



California Comprehensive Major Medical (PPO) for Small Business Certificate of Insurance

This policy and the application of the employer constitute the entire contract between the parties, and any statement made by the employer shall, in the absence or fraud, be deemed a representation and not a warranty.

Group Name: KPIC SMALL NCR SAMPLE GROUP AGREEMENT
Group Policy # 999999805
Contract ID: 1.34
Contract Option ID: 783319527

Notice:

This document is a Sample Certificate of Insurance (COI) for illustration purposes ONLY. COIs that are issued along with the Group Policy may vary from this sample COI. For example, this sample COI does not include any requested customization. This sample COI may be updated at any time for accuracy to comply with laws and regulations. The terms of any group's coverage will be governed solely by the Group Policy issued to the group by Kaiser Permanente Insurance Company.

SAMPLE

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverage funded through a Group Insurance Policy issued to Your group by Kaiser Permanente Insurance Company. It becomes Your Certificate of Insurance when You have met certain eligibility requirements.

This Certificate is not an insurance policy. The complete terms of the coverage are set forth in the Group Policy. Benefit Payment is governed by all the terms, conditions and limitations of the Group Policy. If the Group Policy and this Certificate differ, the Group Policy will govern. Any amendment to the Group Policy will not affect a claim initiated before the amendment takes effect. The Group Policy is available for inspection at the Policyholder's office.

KPIC will provide notice to the Policyholder of the following actions no later than 60 days prior to the effective date of the action: termination of the Group Policy, increasing premiums, reducing or eliminating benefits, or restricting eligibility for coverage. The Policyholder will provide the notice to the Insured.

This Certificate supersedes and replaces any and all certificates that may have been issued to You previously for the coverage described herein.

In this Certificate, Kaiser Permanente Insurance Company will be referred to as: "KPIC", "we", "us", or "our". The Insured Employee named in the attached Schedule of Coverage will be referred to as: "You", or "Your".

This Certificate is important to You, so please read it carefully and keep it in a safe place.

Language Assistance

SPANISH (Español): Para obtener asistencia en Español, llame al 1-(800)-788-0710.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog, tumawag sa 1-(800)-788-0710.

CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-(800)-788-0710.

NAVAJO (Dine): Dinekehgo shika adishwol niniingo, kwijigo holne' 1-(800)-788-0710.

Some hospitals and other providers do not provide one or more of the following services that may be covered under Your policy and that You or Your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before You become a Policyholder or select a network provider. Call Your prospective doctor or clinic, or call the Kaiser Permanente Insurance Company at **1-800-788-0710 (TTY users call 711)** for assistance to ensure that You can obtain the health care services that You need.

Please refer to the General Limitations and Exclusions section of this Certificate for a description of the plan's general limitations and exclusions. Likewise, the Schedule of Coverage contains specific limitations for specific benefits.

Note: If You are insured under a separate group medical insurance policy, You may be subject to coordination of benefits as explained in the COORDINATION OF BENEFITS section.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) does not discriminate based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). We can provide no cost aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats; large print, audio, and accessible electronic formats. We also provide no cost language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. To request these services, please call **1-800-464-4000** (TTY users call **711**).

If you believe that KPIC failed to provide these services or there is a concern of discrimination based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability you can file a complaint by phone or mail with the KPIC Civil Rights Coordinator. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you.

**KPIC Civil Rights Coordinator
Grievance 1557
5855 Copley Drive, Suite 250
San Diego, CA 92161
1-888-251-7352**

You may also contact the California Department of Insurance regarding your complaint.

**By Phone:
California Department of Insurance
1-800-927-7622
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)**

**By Mail:
California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013**

**Electronically:
www.insurance.ca.gov**

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SAMPLE

INTRODUCTION

This Certificate describes the KPIC Participating (Preferred) Provider Organization (PPO) Medical Insurance Plans.

Please read the following information carefully. It will help You understand how the provider You select can affect the dollar amount You must pay in connection with receiving Covered Services. Your coverage under the Group Policy includes coverage for Covered Services received from Participating Providers as well as Non-participating Providers. The provider You select can affect the dollar amount You must pay in connection receiving Covered Services.

Please refer to the General Limitations and Exclusions section of this Certificate for a description of the plan's general limitations and exclusions. Likewise, the Schedule of Coverage contains specific cost sharing amounts when receiving care from Participating Providers and Non-participating Providers and limitations for specific benefits.

For information on how to make a complaint regarding timely access to care please refer to the ACCESS TO HEALTH CARE section in this Certificate.

To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory. You may visit KPIC's contracted provider network web site at: www.Multiplan.com/Kaiser to view KPIC's Participating Provider directory or to request a printed copy at no cost. Additionally, a current printed listing of KPIC's Participating Providers directory is available at no cost to You by calling the phone number listed on Your ID card or by writing to: KPIC Provider Relations Manager, 300 Lakeside Drive, Room 1335D, Oakland, CA 94612. If a Covered Person receives care from a Non-participating Provider, benefits under the Group Policy will be payable at the Non-participating Provider tier.

KPIC is not responsible for Your decision to receive treatment, services or supplies from Participating or Non-participating Providers. Additionally, KPIC is neither responsible for the qualifications of providers nor the treatments, services or supplies provided.

This Certificate uses many terms that have very specific definitions for the purpose of the Group Policy. These terms are defined in the General Definitions section and are capitalized so that You can easily recognize them. Other portions of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Group Policy are defined in those sections. Please read all definitions carefully.

This Certificate includes a Schedule of Coverage that will give You a quick overview of Your coverage. It is very important, however, that You read Your entire Certificate of Insurance for a more complete description of Your coverage and the exclusions and limitations under this medical insurance plan.

This Certificate forms the remainder of the Group Policy. The provisions set forth herein, are incorporated into, and made part of, the Group Policy.

Who Can Answer your Question?

For assistance with questions regarding Your coverage such as Your benefits, our current eligibility status, or name and address changes, please have Your ID card available when You call:

For Coverage :	1-800-788-0710 (TTY users call 711)
Eligibility, name or address change:	1-800-554-3099

INTRODUCTION

Or You may write to the Administrator:

NTT DATA Services
PO Box 261155
Plano, TX 75026

For information or verification of eligibility of coverage, please call the number listed on Your ID card.

PPO plans only - If You have any questions regarding services, facilities, or care You receive from a Participating Provider, please call the toll-free number listed in the Participating Provider directory. For Precertification of Covered Services or Utilization Review please call the number listed on Your ID card or: 1-800-448-9776.

If you have complaints regarding Your coverage under this Plan, You may contact KPIC at:

**KPIC Civil Rights Coordinator
Grievance 1557
5855 Copley Drive, Suite 200
San Diego, CA 92111
1-888-251-7052**

or the California Department of Insurance at the following telephone number, address, or website. The Department of Insurance should be contacted only after discussions with KPIC, or its agent or other representative:

**California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)**

The Covered Person may write the California Department of Insurance at:

**California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013**

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, California 94612

SCHEDULE OF COVERAGE

PPO PLAN FOR SMALL BUSINESS

Metal Plan Designation: BRONZE

NOTE: Please read the following information carefully. It will help You understand how the provider You select can affect the dollar amount You must pay, in connection with receiving Covered Services.

You will be responsible for a larger portion of Your bill including higher deductibles and Your out-of-pocket maximum may be more if You receive care from a Non-Participating Provider.

Payments under the Plan are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service. (Refer to the definition of Maximum Allowable Charge shown in the General Definitions section of the Certificate.)

COVERED PERSONS:

Employee and Dependents (if elected)

Dependent Child Age Limit:

26 unless disabled

ACCUMULATION PERIOD:

Calendar Year

**PARTICIPATING
PROVIDER TIER**

**NON-PARTICIPATING
PROVIDER TIER**

OUT-OF-POCKET MAXIMUMS per ACCUMULATION PERIOD:

Individual Out-of-Pocket Maximum:	\$8,200	\$16,400
Family Out-of-Pocket Maximum:	\$16,400	\$32,800

DEDUCTIBLES per ACCUMULATION PERIOD:

NOTE: Preventive Care Exams and Services required under the Affordable Care Act (ACA) that are received at the Participating Provider tier are not subject to Deductible.

Individual Deductible Maximum:	\$6,300 ¹	\$12,600 ¹
Family Deductible Maximum:	\$12,600 ¹	\$25,200 ¹

You must pay Covered Charges for Services You received in the Accumulation Period until You reach the Deductible amount shown here, unless "Deductible does not apply" is noted on the Service in this Schedule. This Policy will not begin to pay for your health care expenses until after Covered Charges exceed the Deductible amount. You will have to pay for all of your health care bills until these bills exceed your Deductible amount.

SCHEDULE OF COVERAGE

COVERED SERVICES

PARTICIPATING PROVIDER TIER

YOUR COST SHARE

NON-PARTICIPATING PROVIDER TIER

NOTE: Covered Charges applied to satisfy the Deductible, including per admission deductible, if any, apply to satisfy the Out-of-Pocket Maximum. Cost Shares applied to satisfy the Out-of-Pocket Maximums at the Participating Provider tier will not be applied towards satisfaction of the Out-of-Pocket Maximums at the Non-Participating Provider tier. Likewise, Cost Shares applied to satisfy the Out-of-Pocket Maximum at the Non-Participating Provider tier will not apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier, except when Emergency Care Services are obtained from a Non-Participating Provider the Covered Charges will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier.

Deductibles including any benefit-specific deductibles, Copayments and Coinsurance for Covered Charges contribute toward satisfaction of the Out-of-Pocket Maximum.

¹ *Deductibles, Coinsurance and Copayments do not apply to Preventive Benefits required under the Affordable Care Act (ACA) at the Participating Provider tier. Preventive Benefits required under the ACA that are received at the Non-Participating Provider tier, however, may be subject to Deductibles, Coinsurance and Copayments.*

² *The Deductible is waived for a combined first three office visits for: non-preventive provider office visits, urgent care visits, and Mental Health/ Substance Use Disorder Treatment visits. Any visit other than your first three non-preventive visits will be subject to the Deductible.*

Quantitative treatment limits, such as annual or lifetime day or visit limits do not apply to Medically Necessary Treatment for Mental Health and Substance Use Disorders.

IMPORTANT: *Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.*

COVERED SERVICES

PARTICIPATING PROVIDER TIER

YOUR COST SHARE

NON-PARTICIPATING PROVIDER TIER

Hospital Inpatient Care:

40%

100%

Precertification is required for hospital inpatient care (except for emergency admissions, admissions for delivery of a child, and admissions for mastectomy and lymph node surgical procedures). Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification. Please refer to the Precertification Section in Your Certificate of Insurance for details, including the exceptions to the Precertification requirement for emergency admissions; hospital stays related to a maternity admission for a minimum of 48 hours for a vaginal delivery and 96 hours for a caesarean delivery; and length of hospital stay following mastectomy and lymph node dissection.

Physician, Surgeon or Surgical services:

40%

100%

Skilled Nursing Facility Care:

40%

100%

*Combined Maximum of 100 days per Benefit Period. ¹
(The day maximum does not apply to Medically Necessary Treatment of Mental Health and Substance Use Disorder.)*

SCHEDULE OF COVERAGE

COVERED SERVICES

PARTICIPATING PROVIDER TIER

YOUR COST SHARE

NON-PARTICIPATING PROVIDER TIER

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.

Urgent Care:	\$65 Copayment ²	100%
Provider Office Visits:		
Primary Care Physician	\$65 Copayment ²	100%
Other Practitioner office visits (includes other visits not provided by either Primary Care or Specialty Care Physicians or not specified in another benefit category, such as acupuncture visits):	\$65 Copayment ²	100%
Specialty Care Physician	\$65 Copayment ²	100%
Emergency Care or Emergency Services:		
Facility Charges:	40% (waived if admitted)	40% (waived if admitted)
Physician Services:	No Charge Deductible does not apply	No Charge Deductible does not apply

Cost Share for Emergency Care Services obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier and the Non-Participating Provider tier.

Emergency Ambulance Services:	40%	40%
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Cost Share for Emergency Care Services obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier and the Non-Participating Provider tier. For emergency air ambulance services obtained from a Non- Participating Provider, the Participating Provider Deductible, if any, will apply.

Medically Necessary Non-Emergency Ambulance Services:	40%	40%
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Cost Share for Medically Necessary Non-Emergency Ambulance Services obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider tier. For Non-Emergency Ambulance Services obtained from a Non- Participating Provider, including non-emergency air ambulance services, the Non-Participating Provider Deductible, if any, will apply.

