TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)

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

This EOC is for your Group's 2015 contract year.

SCHEDULE OF BENEFITS (WHO PAYS WHAT)
(Formerly SUMMARY CHART)

Benefits for VISA USA

5950 - 001

This Schedule of Benefits discusses:

I. **DEDUCTIBLES (if applicable)**

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

III. **COPAYMENTS AND COINSURANCE**

IV. **DEPENDENT LIMITING AGE**

V. **DEPENDENT STUDENT LIMITING AGE**

IMPORTANT INFORMATION PLEASE READ

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

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

III. COPAYMENTS AND COINSURANCE

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

Outpatient Care	You Pay
Primary care visits *(Does not apply to Out-of-Pocket Maximum)*	$20 Copayment each visit
Specialty care visits *(Does not apply to Out-of-Pocket Maximum)*	$30 Copayment each visit
Consultations with clinical pharmacists *(Does not apply to Out-of-Pocket Maximum)*	$20 Copayment each visit
Allergy injections *(Does not apply to Out-of-Pocket Maximum)*	$20 Copayment each visit Copayment may apply for allergy serum
Allergy evaluation and testing *(Does not apply to Out-of-Pocket Maximum)*	$30 Copayment each visit
Gynecology care visits *(Does not apply to Out-of-Pocket Maximum)*	$30 Copayment each visit
Routine prenatal and postpartum visits *(Does not apply to Out-of-Pocket Maximum)*	No Charge
Outpatient surgery at designated outpatient facilities *(Applies to Out-of-Pocket Maximum)*	$50 Copayment each surgery

Hospital Inpatient Care	You Pay
(Applies to Out-of-Pocket Maximum) *(See III. "Benefits/Coverage (What Is Covered)", B. "Hospital Inpatient Care", in this EOC for the list of covered Services)*	$200 Copayment per admission Excludes bariatric surgery
Inpatient professional Services *(See above line under "Hospital Inpatient Care" for Out-of-Pocket Maximum information)*	See above line under "Hospital Inpatient Care" for applicable Copayment or Coinsurance

Ambulance Services	You Pay
(Does not apply to Out-of-Pocket Maximum)	$50 Copayment per trip

Bariatric Surgery	You Pay
(Does not apply to Out-of-Pocket Maximum)	30% Coinsurance

Drugs, Supplies and Supplements	You Pay
Office administered drugs *(Applies to Out-of-Pocket Maximum)*	20% Coinsurance
• Travel immunizations	Not Covered
Outpatient prescription drugs Copayment/Coinsurance (except as listed below): *(Prescriptions are subject to the pharmacy Deductible except as otherwise listed in this "Drugs, Supplies and Supplements" section. Prescriptions: Do not apply to Out-of-Pocket Maximum)*	$5 Generic/$30 Brand name/$45 Non-Preferred Tobacco cessation and contraceptive drugs at No Charge
• Pharmacy Deductible	Not Applicable
• Infertility drugs	Not Covered
• Over the counter items (OTC): *(Includes federally mandated over the counter items (OTC). OTCs require a prescription and must be filled at a Kaiser Permanente pharmacy.)* *(Not subject to pharmacy Deductible)*	No charge
• Prescribed supplies *(Not subject to pharmacy Deductible)*	20% Coinsurance
• Sexual dysfunction drugs	Not Covered
• Specialty drugs	20% Coinsurance up to $250 per drug dispensed Insulin @ applicable Copayment/Coinsurance Member cost share for all prescription drugs is limited to $3,500
	Supply Limit
Day supply limit	30 days
Mail-order supply limit	90 days @ 2 Copayments See Additional Provisions

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

Emergency Services and Non-Emergency, Non-Routine Care	You Pay
Plan and non-plan emergency room visits and related covered Services unless otherwise noted (covered 24 hours a day) *(Does not apply to Out-of-Pocket Maximum)*	$100 Copayment each visit Excludes X-ray special procedures Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. If X-ray special procedures are excluded above, see "X-ray, Laboratory and Special Procedures" for applicable Copayment or Coinsurance.
Non-emergency, non-routine visits at Plan Facilities **after** regular office hours *(Does not apply to Out-of-Pocket Maximum)*	$50 Copayment each visit

Family Planning Services	You Pay
Family planning counseling *(Does not apply to Out-of-Pocket Maximum)*	$20 Copayment each visit
Associated outpatient surgery procedures *(See "Outpatient Care" for Out-of-Pocket Maximum information)*	See "Outpatient Care" for applicable Copayment or Coinsurance

i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
iii. Non-medical items such as sauna baths or elevators.
iv. Exercise or hygiene equipment.
v. Comfort, convenience, or luxury equipment or features.
vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
vii. Replacement of lost equipment.
viii. Repairs, adjustments or replacements necessitated by misuse.
ix. More than one piece of DME serving essentially the same function, except for replacements.
x. Spare equipment or alternate use equipment is not covered.

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

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

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

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GRANDFATHERED HEALTH PLAN

Health Plan believes this coverage is a ‘‘grandfathered health plan’’ under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call Member Services. (Not applicable to Senior Advantage Plans)

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PREVENTIVE SERVICES RIDER

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

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