilton, Mountain View, New Almaden, Palo Alto, Redwood Estates, San Jose, San Martin, Santa Clara, Saratoga, Stanford, Sunnyvale
Santa Cruz	Aptos, Ben Lomond, Boulder Creek, Brookdale, Capitola, Davenport, Felton, Freedom, Mount Hermon, Santa Cruz, Scotts Valley, Soquel, Watsonville
Solano	Benicia, Birds Landing, Dixon, Elmira, Fairfield, Rio Vista, Suisun City, Travis AFB, Vacaville, Vallejo
Sonoma	Bodega, Bodega Bay, Boyes Hot Springs, Camp Meeker, Cazadero, Cloverdale, Cotati, Duncans Mills, El Verano, Eldridge, Forestville, Fulton, Geyserville, Glen Ellen, Graton, Guerneville, Healdsburg, Jenner, Kenwood, Monte Rio, Occidental, Penngrove, Petaluma, Rio Nido, Rohnert Park, Santa Rosa, Sebastopol, Sonoma, Valley Ford, Villa Grande, Vineburg, Windsor
Stanislaus	Ceres, Crows Landing, Denair, Empire, Hickman, Hughson, Keyes, Modesto, Newman, Oakdale, Patterson, Riverbank, Salida, Turlock, Vernalis, Waterford, Westley
Sutter	Knights Landing, Nicolaus, Pleasant Grove, Rio Oso, Robbins Sacramento
Tulare	Dinuba, Sultana, Traver
Yolo	Capay, Clarksburg, Davis, Sacramento, West Sacramento, Winters, Woodland, Yolo, Zamora
Yuba	Beale AFB, Olivehurst, Wheatland

Section 18: Customer Service Phone Numbers

Member Service
Northern California Region
877-568-0774

Utilization Management for Out-of-Network Emergency Services
Northern California Region
800-225-8883

Advice Nurses
Northern California Region
866-454-8855

Interpreter Services
Northern California Region
877-568-0774, TTY: 771

Pharmacy Benefit Information and Manual Claims
All Regions
866-427-7701
Optum RX
Manual Claims
P.O. Box 650334
Dallas, TX 75265-0334

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

Healthcare Flexible Spending Account (HCFSA) & Health Reimbursement Account (HRA) Administrator
Kaiser Permanente
Health Account Services
PO Box 1540
Fargo, ND 58107-1540
Phone: 877-750-3399
Fax: 877-535-0821
Email: kp@healthaccountservices.com
7:00 am – 9:00 pm CST, M-F