Precertification is required for non-emergency ambulance, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Home Health Care Services:	40%	100%
	Combined Benefit Maximum of 100 visits per Accumulation Period (limit does not apply to physical, occupational, and speech therapists visits in the home). (The visit maximum does not apply to Medically Necessary Treatment of Mental Health and Substance Use Disorders.)	
<i>Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		
Hospice Care:	No Charge Deductible does not apply	100%
Outpatient Surgery:	40%	100%
<i>Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		
Lab Tests:	\$40 Copayment ¹ Deductible does not apply	100%
<i>Some services require Precertification, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		
X-Ray and Diagnostic Testing:	40% ¹	100%
<i>Some services require Precertification, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		
Imaging (CT/PET scans and MRIs):	40% ¹	100%
<i>Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		
Prosthetics and Orthotics:	40%	100%
<i>Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		
Base Durable Medical Equipment (including equipment and supplies, not listed below, for the management and treatment of diabetes) (Base Durable Medical Equipment includes, but is not limited to: canes, crutches; and tracheotomy tubing and supplies):	40%	100%
<i>Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		

SCHEDULE OF COVERAGE

COVERED SERVICES

PARTICIPATING PROVIDER TIER

YOUR COST SHARE

NON-PARTICIPATING PROVIDER TIER

Supplemental Durable Medical Equipment
(Supplemental Durable Medical Equipment
includes, but is not limited to: oxygen;
wheelchairs and hospital beds):

40%

100%

Combined Benefit Maximum of \$2,000 per Accumulation
Period

*Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance.
Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.*

Diabetes equipment and supplies limited
to: infusion set and syringe with needle for
external insulin pump; testing strips;
lancets; skin barrier; adhesive remover
wipes and transparent film (See also,
"Other Covered Preventive Care" in this
Schedule of Coverage.):

40%

40%

*Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance.
Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.*

Diabetic Day-care Management Benefit:

No Charge

40%

Deductible does not apply

Deductible does not apply

Allergy Testing and Treatment
(administered during an office visit):

40%

100%

Rehabilitation Services:

*Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance.
Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.*

Rehabilitative Outpatient Therapy
Services (physical therapy,
occupational therapy, speech therapy
and pulmonary rehabilitation):

\$65 Copayment

100%

Deductible does not apply

Multidisciplinary Rehabilitation Care:

Inpatient:

40%

100%

Outpatient:

\$65 Copayment

100%

Deductible does not apply

Habilitation Services:

*Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance.
Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.*

Habilitative Outpatient Therapy
Services (physical therapy,
occupational therapy, speech therapy
and pulmonary/respiratory therapy):

\$65 Copayment

100%

Deductible does not apply

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Outpatient Therapy Services (including Physical, Speech, Occupational, and Respiratory Therapy) in connection with the treatment of Pervasive Developmental Disorder or Autism):		
Individual Outpatient visits:	\$65 Copayment Deductible does not apply	100%
Group Outpatient visits:	\$32 Copayment Deductible does not apply	100%
Mental Health and Substance Use Disorder Treatment Benefits:		
Outpatient office visits:		
Mental Health or Substance Use Disorder Treatment Individual Outpatient visits:	\$65 Copayment ²	100%
Mental Health or Substance Use Disorder Treatment Group Outpatient visits:	\$32 Copayment ²	100%
Outpatient items and services (other than office visit services):		
Mental health intensive outpatient programs:	No Charge Deductible does not apply	100%
Mental health partial hospitalization:	No Charge Deductible does not apply	100%
Outpatient reconstructive surgery and administered hormones for treating gender dysphoria:	No Charge Deductible does not apply	100%
Substance Use Disorder Treatment intensive outpatient programs:	No Charge Deductible does not apply	100%
Substance Use Disorder Treatment day treatment programs:	No Charge Deductible does not apply	100%

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Behavioral Health Treatment Program for Pervasive Development Disorder or Autism (including treatment provided in the home):	No Charge Deductible does not apply	100%
Inpatient:	40%	100%
<i>Except in an emergency, precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification. Precertification is not required for emergency admissions, however, You or Your attending Physician must notify the Medical Review Program within 24 hours or as soon as reasonably possible.</i>		
Fertility Treatment (except in vitro):	40% Benefit Maximum of \$1,000 per Accumulation Period	Not Covered
Transplant Services:	40%	100%
<i>Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		
Birth Services (except routine prenatal care. Please see ACA Preventive benefits in this SOC):	40%	100%
Second Medical Opinion:	\$65 Copayment ²	100%
Medically Necessary Contact Lenses (including fitting and dispensing) for:		
Treatment of Aniridia (missing iris)	0%	0% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge
	Limited to 2 lenses per eye, subject to Benefit Maximum of 4 lenses per Accumulation Period	
Pediatric Dental (children under age 19):		
Diagnostic & Preventive (D&P):		
X-rays, Exams, Cleanings, Sealants, Including Pulp Vitality Tests	No Charge Deductible does not apply	No Charge up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge. Deductible does not apply

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Basic Services:		
Basic Restorative:	20% Deductible does not apply	20% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge. Deductible does not apply
Major Services:		
Crowns & Casts, Prosthodontics, Endodontics, Periodontics, Oral Surgery:	50% Deductible does not apply	50% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge. Deductible does not apply
Orthodontics (Medically Necessary):	50% Deductible does not apply	50% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge. Deductible does not apply
Pediatric Vision (children under age 19):		
Exams:	No Charge Deductible does not apply	0% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge Combined limit of one visit per Accumulation Period
Lenses (including optional Lenses and Treatments):	No Charge Deductible does not apply	100% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge Combined limit of one set of lenses per Accumulation Period
Frames:	No Charge Deductible does not apply	100% Combined limit of one pair of standard frames per Accumulation Period
Contact Lenses (in lieu of eyeglasses):	No Charge Deductible does not apply	100% Limited to 12-month supply of contact lenses for each eye every Accumulation Period

SCHEDULE OF COVERAGE

COVERED SERVICES

YOUR COST SHARE

PARTICIPATING PROVIDER TIER

NON-PARTICIPATING PROVIDER TIER

Medically Necessary Contact Lenses:

No Charge
Deductible does not apply

0% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge
Limited to 12-month supply of contact lenses for each eye every Accumulation Period

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.

Low Vision services:

Exams:

\$95 Copayment per visit
Limited to one visit every 5 years

Follow up care:

\$95 Copayment per visit
Limited to four visit every 5 years

Low Vision Aids

40%

100%

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.

COVID-19 screening and testing (provider office visit, telehealth, urgent care, emergency department and hospital visit to be screened and tested for COVID-19, and associated lab testing and radiology services), and immunizations:

No Charge
Deductible does not apply

No Charge
Deductible does not apply

Other Covered Services:

40%¹

100%

Some services require Precertification, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.

PREVENTIVE CARE: ¹

Preventive Care Exams and Services

(see Preventive section of the Certificate of Insurance for a complete list of these Preventive Benefits)

Exams (including routine prenatal visits and first postnatal visit):

No Charge
Deductible does not apply

40%
Deductible does not apply

Screenings:

Preventive Lab, X-ray and colorectal cancer screening and other screenings listed in the General Benefits section under Preventive Care Exams and Services.

No Charge
Deductible does not apply

40%
Deductible does not apply

SCHEDULE OF COVERAGE

COVERED SERVICES

YOUR COST SHARE

PARTICIPATING PROVIDER TIER

NON-PARTICIPATING PROVIDER TIER

Health Promotion:	No Charge Deductible does not apply	40% Deductible does not apply
Disease Prevention:	No Charge Deductible does not apply	40% Deductible does not apply
Family Planning including female sterilization, patient education and counseling:	No Charge Deductible does not apply	40% Deductible does not apply

Other Covered Preventive Care:

Unless, otherwise indicated, the following Preventive Benefits may be subject to Deductible (see Preventive section of the Certificate of Insurance for a complete list of these Other Preventive Benefits)

Routine Nursery Care and Physician charges for a newborn while the mother is confined:	40%	100%
Adult Preventive screening:	No Charge Deductible does not apply	40% Deductible does not apply
Adult Routine Physical Examinations:	No Charge Deductible does not apply	Not Covered
Adult Preventive Visions Screenings and Exams:	No Charge Deductible does not apply	Not Covered
Adult Routine Preventive Retinal Photography Screenings:	No Charge Deductible does not apply	40% Deductible does not apply
Other Hearing screenings:	No Charge Deductible does not apply	Not Covered
Other Family Planning such as vasectomy, elective abortion and fertility testing and counseling:	\$65 Copayment Deductible does not apply	100%
AIDS Vaccine:	No Charge Deductible does not apply	40% Deductible does not apply
Prenatal alpha-fetoprotein screening including services through participation in the California Prenatal Screening Program:	No Charge Deductible does not apply	No Charge Deductible does not apply

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Health Education:	No Charge Deductible does not apply	Not Covered
Iron deficiency anemia screening for pregnant women:	No Charge Deductible does not apply	40% Deductible does not apply
Foreign Travel Immunizations:	No Charge Deductible does not apply	Not Covered
Hemoglobin A1C testing for individuals diagnosed with diabetes: ³	No Charge Deductible does not apply	40% Deductible does not apply
Retinopathy Screening for individuals diagnosed with diabetes: ³	No Charge Deductible does not apply	40% Deductible does not apply
Low Density Lipo-Protein testing for individuals diagnosed with heart disease: ³	No Charge Deductible does not apply	40% Deductible does not apply
International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders: ³	No Charge Deductible does not apply	40% Deductible does not apply
Peak flow meters for individuals diagnosed with asthma: ³	40% Deductible does not apply	100%
<i>Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.</i>		
Glucometers including lancets, test strips, control solution and batteries for individuals diagnosed with diabetes: ³	40%	40%

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a \$500 penalty if You fail to obtain Precertification.

³*This service or supply is treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition.*

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Outpatient Prescription Drug Benefit:	PARTICIPATING (MedImpact) PHARMACY TIER	NON-PARTICIPATING PHARMACY TIER
Brand Prescription Drug Deductible:		
Individual:	\$500	Not Covered
Family:	\$1,000	Not Covered
Tier 0: Preventive Drugs: Required under the Affordable Care Act (ACA):	No Charge Deductible does not apply	Not Covered
Tier 1: Generic Drugs:	\$18 Copayment per prescription for up to a 30-day supply, after Prescription Drug Deductible	Not Covered
Tier 2: Brand Name Drugs:	40% for up to a 30-day supply (not to exceed \$500 per prescription), after Prescription Drug Deductible	Not Covered
Tier 3: Specialty Drugs:	40% for up to a 30-day supply* (not to exceed \$500 per prescription), after Prescription Drug Deductible	Not Covered
DME: Other pharmacy items: Disposable blood glucose and ketone urine test strips; blood glucose monitors; lancets and lancet puncture devices; pen delivery systems for the administration of insulin; visual aids excluding eyewear to assist in insulin dosing; and, peak flow meters:	40% for up to a 30-day supply after Prescription Drug Deductible (The Prescription Drug Deductible does not apply when this supply is treated as preventive care, as described under "Other Covered Preventive Care" in this Schedule of Coverage.)	Not Covered

**FDA-approved self-administered hormonal contraceptive drugs are covered when obtained at a Participating Pharmacy or through the mail order program. If so prescribed by the prescribing provider, a maximum of a 12-month supply of the self-administered hormonal contraceptive drug may be obtained at one time.*

SCHEDULE OF COVERAGE

COVERED SERVICES

PARTICIPATING PROVIDER TIER

YOUR COST SHARE

NON-PARTICIPATING PROVIDER TIER

This Outpatient Prescription Drug Benefit uses an open formulary. Unless specifically excluded under the Plan, all FDA-approved drugs are part of this Plan's open formulary. The formulary consists of generic and preferred and non-preferred brand drugs including specialty drugs.

You or Your prescribing physician may request that the pharmacist dispense a partial quantity of the prescribed amount when filling a prescription for an oral, solid dosage Schedule II controlled substance. Your Cost Share will be prorated based on the partial amount that You obtain.

If the pharmacy's retail price for a covered Outpatient Prescription Drug is less than the applicable Copayment, You are not required to pay more than the retail price at the point-of-sale. Your payment will apply to the Deductible, if any, that applies to Outpatient Prescription Drugs and will contribute towards the satisfaction of the Out-of-Pocket Maximum.

Your Cost Share for orally administered anti-cancer drugs shall not exceed \$200 for a 30-day supply.

Prescription drugs covered under the Outpatient Prescription Drug Benefit are subject to the Prescription Drug Deductible unless otherwise indicated. The Prescription Drug Deductible contributes towards the satisfaction of the Out of Pocket Maximum.

Mail Order Service

Copayments payable for Mail Order service is 2 times the corresponding single Copayment per prescription amount shown above for up to a 100-day supply*.

OPTIONAL BENEFITS:

Adult Vision Care (including frames
prescription lenses and prescription contact
lenses):

Not Covered

Not Covered

¹ Deductibles, Coinsurance and Copayments do not apply to Preventive Benefits required under the Affordable Care Act (ACA) at the Participating Provider tier. Preventive Benefits required under the ACA that are received at the Non Participating Provider tier, however, may be subject to Deductibles, Coinsurance and Copayments.

² The Deductible is waived for a combined first three office visits for: non-preventive provider office visits, urgent care visits, and Mental Health/ Substance Use Disorder Treatment visits. Any visit other than your first three non-preventive visits will be subject to the Deductible.

GENERAL DEFINITIONS

The following terms have special meaning throughout this Certificate. Other parts of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Certificate are defined in those sections.

Accumulation Period means: 1) a period of time of not more than twelve (12) months that is available to the Covered Person to satisfy the Deductible or Out-of-Pocket Maximum under the Group Policy; and 2) a period of time applicable to the Benefit Maximums, if any, under the Group Policy, such as visit, day and dollar limits. The Accumulation Period is set forth in the Schedule of Coverage.

Administrator means NTT DATA Services, PO Box 261155, Plano, TX 75026 and Delta Dental of California, PO Box 997330, Sacramento, CA 94105. NTT DATA Services is the Administrator of your medical coverage while Delta Dental is the Administrator of the Pediatric Dental coverage. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior notice. Neither KPIC nor its Administrator is the administrator of the Policyholder's employee benefit plan as that term is defined under Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA) as then constituted or later amended.

Affordable Care Act (ACA) means Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended. It is also known as the Patient Protection and Affordable Care Act (PPACA).

Allowance means a specified credit amount that can be used toward the purchase price of a covered item. If the price of the item(s) selected exceeds the Allowance, amounts in excess of the Allowance are paid by the Covered Person and that payment does not apply toward the satisfaction of the annual Out of Pocket Maximum.

Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

1. The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2500) of, Division 2 of the Business and Professions Code.
2. The treatment is provided under a Treatment Plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
 - a) A Qualified Autism Service Provider.
 - b) A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
 - c) A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.
3. The Treatment Plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The Treatment Plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:
 - a) Describes the patient's behavioral health impairments to be treated.
 - b) Designs 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 patient's progress is evaluated and reported.
 - c) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

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- d) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- 4. The Treatment Plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The Treatment Plan shall be made available to the KPIC upon request.

Benefit Maximum means a maximum amount of benefits that will be paid by KPIC for a specified type of Covered Charges incurred during a given period of time. The charges to which a Benefit Maximum applies are not considered Covered Charges after the Benefit Maximum has been reached. Covered Charges in excess of the Benefit Maximum will not be applied toward satisfaction of the Deductible and Out-of-Pocket Maximum.

Birth Center means an outpatient facility which:

1. complies with licensing and other legal requirements in the jurisdiction where it is located;
2. is engaged mainly in providing a comprehensive Birth Services program to pregnant individuals who are considered normal to low risk patients;
3. has organized facilities for Birth Services on its premises;
4. has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a Licensed Midwife or Certified Nurse Midwife; and
5. has 24-hour-a-day Registered Nurse services.

Birth Services means professional and hospital services for monitoring and managing pregnancy before birth, during delivery and after birth. Birth Services includes prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures. Benefits payable for the treatment of complications of pregnancy will be covered on the same basis as Sickness.

Brand Name Prescription Drug means a prescription drug that has been patented and is only produced by one manufacturer.

Calendar Year means a period of time: 1) beginning at 12:01 a.m. on January 1st of any year; and 2) terminating at midnight on December 31st of the same year.

Certified Nurse-Midwife or Licensed Midwife means any person duly certified or licensed as such in the state in which treatment is received and is acting within the scope of his or her license at the time the treatment is performed.

Certified Nurse Practitioner means a Registered Nurse duly licensed in the state in which the treatment is received who has completed a formal educational nurse practitioner program. He or she must be certified as such by the: 1) American Nurses' Association; 2) National Board of Pediatric Nurse Practitioners and Associates; or 3) Nurses' Association of the American College of Obstetricians and Gynecologists.

Certified Psychiatric-Mental Health Clinical Nurse Specialist means any Registered Nurse licensed in the state in which the treatment is received who: 1) has completed a formal educational program as a psychiatric-mental health clinical nurse specialist; and 2) is certified by the American Nurses' Association.

Coinsurance means a percentage of charges that You must pay when You receive a Covered Service as described under the **GENERAL BENEFITS** section and the Schedule of Coverage. Coinsurance amount is applied against the Covered Charge.

Community Mental Health Facility means a facility approved by a regional health planning agency or a facility providing services under a community mental health board established under applicable federal and state laws.

Complications of Pregnancy means any disease, disorder or conditions whose diagnoses are distinct from pregnancy, but are adversely affected by or are caused by pregnancy, and: (a) require Physician

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prescribed supervision; and (b) result in a loss or expense which, if not related to pregnancy, would be a Covered Service under the applicable provisions of this Group Policy.

Comprehensive Rehabilitation Facility means a facility primarily engaged in providing diagnostic, therapeutic, and restorative services through licensed health care professionals to injured, ill or disabled individuals. The facility must be accredited for the provision of these services by the Commission on Accreditation for Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association.

Confinement means physically occupying a room and being charged for room and board in a Hospital or other covered facility on a 24-hour a day basis as a registered inpatient upon the order of a Physician.

Copayment means the predetermined amount, as shown in the Schedule of Coverage, which is to be paid by the Insured for a Covered Service, usually at the time the health care is rendered. All Copayments applicable to the Covered Services are shown in the Schedule of Coverage.

Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.

Cost Share means: 1) Coinsurance; 2) Copayment; 3) Deductible; and 4) any benefit specific deductible incurred by a Covered Person.

Covered Charge or Covered Charges means the Maximum Allowable Charge(s) for a Covered Service.

Covered Person means a person covered under the terms of the Group Policy and who is, duly enrolled as an Insured Employee or Insured Dependent under the Plan. Covered Person is sometimes referred to as "member".

Covered Services means those services which a Covered Person is entitled to receive pursuant to the Group Policy and are defined and listed under the section entitled General Benefits.

Creditable Coverage means:

1. Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, internal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation coverage but does not include accident only credit disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2. The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3. The Medicaid program pursuant to Title XIX of the Social Security Act.
4. Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
5. A health plan offered under 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
9. A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191.
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504)).

Deductible means the amount of Covered Charges a Covered Person must incur, while insured under the Group Policy, before any benefits will be payable during that Accumulation Period. The Deductible will apply to each Covered Person separately, and must be met within each Accumulation Period. When

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Covered Charges equal to the Deductible are incurred during the Accumulation Period and are submitted to Us, the Deductible will have been met for that Covered Person. In a family plan, once the total of Covered Charges applied toward each family member's individual Deductible equals the family Deductible amount, the Deductible will be satisfied for all family members for that Accumulation Period.

Benefits will not be payable for Covered Charges applied to the Deductible. Covered Charges applied to satisfy the Deductible will be applied toward satisfaction of the Out-of-Pocket Maximum. Charges in excess of the Maximum Allowable Charge and additional expenses a Covered Person must pay because Pre-certification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

Some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage.

Dental Consultant means a Dentist who is responsible for the review and final adjudication of claims and re-evaluation requests that require professional review to ensure that the service was deemed necessary, appropriate and meets Generally Accepted Dental Practice Standards or has reasonable prognosis.

Dependent means only: a) Your spouse or Domestic Partner; and b) Your child who is of an age within the Age Limits for Dependent Children shown in the **ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE** section, or is a disabled child of any age. The word "child" includes: Your step-child; adopted child; child of Your Domestic Partner; or recognized natural child; and any other child for whom You have assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by You, as certified at the time of enrollment of the child, and annually thereafter.

Domestic Partner is an adult in a domestic partnership. A Domestic Partner may be regarded as your Dependent if: a) the domestic partnership meets all of the domestic partnership requirements under California law, or was validly formed in another jurisdiction; or b) the domestic partnership is in accord with your Group's eligibility requirements, if any, that are less restrictive than California law.

Durable Medical Equipment means equipment that is:

- designed for repeated use;
- mainly and customarily used for medical purposes;
- not generally of use to a person in the absence of a Sickness or Injury; and
- approved for coverage under Medicare, except for apnea monitors; or
- is otherwise required by law.

Supplies necessary for the effective use of Durable Medical Equipment are also considered Durable Medical Equipment, such as oxygen or drugs dispensed by Durable Medical Equipment vendors for use in Durable Medical Equipment items. However, drugs obtained at pharmacies are considered under the Outpatient Prescription Drug benefit even when obtained for use in a Durable Medical Equipment item.

Emergency Care or Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient

Emergency Medical Condition: A medical condition, including psychiatric conditions, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person, who

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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 in active labor, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Essential Health Benefits means the general categories of benefits including the items and services covered within these categories of benefits that comprise an essential health benefit package as defined under California Insurance Code section 10112.27 and the Affordable Care Act of 2010 (ACA) as then constituted or later amended.

Expense Incurred or Expenses Incurred means Expenses Incurred for Covered Services. An expense is deemed incurred as of the date of the service, treatment or purchase, giving rise to the charge or charges.

Experimental or Investigational means that one of the following is applicable:

1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or
2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered

External Prosthetics and Orthotics means:

1. 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. Examples of external prosthetics includes artificial limbs, parental and enteral nutrition, urinary collection and retention systems, colostomy bags and other items and supplies directly related to ostomy care and eyewear after cataract surgery or eyewear to correct aphakia. Other examples are prosthetic devices incident to a mastectomy, including custom-made prostheses when medically necessary, adhesive skin support attachment for use with external breast prosthesis; and brassieres for breast prostheses and Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect. Supplies necessary for the effective use of prosthetic device are also considered prosthetics.
2. Orthotics that are rigid or semi-rigid external devices. They must: a) support or correct a defective form or function of an inoperative or malfunctioning body part; or b) restrict motion in a diseased or injured part of the body. Orthotics do not include casts.

Free-Standing Surgical Facility means a legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC that:

1. has permanent operating rooms;
2. has at least one recovery room;
3. has all necessary equipment for use before, during and after surgery;
4. is supervised by an organized medical staff, including Registered Nurses available for care in an operating or recovery room;
5. has a contract with at least one nearby Hospital for immediate acceptance of patients requiring Hospital care following care in the Free-Standing Surgical Facility;
6. is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
7. requires that admission and discharge take place within the same working day.

Generally Accepted Dental Practice Standards means treatment that is consistent with sound, professionally recognized dental standards of practice as determined by the treating licensed Dentist acting within the scope of their practice in California for the dental condition in question.

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Generally Accepted Standards of Mental Health and Substance Use Disorder Care means standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to California Insurance Code Section 10144.51. Valid, evidence-based sources establishing Generally Accepted Standards of Mental Health and Substance Use Disorder Care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit Health Care Provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

Generic Prescription Drug is a prescription drug which does not bear the trademark of a specific manufacturer. It is chemically the same and generally costs less than a Brand Name Prescription Drug.

Group Policy means the contract issued by KPIC to the Policyholder that establishes the rights and obligations of KPIC and the Policyholder.

Habilitative Services means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Provider means any of the following:

1. A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
2. An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
3. A Qualified Autism Service Provider or Qualified Autism Service Professional certified by a national entity pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51.
4. An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
5. An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.1 of the Business and Professions Code.
6. A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
7. A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
8. A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

Home Health Care Agency means a public or private agency that is engaged in arranging and providing nursing services, Home Health Services and other therapeutic services in the home. The agency must be licensed as such (or if no license is required, approved as such) by a state department or agency having authority over Home Health Agencies. Home Health Services may consist of, but are not limited to the following:

1. part-time or intermittent skilled nursing services provided by a Registered Nurse or Licensed Vocational Nurse;
2. part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a Registered Nurse or a physical, speech or occupational therapist;
3. physical, occupational or speech therapy; and
4. medical supplies, drugs and medicines prescribed by a Physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the Group Policy if the Covered Person had remained in the Hospital.

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Home Health Care means services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists when:

1. You are substantially confined to Your home (or a friend's or relative's home).
2. Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide).
3. A Physician determines that it is feasible to maintain effective supervision and control of your care in Your home and that the services can be safely and effectively provided in your home.

Hospice Care means a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of an insured experiencing the last phases of life due to a terminal illness. The care must be provided: 1) directly; or 2) on a consulting basis with the patient's Physician or another community agency, such as a visiting nurses' association. For purposes hereof, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 12 months.

Hospital means an institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC that:

1. is legally operated as a Hospital in the jurisdiction where it is located;
2. is engaged mainly in providing inpatient medical care and treatment to Injury and Sickness in return for compensation;
3. has organized facilities for diagnosis and major surgery on its premises;
4. is supervised by a staff of at least two Physicians;
5. has 24-hour-a-day nursing service by Registered Nurses; and
6. is not: a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; or a Skilled Nursing Facility or similar institution.

The term "**Hospital**" will also include a psychiatric health facility which: a) is licensed by the California State Department of Health Services; and b) operates under a waiver of licensure granted by the California State Department of Mental Health.

Hospital Confinement means being registered as an inpatient in a Hospital upon the order of a Physician.

Iatrogenic Infertility means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

Indemnity Plan means a KPIC indemnity plan type in which Covered Persons are reimbursed for Covered Charges.

Injury means bodily damage or harm of a Covered Person.

Insured Dependent means a Dependent family member of an Insured Employee who is enrolled as such under the Group Policy. An Insured Dependent may include but not limited to Your spouse, Domestic Partner, or children up to age 26, and disabled children of any age.

Insured Employee means a Covered Person who is an employee of the Policyholder or is one entitled to coverage under a welfare trust agreement.

Intensive Care Unit means a section, ward or wing within the Hospital which:

1. is separated from other Hospital facilities;
2. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;

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3. has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
4. provides Room and Board; and
5. provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Licensed Vocational Nurse (LVN) means an individual who has 1) specialized nursing training; 2) vocational nursing experience; and 3) is duly licensed to perform nursing service by the state in which he or she performs such service.

Maximum Allowable Charge means:

1. For Covered Services from a Participating Provider, the Negotiated Rate as defined under part 2 b below;
2. For Covered Services from a Non-Participating Provider, the lesser of:
 - a) The Usual, Customary and Reasonable Charge (UCR):
The UCR is the charge generally made by a Physician or other provider of Covered Services. The charge cannot exceed the general level of charge made by other providers within an area in which the charge is incurred for Injury or Sickness comparable in severity and nature to the Injury or Sickness being treated. The general level of charges is determined in accord with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules, KPIC will establish the UCR. KPIC reserves the right to periodically adjust the charges listed in the schedules.

The term "**area**" as it would apply to any service, medicine or supply means a city or such greater area as is necessary to obtain a representative cross section of level of charges.

If the Maximum Allowable Charge is the UCR, the Covered Person will be responsible for payment to the provider of any amount in excess of the UCR when the UCR is less than the actual billed charges. Such difference will not apply towards satisfaction of the Out-of-Pocket Maximum nor any Deductible under the Group Policy.

b) The Negotiated Rate:

KPIC or its authorized Administrator may have a contractual arrangement with the provider or supplier of Covered Services, under which discounts have been negotiated for certain services or supplies. Any such discount is referred to as the Negotiated Rate.

If there is a Negotiated Rate, the provider will accept the Negotiated Rate as payment in full for Covered Services, subject to the payment of Deductibles and coinsurance by the Covered Person.

c) The Actual Billed Charges for the Covered Services:

The charges billed by the provider for Covered Services.

IMPORTANT: Notwithstanding the foregoing, the Maximum Allowable Charge for a Hospital or other licensed medical facility confinement may not exceed:

Hospital Routine Care Daily Limit:	the Hospital's average semi-private room rate
Intensive Care Daily Limit:	the Hospital's average Intensive Care Unit room rate
Other licensed medical facility Daily Limit:	the facility's average semi- private room rate

For Emergency Services rendered by Non-Participating Providers, the following rules apply:

If the amount payable by KPIC is less than the Actual Billed Charges by Non-Participating Providers for Emergency Service, KPIC will pay no less than the greater of the following:

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- a. The Negotiated Rate for the service. If there is more than one Negotiated Rate with a Participating Provider for a particular service, then such amount is the median of these Negotiated Rates, treating the Negotiated Rate with each provider as a separate Negotiated Rate, and using an average of the middle two Negotiated Rates if there is an even number of Negotiated Rates.
- b. The amount it would pay for the service if it used the same method (for example, Usual and Customary charges) that it generally uses to determine payments for services rendered by Non-Participating Providers and if there were no cost sharing (for example, if it generally pays 80% of UCR and the cost sharing is 20%, this amount would be 100% of UCR).
- c. The amount that Medicare (Part A or B) would pay for the service.

Under any of the above, KPIC may deduct, any Participating Provider Copayments and/or Coinsurance amount that would have been paid had the Emergency Service been rendered at a Participating Provider and/or any Non-Participating Provider deductible amount.

For Non-Emergency Covered Services obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility located in California:

In accordance with California law, if the Covered Person receives Non-Emergency Covered Services at a Participating Provider facility located in California at which, or as a result of which, the Covered Person receives Non-Emergency Covered Services from a Non-contracting Individual Health Professional, unless otherwise agreed to by the Non-contracting Individual Health Professional and KPIC the greater of:

- a. The average contracted rate. For the purposes of this section, "average contracted rate" means the average of the contracted commercial rates paid by KPIC for the same or similar services in the geographic region; or,
- b. 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.

Notwithstanding the above, unless the Covered Person provides written consent that meets the requirements as described under the **ACCESS TO HEALTH CARE** section of this Certificate, the Covered Person will be responsible for paying only the "in-network cost sharing amount". For purposes of this section, "in-network cost sharing amount" means an amount no more than the same cost sharing the insured would pay for the same covered service received from a Participating Provider. The "in-network cost sharing amount" shall be based on the amount paid by KPIC as set forth above. Additionally, the "in-network cost sharing amount" paid by the insured shall satisfy the insured's obligation to pay cost sharing for the health service. This constitutes the "applicable cost sharing amount owed by the insured".

Under any of the above, KPIC may deduct, any Participating Provider Cost Sharing amount that would have been paid had the Covered Service been rendered by a Participating Provider at a Participating Provider facility.

For COVID-19 preventive Covered services rendered by Non-Participating Providers, the following rules apply:

- a) The Covered Person will be responsible for paying only the "in-network cost sharing amount". For purposes of this section, "in-network cost sharing amount" means an amount no more than the same cost sharing the insured would pay for the same Covered Service received from a Participating Provider.
- b) Non-Participating Provider reimbursement for COVID-19 covered preventive services will be in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

Medical Review Program means the organization or program that: 1) evaluates proposed treatment or services; and 2) when appropriate, determines that KPIC will deny coverage on the grounds that the care

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is not Medically Necessary or is not Medically Necessary Treatment of a Mental Health or Substance Use Disorder. The Medical Review Program may be contacted 24 hours per day, 7 days per week.

Medically Necessary means services that are:

1. Essential for the diagnosis or treatment of a Covered Person's Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the Covered Person or the convenience of the health care provider or facility; and
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility. When applied to Confinement in a Hospital or other facility, this test means that the Covered Person needs to be confined as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

The fact that a Physician may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

This definition of Medically Necessary does not apply to benefits for Mental Health and Substance Use Disorders. Please refer to the definition of Medically Necessary Treatment of a Mental Health or Substance Use Disorder for the medically necessary definition that applies to Mental Health and Substance Use Disorders benefits.

Medically Necessary Treatment of a Mental Health or Substance Use Disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

- a) In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care.
- b) Clinically appropriate in terms of type, frequency, extent, site, and duration.
- c) Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other Health Care Provider.

Medical Necessity coverage determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge will be made exclusively by using the following nonprofit professional specialty association guidelines:

- For a primary Substance Use Disorder diagnosis, The ASAM Criteria developed by the American Society of Addiction Medicine;
- For a primary Mental Health diagnosis in adults age 19 and older, Level of Care Utilization System (LOCUS) developed by the American Association for Community Psychiatry (AACP);
- For a primary Mental Health diagnosis in children ages 6-18, Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) developed by AACP and the American Academy of Child & Adolescent Psychiatry (AACAP);
- For a primary Mental Health diagnosis in children ages 5 and younger, Early Childhood Service Intensity Instrument (ECSII) developed by AACAP.

Medically Necessary Treatment of Mental Health and Substance Use Disorders are covered under the same terms and conditions applied to other medical conditions under this Plan

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Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Mental Health and Substance Use Disorders means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by Health Care Providers practicing in relevant clinical specialties.

Medically Necessary Treatment of Mental Health and Substance Use Disorders are covered under the same terms and conditions applied to other medical conditions under this Plan.

Month means a period of time: 1) beginning with the date stated in the Group Policy; and 2) terminating on the same date of the succeeding calendar month. If the succeeding calendar month has no such date, the last day of the month will be used.

Necessary Services and Supplies means Medically Necessary Covered Services and supplies administered during any covered confinement or administered during other covered treatment, such as during a Physician office visit. Only drugs and materials that require supervision or administration by medical personnel during a covered confinement or other covered treatment are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to, surgically implanted prosthetic devices, oxygen, blood, blood products, and biological sera. The term does not include charges for: 1) Room and Board; 2) an Intensive Care Unit; or 3) the services of a private duty nurse, Physician, or other practitioner. This does not include drugs and materials obtained from a pharmacy under the Outpatient Prescription Drug benefit.

Non-Emergency use of Emergency Services means services rendered in an Emergency Department which do not meet the definition of Emergency Services.

Non-contracting Individual Health Professional means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with KPIC. For this purpose, a "Non-contracting Individual Health Professional" shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a Non-contracting Individual Health Professional's affiliation with a group.

Non-Participating Pharmacy means a pharmacy that does not have a Participating Pharmacy agreement with KPIC or its administrator in effect at the time services are rendered. Please consult with your group administrator for a list of Participating Pharmacies.

Non-Participating Provider means a Hospital, Physician or other duly licensed health care provider or facility that does not have a participation agreement with KPIC in effect at the time services are rendered. In most instances, You will be responsible for a larger portion of Your bill when You visit a Non-Participating Provider. Participating Providers are listed in the Participating Provider directory.

Open Enrollment Period means a fixed period of time, occurring at least once annually, during which Eligible Employees of the Policyholder may elect to enroll under this plan without incurring the status of being a Late Enrollee.

Out-of-Pocket means the Cost Share incurred by a Covered Person.

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Out-of-Pocket Maximum means the maximum amount of Cost Share a Covered Person will be responsible for in a given period of time (the Accumulation Period). The Accumulation Period is set forth in the Schedule of Coverage. Cost sharing for Emergency Care Services, including emergency hospital care and emergency medical transportation, obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier.

Participating Pharmacy means a pharmacy which has a Participating Pharmacy agreement in effect with KPIC at the time services are rendered. Please consult with your group administrator for a list of Participating Pharmacies.

Participating Provider means a provider duly licensed in the state where services are rendered and who is providing care under a written contract with KPIC or KPIC's contracted provider network.

Participating Provider Organization (PPO) means a KPIC indemnity plan type, in which Covered Persons have access to a network of contracted providers and facilities referred to as preferred providers. In most instances, a higher level of benefits applies to Covered Services received from preferred providers and facilities. The Schedule of Coverage shows the plan type under which the Covered Person is insured.

Patient Protection and Affordable Care Act (PPACA) – means Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended. It is commonly referred to as the Affordable Care Act (ACA).

Percentage Payable means that percentage of Covered Charges to be paid by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services.

Pervasive Developmental Disorder or Autism has the same meaning and interpretation as used in Section 10144.5 of the California Insurance Code.

Physician means a practitioner who is duly licensed as a Physician in the state in which the treatment is received. He or she must be practicing within the scope of that license. The term does not include a practitioner who is defined elsewhere in this General Definitions section.

Plan/This Plan means the part of the Group Policy that provides benefits for health care expenses. If "Plan" has a different meaning for another section of this Certificate, the term will be defined within that section and that meaning will supersede this definition only for that section.

Policyholder means the employer(s) or trustor(s) or other entity noted in the Group Policy as the Policyholder who conforms to the administrative and other provisions established under the Group Policy.

Policy Year means a period of time: 1) beginning with This Plan Effective Date of any year; and 2) terminating on the same date shown on the Schedule of Coverage. If This Plan Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

PPO Service Area means the entire state of California.

Precertification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment made by the Medical Review Program. Request for Precertification must be made by the Covered Person or the Covered Person's attending Physician prior to the commencement of any service or treatment. If Precertification is required, it must be obtained to avoid a reduction in benefits in a form of a penalty.

Pre-certification will not result in payment of benefits that would not otherwise be covered under the Group Policy.

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Preventive Care means measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care: 1) protects against disease such as in the use of immunizations, 2) promotes health, such as counseling on tobacco use, and 3) detects disease in its earliest stages before noticeable symptoms develop such as screening for breast cancer.

Unless otherwise specified, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to Preventive Care.

Primary Care Physician means a Physician specializing in internal medicine, family practice, general practice, general internal medicine, obstetrics and gynecology and general pediatrics.

Prosthetic Devices (Internally Implanted) means a prosthetic device is a device that replaces all or part of a body organ or that replaces all or part of the function of a permanently inoperative or malfunctioning body organ. We cover internally implanted prosthetic devices that replace the function of all or part of an internal body organ, including internally implanted breast prostheses following a covered mastectomy. The devices must be approved for coverage under Medicare and for general use by the Food and Drug Administration (FDA). Examples of internally implanted prosthetics include pacemakers, cochlear implants, osseointegrated hearing devices, surgically implanted artificial hips and knees and intraocular lenses.

Qualified Autism Service Paraprofessional means an unlicensed and uncertified individual who meets all of the following criteria:

1. Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
2. Provides treatment and implements services pursuant to a Treatment Plan developed and approved by the Qualified Autism Service Provider.
3. Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
4. Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider.
5. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism Treatment Plan.

Qualified Autism Service Professional means an individual who meets all of the following criteria:

1. Provides Behavioral Health Treatment, which may include clinical case management and case supervision of a Qualified Autism Service Provider.
2. Is supervised by a Qualified Autism Service Provider.
3. Provides treatment pursuant to a Treatment Plan developed and approved by the Qualified Autism Service Provider.
4. Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
5. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
6. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism Treatment Plan.

Qualified Autism Service Provider means either of the following:

1. A person who is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive developmental disorder or Autism, provided the services are within the experience and competence of the person who is nationally certified; or
2. A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker,

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professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for Pervasive developmental disorder or Autism, provided the services are within the experience and competence of the licensee.

Reconstructive Surgery means a surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function; or 2) to create a normal appearance to the extent possible. Reconstructive Surgery includes, but is not limited to, incidental surgery to a covered mastectomy and Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures, or other craniofacial conditions, such as Apert, Pfeiffer and Crouzon Syndromes, and hemifacial microsomia.

Registered Nurse (RN) means a duly licensed nurse acting within the scope of his or her license at the time the treatment or service is performed in the state in which services are provided.

Rehabilitation Services means services provided to restore previously existing physical function.

Residential Treatment means Medically Necessary Treatment of a Mental Health or Substance Use Disorder provided in a licensed residential treatment facility that provides 24-hour individualized Substance Use Disorder or mental health treatment. Services must be above the level of custodial care and include:

1. Room and board;
2. Individual and group Substance Use Disorder therapy and counseling;
3. Individual and group mental health therapy and counseling;
4. Physician services;
5. Medication monitoring;
6. Social services; and
7. Drugs prescribed by a physician and administered during confinement in the residential facility.

Room and Board means all charges commonly made by a Hospital or other inpatient medical facility on its own behalf for room and meals essential to the care of registered bed patients.

Routine Patient Care Costs means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:

1. Health care services typically provided absent a clinical trial.
2. Health care services required solely for the provision of the investigational drug, item, device, or service.
3. Health care services required for the clinically appropriate monitoring of the investigational item or service.
4. Health care services provided for the prevention of complications arising from the provision of the investigational drug item, device, or service.
5. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine Patient Care Costs do not include the costs associated with the provision of any of the following:

1. Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a Covered Person may require as a result of the treatment being provided for purposes of the clinical trial.
3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.

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4. Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under the Group Policy.
5. Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Sickness means illness or a disease of a Covered Person. Sickness will include congenital defects or birth abnormalities or Mental Disorders.

Skilled Nursing Care Services means skilled inpatient services that are: 1) ordered by a Physician; 2) customarily provided by Skilled Nursing Facilities; and 3) above the level of custodial or intermediate care.

Skilled Nursing Facility means an institution (or a distinct part of an institution) which: 1) provides 24-hour-a-day licensed nursing care; 2) has in effect a transfer agreement with one or more Hospitals; 3) is primarily engaged in providing skilled nursing care as part of an ongoing therapeutic regimen; and 4) is licensed under applicable state law.

Specialty Care Physician means a Physician in a board-certified specialty, other than those listed under the definition of Primary Care Physician.

Specialty Drugs means high-cost drugs that are listed on KPIC's specialty drug list.

Stabilize means 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).

Substance Use Disorder – Please see definition of "Mental Health and Substance Use Disorders".

Treatment Plan means a written document developed and approved by a Qualified Autism Service Provider for the specific patient being treated for Pervasive Developmental Disorder or Autism. The Treatment Plan must have measurable goals over a specific timeline and shall be reviewed at least once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the Qualified Autism Service Provider does all of the following:

1. Describes the patient's behavioral health impairments to be treated.
2. Designs an intervention plan that includes:
 - a) the service type,
 - b) number of hours, and
 - c) parent participation needed to achieve the plan's goal and objectives, and
 - d) the frequency at which the patient's progress is evaluated and reported.
3. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
4. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

The Treatment Plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The Treatment Plan shall be made available to KPIC upon request.

Urgent Care means non-life threatening medical and health services for the treatment of a covered Sickness or Injury. Urgent Care services may be covered under the Group Policy the same as a Sickness or an Injury.

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Urgent Care Center means a facility legally operated to provide health care services in emergencies or after hours. It is not part of a Hospital.

Urgent Care Facility means a facility legally operated to provide health care services requiring immediate medical attention, but which do not meet the definition of an emergency.

You/ Your refers to the Insured Employee who is enrolled for benefits under This Plan.

SAMPLE

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Eligibility for Insurance

You must be an Eligible Employee or Dependent of an Eligible Employee to become insured under the Group Policy.

Eligible Employee

An **"Eligible Employee"** is a person who, at the time of original enrollment: a) resides in an area specified by the plan type as listed below; b) is working for a Policyholder as a permanent full-time employee as shown below or is entitled to coverage under a trust agreement or employment contract; c) by virtue of such employment enrolls for the Group Policy and d) reached an eligibility date. Eligible Employee includes sole proprietors and partners of a partnership actively engaged on a full-time basis in the employer's business or are entitled to coverage under a trust agreement or employment contract.

NOTE: The term **"Eligible Employee"** does not include a person who is eligible for Medicare Part A or Medicare Part B, except that this does not apply to those entitled to Medicare benefits who under federal law elect, or are required, to have the Policyholder's health coverage as their primary health care coverage.

Full-Time Work

The terms **"full-time"**, **"working full-time"**, **"work on a full-time basis"**, and all other references to full-time work mean that the Eligible Employee is actively engaged in the business of a Policyholder for at least the minimum number of hours per week specified in the Policyholder's Application for coverage, subject to any applicable state and federal requirements.

Permanent Employee

A **"permanent employee"** is a person scheduled to work full-time and is not a seasonal, temporary or substitute employee.

Plan Service Area Enrollment Requirement

PPO Plan - An eligible Employee must live or work within the PPO Service Area as defined under the General Definitions section of this Certificate. For purposes of this provision, "work within the PPO Service Area" means working for a Policyholder whose situs is within the PPO Service Area."

Eligibility Date

Your eligibility date is the date Your employer becomes a Policyholder if You are an eligible employee on that date, or the Policyholder's Application for coverage indicates that the eligibility waiting period does not apply to initial employees. Otherwise, Your eligibility date is the first day of the calendar month coinciding with or next following the date You complete the eligibility waiting period elected by the Policyholder.

Effective Date of Your Insurance

Your effective date of insurance is described in the subsection **Enrollment Rules for Eligible Employee or Dependent** provision set forth below under this section.

If an Eligible Employee is not in Active Service on the date coverage would otherwise become effective, the coverage for that individual will not be effective until the date of return to Active Service. Any delay in an eligible employee's Effective Date will not be due to a health status-related factor as defined under the Health Insurance and Portability and Accountability Act of 1996, or as later amended.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

"Active Service" means that a Covered Person: 1) is present at work with the intent and ability to work the scheduled hours; and 2) is performing in the customary manner the regular duties of his or her employment

Eligibility of an Eligible Employee's Dependent (Please check with your employer if Dependent coverage is available under Your plan)

The term **"Dependent"** means only: a) Your spouse or Domestic Partner; and b) Your child who is of an age within the Age Limits for Dependent Children shown below, or is a disabled child of any age. The word **"child"** includes: a) Your step-child; b) adopted child; c) child of Your Domestic Partner; d) recognized natural child; and e) any other child whom You have assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by YOU, as certified at the time of enrollment of the child, and annually thereafter.

An Insured Dependent is not required to live with the parent or within an applicable service area. Coverage outside the United States is limited to Emergency Services.

Age Limits for Dependent Children

The age limit for Dependent children is under **26** years, except for a full-time student who is on medical leave of absence as described below in this subsection, and for Disabled Dependent children, as described below under the "Age Limits for Disabled Dependent Children" subsection. If Your employer elected to make coverage available under Your Plan beyond this age limit for Dependent children who are full-time students, then a Dependent child beyond this age limit who is a full-time student may be covered. The Dependent child must be of an age within the Student Age Limit as shown in Your Schedule of Coverage. A **"full-time student"** is a Dependent child who is enrolled at a high school, college, university, technical school, trade school, or vocational school on a full-time basis. A **"full-time student"** may also include, those who are on medical leave of absence from the school or those who have any other change in enrollment in school) due to a Medically Necessary condition as certified by the attending Physician. Such student coverage shall commence on the earlier of: the first day of the medical leave of absence; or on the date certified by the Physician. Coverage for students on medical leave of absence is subject to a maximum of 12 months and shall not continue beyond the effective date of the termination of the Group Policy.

Proof of status as a **"full-time student"** must be furnished to KPIC at time of enrollment or within 31 days after attaining such status and subsequently as may be required by KPIC.

The age limit for Dependent children does not apply to a **"full-time student"** who is on medical leave of absence as described above, if, as a result of the nature of the sickness, injury, or condition, would render the dependent child incapable of self-sustaining employment and is chiefly dependent upon You for support and maintenance.

Age Limits for Disabled Dependent Children

A Disabled Dependent child means Your child of any age who is both: 1) incapable of self-sustaining employment by reason of a physically or mentally disabling sickness, injury or condition; and 2) chiefly dependent upon You for support and maintenance.

Initial enrollment of a Disabled Dependent child age 26 or over

If You are requesting coverage for a Disabled Dependent child age 26 or over who is not currently covered under the plan You must provide us documentation of the Dependent's incapacity and dependency within 60 days after we request it so that we can determine if the Dependent is eligible for coverage as a disabled Dependent.

Initial enrollment of a Dependent child under age 26 will be the same as any other Dependent child.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Continued Enrollment for Disabled Dependents age 26 and over

Such child will continue to qualify as a Dependent until the earlier of the following dates: a) the date the child recovers from the physically or mentally disabling sickness, injury or condition; or b) the date the child no longer chiefly depends on You for support and maintenance.

KPIC shall send a termination notice to the Insured Employee at least 90 days prior to the date of the Dependent child's attainment of limiting age. KPIC shall require the Insured Employee's submission of proof of such incapacity and dependency during the period commencing 60 days before and ending 60 days after the child's 26th birthday. Coverage will continue while KPIC is making a determination as to the child's eligibility for continued coverage.

Subsequently, proof of continued incapacity may be required by KPIC, but not more frequently than annually after the two-year period following the Dependent child's attainment of the limiting age. Proof of such incapacity and dependency must be submitted to KPIC within 60 days of KPIC's request.

Eligibility Date

A Dependent's eligibility date is the later of a) Your eligibility date; or b) the date the person qualifies as Your Dependent. A child named in a Qualified Medical Child Support Order qualifies as Your Dependent on the date specified in the court order. An adopted child qualifies as Your Dependent on the earlier of: the date of adoption or the date of placement for adoption.

Effective Date of Dependent Coverage

A Dependent's effective date of insurance is subject to the Enrollment Rules that follow.

Enrollment Rules for Eligible Employee or Dependent

If You are an Eligible Employee, Your effective date of insurance is determined by the Enrollment Rules that follow. Your Dependent's effective date is likewise determined by the following Enrollment Rules:

1. Initial Open Enrollment

The Policyholder will offer an initial enrollment to newly Eligible Employees and Dependents when the Employee is first eligible for coverage.

Effective date. Initial enrollment for newly eligible Employees and Dependents is effective following completion of any waiting period or probationary period, (not to exceed 60 days), if required by the Policyholder is completed. In the absence of a waiting period or probationary period, the enrollment becomes effective according to the eligibility rules established by the Policyholder, either on the date of hire or on the first day of the calendar month following the month in which the employee was hired.

If You did not enroll Yourself and/or Your Dependents during the initial enrollment period, You and/or Your Dependents will need to wait until the next Open Enrollment period to enroll or during the Special Enrollment Period or as a Late Enrollee, as described below.

2. Rolling Enrollment Period

Employers can purchase coverage for their small group at any time in the year (rolling enrollment). The Policyholder's plan year must consist of the 12- month period beginning with the employer's effective date of coverage.

3. Annual Employer Election Period.

The Policyholder shall be afforded an annual employer election of no less than 30 days prior to the completion of the Policyholder's plan year and before the annual employee Open Enrollment period, in which the Policyholder may change its participation for the next plan year.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

KPIC will provide notification to the Policyholder of the annual election period in advance of such period.

4. Annual Open Enrollment

Open Enrollment refers to a standardized annual period of time of no less than 30 days prior to the completion of the employer's plan year for Eligible Employees to enroll. During the annual open enrollment period, Eligible Employees and Dependents can apply for or change coverage without incurring the status of being a Late Enrollee.

Effective date. Enrollment is effective on the first day following the end of the prior plan year. Open Enrollment occurs only once per year. The Policyholder will notify You when Open Enrollment is available in advance of such period.

5. Late Enrollment

If You do not enroll yourself and/or Your Dependent when first eligible, You and/or Your Dependent may apply for coverage at any time during the year as a Late Enrollee, but You and/or Your Dependent will only be eligible to enroll during the next Open Enrollment Period, or during a Special Enrollment Period if You and/or Your Dependent have experienced a triggering event.

6. Special Enrollment – Exceptions to Late Enrollment

You and/or Your Dependent may be able to enroll for coverage prior to Open Enrollment if You and/or Your Dependent have experienced a special enrollment triggering event. You and/or Your Dependent must request coverage within 60 days of a triggering event. Special enrollment triggering events include:

- 1) Loss of health care (minimum essential) coverage, resulting from any of the following:
 - a. loss of employer sponsored coverage because You or Your Dependent no longer meet the eligibility requirements;
 - b. Your or Your Dependent's employer no longer offers coverage or stops contributing premium payments;
 - c. loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium);
 - d. Your and/or Your Dependent's individual, Medi-Cal, Medicare, or other governmental coverage ends;
 - e. for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission under Section 10384.17 of the California Insurance Code (fraud or intentional misrepresentation of material fact); or
 - f. loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code.
- 2) Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption or assumption of a parent-child relationship;
- 3) A valid state or federal court orders that you or your dependent be covered;
- 4) Permanent relocation, such as moving to a new location and having a different choice of health plans;
- 5) Being released from incarceration;
- 6) The prior health coverage issuer substantially violated a material provision of the health coverage contract;
- 7) A network provider's participation in Your and/or Your Dependent's health plan ended when You were under active care for one of the following conditions
 - a. an acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration;

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

- b. a serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration;
 - c. pregnancy;
 - d. terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less;
 - e. care of a newborn child between birth and age 36 months; or
 - f. performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured.
- 8) A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.
- 9) An individual demonstrates to the Department of Insurance, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

Effective date. In the case of birth, adoption, or placement for adoption, enrollment is effective on the date of birth, adoption, or placement for adoption. In the case of any other triggering event listed above, including marriage, or becoming a registered domestic partner, or loss of minimum essential coverage, enrollment is effective on the first day of the month following the date we receive the request for special enrollment.

Court or Administrative Ordered Coverage for a Dependent Child

If a Covered Person is required by an Order to provide health coverage for an eligible child and the Covered Person is eligible for coverage under a family plan, the Covered Person, employee, employer or group administrator may enroll the eligible child under family coverage by sending KPIC a written application and paying KPIC any additional amounts due as a result of the change in coverage. Enrollment period restrictions will not apply in these circumstances. However, the child should be enrolled within 60 days of the court or administrative order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

If the Covered Person, employee, administrator or employer fails to apply for coverage for the Dependent child pursuant to the Order, the custodial parent, district attorney, child's legal custodian or the State Department of Health Services may submit the application for insurance for the eligible child. Enrollment period restrictions will not apply in these circumstances. However, the child must be enrolled within 60 days of the Order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

Effective date. Enrollment is effective on the first day of the month following the date We receive the request for special enrollment.

Effective Date for Future Dependents

The effective date of insurance for a Dependent will be the date You acquire the Dependent in the case of birth, adoption, or placement for adoption. In the case of marriage or becoming a registered domestic partner, enrollment is effective on the first day of the month following the date we receive the request for special enrollment. The Dependent must be enrolled within 60 days of their eligibility date or they will be considered a Late Enrollee.

Exception for Newborns

A newborn Dependent child is insured from the moment of birth for the first 31 days (including the date of birth). You must enroll the newborn Dependent within 60 days of that Dependent's birth in order for insurance to extend beyond the 60-day period. If coverage terminates at the expiration of the 60-day

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period, the child will be considered a Late Enrollee and You must wait until the next annual Open Enrollment period to enroll the child for coverage.

Exception for Adopted Children

An adopted child is insured from the earlier of the date of adoption or the date of placement for adoption. You must enroll the adopted child within 60 days of his eligibility date in order for insurance to extend beyond the 60-day period. If coverage terminates at the expiration of the 60-day period, the child will be considered a Late Enrollee and You must wait until the next annual Open Enrollment period to enroll the child for coverage.

Termination of an Insured Employee's Insurance

Your insurance will automatically terminate on the earlier of:

1. the date You cease to be covered by KPIC;
2. the date the Group Policy is terminated;
3. the date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. the end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion. (The grace period that the Policyholder has in which to pay the premium then due is the later of 31 days from each premium due date (except the first) or 31 days from the date KPIC provides notice of non-renewal due to non-payment of premium to the Policyholder.);
5. the last day of the month You cease to qualify as an Eligible Employee; or
6. the date You relocate to a place outside of the geographic service area of a provider network, if applicable. (See the eligibility section for information about the Plan Service Areas.) If You cease to qualify as an Eligible Employee because You no longer live in an area specified for the Plan in which You are enrolled, Your insurance will end on the last day of the Policy Year in which You change residence.

In no event will Your insurance continue beyond the earlier of the date Your employer is no longer a Policyholder and the date the Group Policy terminates.

If You or Your Dependent's Policy is rescinded or cancelled, You have the right to appeal the rescission or cancellation. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeal process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Termination of Insured Dependent Coverage

An Insured Dependent's coverage will end on the earlier of:

1. the date You cease to be covered by KPIC;
2. the last day of the of the calendar month in which the person ceases to qualify as a Dependent;
3. the date Your insurance ends, unless continuation of coverage is available to the Dependent under the provisions of the Group Policy;
4. the end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion. (The period that the Policyholder has in which to pay the premium then due is the later of 31 days from each premium due date (except the first) or 31 days from the date KPIC provides notice of non-renewal due to non-payment of premium to the Policyholder.);
5. the date the Group Policy is terminated;
6. the date the Dependent, or the Dependent's representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
7. the date the Dependent relocates to a place outside of the geographic service area of a provider network, if applicable, unless specifically provided otherwise in the Group Policy.

To the extent required by California law, if Your coverage terminates, KPIC will provide Your name, address and other contact information, such as email address to the state Exchange

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(Covered California) so that Covered California may communicate with You about available coverage options after You cease to be enrolled. You have the right to opt out of this transfer of Your information to Covered California, by calling toll-free 1-800-464-4000 the telephone number on Your I.D. card.

Continuation of Coverage during Layoff or Leave of Absence

If Your full-time work ends because of a disability, an approved leave of absence or layoff, You may be eligible to continue insurance for Yourself and Your Dependents up to a maximum of three months if full-time work ends because of disability or two months if work ends because of layoff or leave of absence other than family care leave of absence. These provisions apply as long as You continue to meet Your Groups written eligibility requirements and This Plan has not terminated. You may be required to pay the full cost of the continued insurance during any such leave.

See Your employer for details regarding the continuation of coverage available to You and Your Dependents under both state and federal laws.

Rescission for Fraud or Intentional Misrepresentation

Subject to any applicable state or federal law, if You performed an act or practice constituting fraud or made an intentional misrepresentation of material fact under the terms of the Group Policy, KPIC may rescind Your coverage under the Group Policy by giving You no less than 31 days advance written notice. The rescission will be effective, on:

1. The effective date of Your coverage, if we relied upon such information to provide coverage; or
2. The date the act of fraud or intentional misrepresentation or material fact occurred, if the fraud or intentional misrepresentation of a material fact was committed after the Effective Date of Your coverage.

After 24 months following the Group Policy Effective Date, Your coverage under the Group Policy will not be rescinded or cancelled for any reason.

If KPIC rescinds the Group Policy, we will send a notice to the Insured via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the Insured of his or her right to appeal that decision to the California Insurance Commissioner.

If Your or Your Dependent's Policy is rescinded, you have the right to appeal the rescission. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for your right to an Independent Medical Review.

ACCESS TO HEALTH CARE

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

Benefit levels for Participating Providers or Non-Participating Providers

Your coverage provided under the Group Policy may include coverage for Covered Services that are received from either Participating Providers or Non-Participating Provider. See Your Schedule of Coverage to determine if Your coverage includes Participating Providers. Normally, benefits payable under the Group Policy are greater for Covered Services received from Participating Providers than those benefits payable for Non-Participating Providers. Except as otherwise provided under federal or state law, in order for benefits to be payable at the Participating Provider tier, the Covered Person must receive care from a Participating Provider.

You may visit KPIC's contracted provider network web site at: www.Mutiplan.com/Kaiser to view the provider directory or to request a printed copy at no cost. Additionally, a current printed listing of KPIC's Participating Providers directory is available at no cost to You by calling the phone number listed on Your ID card or by writing to: KPIC Provider Relations Manager, 300 Lakeside Drive, Room 1335D, Oakland, CA 94612. To verify the current participation status of any provider, please call the toll-free number listed in the provider directory. If the Covered Person receives care from a Non-Participating Provider, benefits under the Group Policy are payable at the Non-Participating Provider tier.

If you require interpreter services or require the provider directory to be translated in another language other than English, please call 1-800-788-0710. The English version of this document is the official version. The foreign language version is for informational purposes only.

Geographic Standards for Access to Participating Providers

In accordance with the provisions of state law, access to health care from a Participating Provider will meet the following distance or travel time from the Covered Person's residence or place of work :

1. 15 miles or 30 minutes for Primary Care Physicians;
2. 15 miles or 30 minutes for Mental Health or Substance User Disorder providers; and
3. 30 miles or 60 minutes for Specialty Care Provider; and
4. 15 miles or 20 minutes for Hospitals.

If medically appropriate care cannot be provided by a Participating Provider within the required distance or travel shown above, KPIC shall arrange for the required care with an available and accessible licensed provider. The Covered Person shall be responsible for paying only the applicable Participating Provider Cost Sharing for the service and will not be liable for the payment of any amount in excess of the Usual, Customary and Reasonable Charge or the Actual Billed Charges. The Cost Share for this service will apply to the satisfaction of the Deductible and the Out of Pocket Maximum at the Participating Provider tier.

Please see the **TIMELY ACCESS TO CARE** section of this Certificate for information about appointment wait time standards for Participating Providers.

Non-Emergency Services Obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility located in California

This provision does not apply to Emergency Care Services.

ACCESS TO HEALTH CARE

Except as provided under the exception below, in accordance with California law, if the Covered Person receives Non-Emergency Covered Services at a Participating Provider facility located in California at which, or as a result of which, the Covered Person receives Covered Services from a Non-contracting Individual Health Professional, the Covered Person will be responsible for paying no more than the same Cost Sharing that the Covered Person would pay for the same Covered Services received from a Participating Provider (the in-network cost-sharing amount) and will not be liable for the payment of any additional amounts that would generally apply to services rendered by a non-contracting provider. The Cost Share incurred for the non-emergency service described above will apply to the Deductible and the Out of Pocket Maximum accumulation at the Participating Provider tier. No Deductible will apply if the Participating Provider Deductible has already been met. The Covered Person will not pay any amount if the Out-of-Pocket Maximum at the Participating Provider tier has already been reached.

Exception to the above rule. For services subject to this section, the above rule does not apply and a Non-contracting Individual Health Professional may bill or collect from the Covered Person the out-of-network cost sharing, if applicable, if the Covered Person gave his or her written consent to the Non-contracting Individual Health Professional rendering the service and that written consent demonstrates satisfaction of all the following criteria:

- (1) At least 24 hours in advance of care, the Covered Person consents in writing to receive services from the identified Non-contracting Individual Health Professional.
- (2) The consent obtained by the Non-contracting Individual Health Professional is in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent must not be obtained by the facility or any representative of the facility. The consent must not be obtained at the time of admission or at any time when the Covered Person is being prepared for surgery or any other procedure.
- (3) At the time consent is provided, the Non-contracting Individual Health Professional must give the Covered Person a written estimate of the Covered Person's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The Non-contracting Individual Health Professional must not attempt to collect more than the estimated amount without receiving separate written consent from the Covered Person or their authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.
- (4) The consent must advise the Covered Person that he or she may elect to seek care from a contracted provider or may contact the Covered Person's insurer in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.
- (5) The consent and estimate must be provided to the Covered Person in the language spoken by the Covered Person, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 126052 of the Health and Safety Code.
- (6) The consent shall also advise the Covered Person that any costs incurred as a result of the Covered Person's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

When You're Not Sure What Kind of Care You Need

Sometimes it's difficult to know what kind of care You need, so we have licensed health care professionals available to assist You by phone 24 hours a day, seven days a week. Here are some of the ways they can help You:

- They can answer questions about a health concern, and instruct You on self-care at home if appropriate
- They can advise You about whether You should get medical care, and how and where to get care (for example, if You are not sure whether Your condition is an Emergency Medical Condition, they can help You decide whether You need Emergency Care or Urgent Care, and how and where to get that care)
- They can tell You what to do if You need care and a health care provider's office is closed

ACCESS TO HEALTH CARE

You can reach one of these licensed health care professionals by calling 1-888-251-7052. When You call, a trained support person may ask You questions to help determine how to direct Your call.

If You have a complaint regarding Your ability to access needed health care in a timely manner you may contact KPIC at:

**KPIC Civil Rights Coordinator
Grievance 1557
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-251-7052**

You may also contact the California Department of Insurance regarding Your complaint at:

**California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)**

The Covered Person may write the California Department of Insurance at:

**California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013**

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

TIMELY ACCESS TO CARE

Your coverage provided under the Group Policy may include coverage for Covered Services that are received from either Participating Providers or Non-Participating Providers. See Your Schedule of Coverage to determine if Your coverage includes Participating Providers.

This section describes standards for appointment wait times and the availability of interpreter services when health care is obtained from Participating Providers. Please refer to the **ACCESS TO HEALTH CARE SECTION** of this Certificate for further information about obtaining health care under this Policy.

Appointment Wait Times

In accordance with the provisions of state law, access to health care from a Participating Provider will meet the following appointment availability standards:

- 1) Urgent care appointments for services that do not require precertification shall be available within 48 hours of the request for appointment;
- 2) Urgent care appointments for services that require precertification as shown in the **PRECERTIFICATION** section of this Certificate shall be available within 96 hours of the request for appointment;
- 3) Non-urgent appointments for primary care shall be available within ten business days of the request for appointment;
- 4) Non-urgent appointments with specialist physicians shall be available within fifteen business days of the request for appointment;
- 5) Non-urgent appointments with a non-physician Mental Health or Substance User Disorder care provider shall be available within ten business days of the request for appointment;
- 6) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition shall be available within fifteen business days of the request for appointment; and,
- 7) Telephone triage or screening services shall be provided in a timely manner appropriate for the Covered Person's condition. The triage or screening waiting time shall not exceed 30 minutes.

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the Covered Person's health.

Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Notice of the Availability of Interpreter Services from a Participating Provider

Language interpretation services in languages other than English are available to limited-English-proficient Covered Persons at no cost and shall be coordinated with scheduled appointments for health care services from a Participating Provider in a manner that ensures the provision of interpreter services at the time of the appointment without imposing an undue delay on the scheduling of the appointment. If You require interpreter services for Your health care appointment, please request such services at the time You call to schedule Your appointment.

PRECERTIFICATION

This section describes:

1. How failure to obtain Precertification affects coverage;
2. Precertification administrative procedures; and
3. Which clinical procedures require Precertification.

If Precertification is not obtained, benefits will be reduced through the application of a penalty as described herein even if the treatment or service is deemed Medically Necessary. If the treatment or service is deemed not to be Medically Necessary, the treatment or service will not be covered. If a Hospital Confinement or other inpatient care is extended beyond the number of days first precertified without further Precertification, benefits for the extra days: 1) similarly will be penalized; or 2) will not be covered at all if deemed not to be Medically Necessary. For Mental Health and Substance Use Disorders, medical necessity will be based on the standards set forth under the definition of "Medically Necessary Treatment of a Mental Health or Substance Use Disorder".

If Precertification is not obtained, benefits payable for all Covered Charges incurred in connection with any of these services will be reduced by a penalty of \$500 each time Precertification is required. However, the penalty will not result in a reduction greater than 50% of the Covered expenses or \$500 whichever is less per occurrence or per claim. This \$500 penalty will not count toward the satisfaction of any Deductible, coinsurance or Out-of-Pocket Maximum applicable under the Group Policy.

If Your request for Precertification is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Medical Review Program means the organization or program that: 1) evaluates proposed treatment or services; and 2) when appropriate, determines that KPIC will deny coverage on the grounds that the care is not Medically Necessary or is not Medically Necessary Treatment of a Mental Health or Substance Use Disorder. The Medical Review Program may be contacted 24 hours per day, 7 days per week.

Precertification Through the Medical Review Program

The following treatment or services must be precertified by the Medical Review Program:

1. Inpatient Hospital admissions and services.*
2. Inpatient Mental Health admissions and services.*
3. Inpatient Substance Use Disorder admissions and services.*
4. Inpatient care at a Skilled Nursing Facility or any other licensed medical facility.*
5. Home Health Care Services, including Home Infusion and Home Therapy.
6. Inpatient Rehabilitation Therapy admissions, services and programs.*
7. Inpatient Residential Treatment*
8. Outpatient surgery at a Hospital, Free-Standing Surgical Facility or other licensed medical facility.
9. The following specific treatments and procedures:
 - a) Bariatric Surgery
 - b) Blepharoplasty, Pitosis Repair
 - c) Breast Augmentation/Implants
 - d) Breast Reduction
 - e) Clinical Trials
 - f) Cosmetic Procedures
 - g) Craniofacial Reconstruction
 - h) Dental and Endoscopic Anesthesia

PRECERTIFICATION

- i) Durable Medical Equipment (DME):
 - i. Airway Clearance Vest
 - ii. Bone stimulator/ Cardioverter Defibrillator Vest
 - iii. Cough Stimulator Device
 - iv. Communicators
 - v. CPAP/BIPAP
 - vi. External Vacuum Erection Devices
 - vii. Hospital-grade electric breast pump
 - viii. Insulin pump
 - ix. Neuromuscular Stimulators
 - x. Oxygen
 - xi. Patient Lifts
 - xii. Specialty beds
 - xiii. TENS Units
 - xiv. Wheelchair Cushions/Seating Systems
 - xv. Woundvac
- j) Enteral Solutions
- k) Fertility Preservation Services
- l) Genetic Testing
- m) Habilitative Services (outpatient physical therapy, occupational therapy, and speech therapy and pulmonary therapy)
- n) Injectable Medications
- o) Imaging Services: MRI, MRA, CT, CTA, PET, EB, CT
- p) Implantable prosthetics (includes breast, bone conduction, cochlear, and ocular)
- q) Medical Food Products for treatment of Phenylketonuria (PKU)
- r) Non-Emergency Air or Ground Ambulance Transport
- s) Orthognathic Surgery (non-dental jaw surgery)
- t) Orthotics/Prosthetics
- u) The following Outpatient Procedures:
 - i. Outpatient sleep studies (lab or home)
 - ii. Outpatient vein procedures (office or outpatient); includes sclerosing, ablations, stripping
 - iii. Cosmetic procedures (office or outpatient)
 - iv. Dermatology procedures (office or outpatient); includes injection of fillers, photopheresis, laser, tattooing, phototherapy
 - v. Outpatient hyperbaric treatment
 - vi. Pill or wire endoscopy (office or outpatient)
 - vii. Oral procedures (office or outpatient); includes palate, tongue, floor of mouth, prosthesis
 - viii. External counterpulsation
 - ix. Complex wound care (office or outpatient); includes wound vacuum, cultured or biomechanical skin graft
 - x. Insertion or removal of Neurostimulator
- v) Pain Management.
 - i. Epidural Injections
 - ii. Use of Neurolytic agent
 - iii. Decompression Procedure
 - iv. Epidural or Intrathecal Implant procedures
 - v. Epidural or Intrathecal Pump use.
 - vi. Injection of anesthetic agent
 - vii. Insertion or removal of Neurostimulator
 - viii. Paravertebral or Transforaminal injections
 - i. Sacroiliac Injection.
- w) Pediatric low vision aids
- x) Pediatric Medically Necessary contact lenses
- y) Radiation Therapy Services

PRECERTIFICATION

- z) Reconstruction Surgery (including all procedures by plastic surgeon)
- aa) Rehabilitative Services (outpatient physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation)
- bb) Spinal surgery
- cc) Temporomandibular Joint Surgery
- dd) Transgender Surgery
- ee) Transplants

* Precertification for inpatient admissions and services

Precertification is required for all inpatient admissions and services except for the following:

- Maternity admissions and services for delivery of a child for a minimum of 48 hours for a vaginal delivery and 96 hours for a caesarean delivery.
- Emergency admissions or services. You or Your attending Physician should notify the Medical Review Program of the admission as soon as reasonably possible and not later than 24 hours following the emergency.
- Length of stay following a mastectomy or lymph node surgical procedure. The treating physician and surgeon is not required to receive prior approval from KPIC in determining the length of hospital stay following these procedures.

Precertification Administrative Procedures - For All Plans

1. The Covered Person or his or her attending Physician must notify the Medical Review Program as follows:
 - a) Planned Hospital Confinement - at least 3 days prior to admission for such Hospital Confinement.
 - b) Extension of a Hospital Confinement - As soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond: i) the number of days originally precertified; or ii) the date on which coverage of the Hospital Confinement by KPIC under This Plan terminates.
 - c) Other treatments or procedures requiring Precertification - At least 3 days prior to performance of any other treatment or service requiring Precertification or as soon as reasonably possible.
 - d) Emergency Hospital Confinement - within 24 hours after care has commenced. This requirement is not applied if notice is given as soon as reasonably possible.
2. The Medical Review Program will:
 - a) precertify the requested treatment or service, however, in no event will the Medical Review Program require a treating Physician to request or obtain prior approval for the purpose of determining the length of hospital stay following a covered mastectomy or lymph node dissection; or
 - b) deny Precertification entirely; or
 - c) deny the requested treatment or service but precertify an alternative treatment or service; and
3. Under the Medical Review Program, a Covered Person may be required to:
 - a) obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second surgical opinion, it will be provided at no charge to the Covered Person.
 - b) obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service.

The Medical Review Program may request Your agreement to participate in the following voluntary case management programs: a) case management; b) Hospital discharge planning; and or c) long-term case management programs.

Pregnancy Precertification: When a Covered Person is admitted to a Hospital for the delivery of a child, the Covered Person is entitled to stay in the hospital without any Precertification for a minimum of:

Forty-eight (48) hours for a normal vaginal delivery; and
Ninety-six (96) hours for a Cesarean section delivery.

PRECERTIFICATION

A stay longer than the above may be allowed provided the attending provider obtains authorization for an extended confinement through KPIC's Medical Review Program. Under no circumstances will KPIC require that a provider reduce the mother's or child's Hospital Confinement below the allowable minimums cited above.

Treatment for Complications of Pregnancy is subject to the same Precertification requirements as any other Sickness.

Length of Stay for Mastectomy and Lymph Node Surgical Services

The length of a hospital stay associated with mastectomy or lymph node surgical procedures will be determined by the attending Physician in consultation with the patient, post-surgery, consistent with sound clinical principles and processes. The treating physician and surgeon is not required to receive prior approval from KPIC in determining the length of hospital stay following these procedures.

Review Process

If a request for Precertification is denied, in whole or in part, the Covered Person, or the individual legally responsible for the Covered Person, will be: 1) notified in writing; and 2) given an opportunity for review. A copy of the procedures by which the Covered Person may seek review will be provided to the Covered Person or the individual legally responsible for the Covered Person at the time of denial.

Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Failure to Comply with the Precertification Procedures

Failure to comply with any of the Precertification procedures set forth above will result in a penalty as previously described.

The dollar amount of any penalty applied will not count toward satisfaction of any Deductible, coinsurance, or Out-of-Pocket Maximum.

DEDUCTIBLES AND MAXIMUMS

Individual Deductible

Unless otherwise indicated in the Schedule of Coverage or elsewhere in the Policy, the Deductible as shown in the Schedule of Coverage applies to all Covered Charges incurred by a Covered Person during the Accumulation Period. The Deductible applies separately to each Covered Person during each Accumulation Period. When Covered Charges equal to the individual Deductible Maximum are incurred during the Accumulation Period and are submitted to Us, the Deductible will have been met for that Covered Person. Benefits will not be payable for Covered Charges applied to the Deductible. The Accumulation Period is set forth in the Schedule of Coverage.

Family Deductible Maximum

When Covered Charges equal to the individual Deductible Maximum are incurred during the Accumulation Period and are submitted to Us, the Deductible will have been met for that Covered Person. All remaining family members must continue paying for Covered Charges for services that are subject to the Deductible until they either meet their individual Deductible Maximum or until the family collectively reaches the family Deductible Maximum. Once the family Deductible Maximum is satisfied, benefits begin for the rest of the family for that Accumulation Period whether or not each of their individual Deductible maximum has been met. The Individual Deductible will not be further applied to any other Covered Charges incurred during the remainder of that Accumulation Period by any other person in Your family. The Accumulation Period is set forth in the Schedule of Coverage.

Benefit-specific deductibles

Some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles do not contribute towards satisfaction of the Individual or Family Deductible.

NOTE: Please refer to the Schedule of Coverage for the actual amount of Your Individual and Family Deductible.

Doctor Office Visit Copayment Exception - Not subject to Deductible

For PPO Plans only

Unless otherwise noted in the Schedule of Coverage, the Deductible does not apply to practitioner charges incurred for an office visit. Instead, the Covered Person pays the office visit Copayment for each visit to a Participating Provider.

Percentage Payable

The Percentage Payable by KPIC is applied to Covered Charges after any applicable Deductible has been met. The Percentage Payable is set forth in the Schedule of Coverage.

Out-of-Pocket Maximums

Any part of a charge that does not qualify as a Covered Charge, will not be applied toward satisfaction of the Out-of-Pocket Maximum. Cost Sharing incurred under the following apply to the Out-of-Pocket Maximum.

1. Cost Sharing incurred for all Covered Services under the Participating Provider tier will be applied towards the Out-of-Pocket Maximum under the Participating Provider tier;
2. Cost Sharing incurred for all Covered Services under the Non-Participating Provider tier will be applied towards the Out-of-Pocket Maximum under the Non-Participating Provider tier; except that:
 - a) Cost Sharing for Emergency Care Services, including emergency hospital care and emergency medical transportation, obtained from a Non-Participating Provider will be applied towards the

DEDUCTIBLES AND MAXIMUMS

Out-of-Pocket Maximum at the Participating Provider tier and the Non-Participating Provider tier; and,

- b) Cost Sharing for Non-Emergency Covered Services obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility will be applied towards the Out-of-Pocket Maximum under the Participating Provider tier. Refer to the “Non-Emergency Services Obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility” provision under the **ACCESS TO HEALTH CARE** section of this Certificate for additional information.

Charges in excess of the Maximum Allowable Charge or Benefit Maximum and additional expenses a Covered Person must pay because Precertification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

Individual Out-of-Pocket Maximums: When the Covered Person's Cost Share equals the Out-of-Pocket Maximum shown in the Schedule of Coverage during the Accumulation Period, the Covered Person is not required to pay a Cost Share for any further Covered Charges incurred by that same Covered Person for the remainder of that Accumulation Period. The Accumulation Period is set forth in the Schedule of Coverage.

Family Out-of-Pocket Maximums: Once a family member reaches their Individual Out-of-Pocket Maximum, no further Cost Share will apply for Covered Services for that individual during the Accumulation Period. All remaining family members must continue paying Cost Share for Covered Services until they either satisfy their individual Out-of-Pocket Maximum or until the family collectively satisfies the family Out-of-Pocket Maximum. When the family's Cost Share equals the family Out-of-Pocket Maximum shown in the Schedule of Coverage during the Accumulation Period, all family members are not required to pay a Cost Share for any further Covered Charges incurred by all family members for the remainder of that Accumulation Period. The Accumulation Period is set forth in the Schedule of Coverage.

Maximum Allowable Charge

Payments under the Plan are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service. (Refer to the definition of Maximum Allowable Charge shown in the General Definitions section of the Certificate.)

Other Maximums

To the extent allowed by law, certain treatments, services and supplies are subject to benefit-specific limits or maximums. These additional limits or maximums are shown in the Schedule of Coverage

GENERAL BENEFITS

This section describes the general benefits provisions. Outpatient Prescription Drug Benefits are listed in the Outpatient Prescription Drug Benefits section. General limitations and exclusions are listed in the General Limitations and Exclusions section. Optional benefits are set forth under the section entitled Optional Benefits, Limitations and Exclusions. Please refer to your Schedule of Coverage to determine which, if any, optional benefits Your employer elected.

Insuring Clause

Upon receipt of a satisfactory notice of claim and proof of loss, KPIC will pay the Percentage Payable for Expenses Incurred up to the Maximum Allowable Charge for a Covered Service, provided:

1. the expense is incurred while the Covered Person is insured for this benefit;
2. the expense is for a Covered Service that is Medically Necessary or is Medically Necessary Treatment of a Mental Health or Substance Use Disorder;
3. the expense is for a Covered Service prescribed or ordered by the attending Physician or those prescribed or ordered by Non-Participating Provider who are duly licensed by the state to provide medical services without the referral of a Physician;
4. the Covered Person has satisfied the applicable Deductibles, Co-payments, and other amounts payable; and
5. the Covered Person has not exceeded any benefit maximum shown in the Schedule of Coverage.

Payments under this Group Policy:

1. Will be subject to the limitations shown in the Schedule of Coverage;
2. Will be subject to the General Limitations and Exclusions; and
3. May be subject to Precertification.

Covered Services:

1. Room and Board in a Hospital, including private room accommodation or semi-private room accommodation, upon determination by the attending Physician that such is Medically Necessary.
2. Room and Board in a Hospital Intensive Care Unit.
3. Skilled Nursing Care Services provided in a Skilled Nursing Facility or other licensed medical facility include:
 - a) Physician and nursing services;
 - b) Room and board;
 - c) Drugs prescribed by a physician as part of the plan of care in the plan skilled nursing facility in accord with the plan's drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel;
 - d) Durable medical equipment in accord with the plan's durable medical equipment formulary if skilled nursing facilities ordinarily furnish the equipment;
 - e) Imaging and laboratory services that skilled nursing facilities ordinarily provide;
 - f) Medical social services; Blood, blood products, and their administration;
 - g) Medical supplies;
 - h) Physical, occupational, and speech therapy;
 - i) Behavioral health treatment for pervasive developmental disorder or autism;
 - j) and Respiratory therapy.Care in a Skilled Nursing Facility is limited to: a) the maximum number of covered days shown in the Schedule of Coverage; b) care in a licensed Skilled Nursing Facility or other licensed medical facility; c) care under the active medical supervision of a Physician; and d) services consistent with medical needs
4. Necessary Services and Supplies, including medication dispensed while confined in a Hospital. or administered during other covered treatment, such as a Physician office visit.
5. Treatment in an Emergency Department of a Hospital or an Urgent Care Center. Please refer to the subsection, "Benefits for Emergency Services" in this General Benefits section for further information.

GENERAL BENEFITS

6. Physicians' services, including office visits, and house calls when care can best be provided in Your home as determined by the Physician.
7. Transportation of a Covered Person to or from Covered Services, by licensed ambulance or licensed psychiatric transport van service, when a Physician determines that the use of other means of transportation may endanger the Covered Person's health.
8. Emergency medical transportation without Precertification provided through the 911 emergency response system in the following situations:
 - a) the request was made for an emergency medical condition and ambulance transport services were required;
 - b) the Covered Person reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.
9. Nursing care by an RN, or, an LVN, as certified by the attending Physician if an RN is not available. Outpatient private duty nursing will only be covered for the period for which KPIC validates a Physician's certification that: a) the services are Medically Necessary and b) that, in the absence of such nursing care, the Covered Person would be receiving Covered Services as an inpatient in a Hospital or Skilled Nursing Facility in the absence of these nursing services.
10. Services by a Certified Nurse Practitioner; Certified Clinical Nurse Specialist; Licensed Midwife; or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
11. Radiation treatment limited to: a) radiation therapy when used in lieu of generally accepted surgical procedures or for the treatment of malignancy; or b) the use of isotope, radium or radon for diagnosis or treatment.
12. X-ray, other imaging including diagnostic mammogram and lab tests.
13. Ultraviolet light treatment
14. Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.
15. Genetic testing, including genetic testing used to diagnose, treat, or determine predisposition to breast cancer and prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures and all other laboratory tests for specific genetic disorders for which genetic counseling is available.
16. Home Health Care Services except:
 - a) meals;
 - b) personal comfort items; and
 - c) housekeeping services.

Covered Home Health Care Services are limited to part-time or intermittent home health care consisting of up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide. Up to three visits per day (counting all home health visits from nurses, medical social workers, and home health aides; the visit limit does not apply to physical, occupational, and speech therapists visits) are covered. Up to 100 visits per Accumulation Period (counting all home health visits from nurses, medical social workers, and home health aides; the visit limit does not apply to physical, occupational, and speech therapists visits) are covered. They must be provided in the Covered Person's home and according to a prescribed treatment plan.

If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to Your home for three hours and then leaves, that counts as two visits. Also, each person providing services counts toward these visit limits. For example, if a home health aide and a nurse are both at Your home during the same two hours, that counts as two visits.
17. Outpatient surgery in a Free-Standing Surgical Facility or other licensed medical facility.
18. Hospital charges for use of a surgical room on an outpatient basis.
19. Hospice Care limited to:
 - a) Interdisciplinary team care with development and maintenance of an appropriate plan of care.
 - b) Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse.
 - c) Bereavement Services.

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- d) Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
- e) Medical direction with the medical director being also responsible for meeting the general medical needs of the enrollees to the extent that these needs are not met by the attending physician.
- f) Volunteer services.
- g) Short-term inpatient care arrangements.
- h) The following shall be provided to the extent reasonable and necessary for the palliation and management of terminal illness and related conditions: pharmaceuticals, medical equipment and supplies.
- i) Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
- j) Ostomy and urological supplies including incontinence supplies
- k) The following care during periods of crisis when You need continuous care to achieve palliation or management of acute medical symptoms:
 - i. nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain You at home.
 - ii. respite care (short-term inpatient care) required at a tier that cannot be provided at home.

Covered Persons who elect to receive Hospice Care are not entitled to any other benefits under the Plan for the terminal illness while receiving hospice care.

- 20. Pre-admission testing, limited to diagnostic, x-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital Confinement for which a Room and Board charge is made.
- 21. Birth Services including those performed in a Birth Center. For information regarding the length of stay for inpatient maternity care, please refer to the subsection, "Length of Stay for Inpatient Maternity Care" in this General Benefits section.
- 22. External Prosthetic and Orthotic Devices that are Medically Necessary including prosthetics and orthotics needed following surgery, such as removal of a tumor mastectomy or laryngectomy. Coverage for external breast prostheses after a full or partial mastectomy, or lumpectomy will include up to three bras each Accumulation Period designed for the exclusive use with the prosthetic. Coverage for prosthetic and orthotic devices is limited to standard mode or item that adequately meets the medical needs of the Covered Person. Convenience and luxury items and features are not covered. Repair or replacement of prosthetic and orthotic devices is limited to: a) that needed because of growth; b) Prosthetics needed following surgical removal of a tumor.
- 23. Prosthetics (internally implanted).
- 24. Rental of Durable Medical Equipment. However, purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental. Repair or replacement of Durable Medical Equipment is covered if such repair or replacement is necessary as a result of ordinary wear and tear, subject to any limitation specified in the Schedule of Coverage; Repair or replacement of Durable Medical Equipment is not covered if it is needed due to negligence, misuse or disuse of the equipment. Replacement of lost or stolen Durable Medical Equipment is not covered. Durable Medical Equipment is limited to the standard item of Durable Medical Equipment that adequately meets the medical need of the Covered Person. Durable Medical Equipment includes special footwear for individuals who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.

Durable Medical Equipment includes but is not limited to

- a. the following Base Durable Medical Equipment items:
 - i. Diabetic Shoes and Inserts: off-the-shelf depth-inlay shoes; custom-molded shoes; custom-molded multiple density inserts; fitting, modification, and follow-up care for podiatric devices; repair or replacement of podiatric devices.
 - ii. Glucose Monitors, Infusion Pumps, and Related Supplies: external single or multiple channel electric or battery-operated ambulatory infusion pumps; home blood glucose

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monitors; blood glucose test or reagent strips for home blood glucose monitors; interstitial glucose monitors; programmable and non-programmable implantable infusion pumps; infusion pump used for uninterrupted parenteral administration of medication; infusion sets for external insulin pumps; infusion supplies for external drug infusion pumps; lancets; calibrator solution/chips; single or multi-channel stationary parenteral infusion pumps; replacement batteries for home blood glucose monitors and infusion pumps; spring-powered device for lancet; syringe with needle for insulin pump.

- iii. Respiratory Drug Delivery Devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; water collection device for nebulizer, spacer for use with metered dose inhaler.
 - iv. Tracheostomy Equipment: artificial larynx; replacement battery for artificial larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits.
 - v. Canes and Crutches: adjustable and fixed canes, including standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips, and underarm pads.
 - vi. Dry pressure pad for a mattress.
 - vii. Cervical traction equipment (over door).
 - viii. Osteogenesis Stimulation Devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low-density ultrasound osteogenesis stimulator.
 - ix. IV pole.
 - x. Phototherapy (bilirubin) light with photometer.
 - xi. Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage.
 - xii. Non-segmental home model pneumatic compressor for the lower extremities; and
- b. Supplemental Durable Medical Equipment not described under bulleted item "a" above that is approved by Medicare such as oxygen, wheelchairs, and hospital beds.

Coverage of enteral and parenteral nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections is included under the prosthetic and orthotic benefit. Please refer to the Schedule of Coverage for the specific prosthetic and orthotic benefit coverage.

Please refer to Preventive Care Exams and Services in this General Benefits section for coverage of breast pumps.

25. Management and treatment of diabetes which includes equipment, supplies and medications as follows:
- a) Blood glucose monitors and blood glucose testing strips.
 - b) Blood glucose monitors designed to assist the visually impaired.
 - c) Insulin pumps and all related necessary supplies.
 - d) Ketone urine testing.
 - e) Lancet and lancet puncture devices.
 - f) Pen delivery systems for the administration of insulin.
 - g) Podiatric devices to prevent or treat diabetes-related complications.
 - h) Insulin syringes.
 - i) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

This benefit includes coverage for diabetic day-care self-management program, training, education and medical nutrition therapy services. For the purposes of this provision, **"diabetic day-care self-**

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management program" means an educational program of instruction which will enable diabetic patients and their families to gain an understanding of the diabetic process, and the daily management of diabetic therapy in order to avoid frequent hospitalizations and complications.

Such programs will only apply to diabetic programs directed and supervised by a licensed Physician certified in internal medicine or pediatrics. The diabetic self-management program may be provided by a health care professional, including but not limited to, a Physician, a Registered Nurse, a registered pharmacist, or a registered dietitian. Benefits will be limited to those charges of the first program that a Covered Person has been certified to have completed.

26. Inpatient and Outpatient dialysis services related to acute renal failure and end-stage renal disease. Equipment, training, and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.
27. Rehabilitative Services. The following Services are covered
 - a) Physical therapy rendered by a certified physical therapist or other provider practicing within the scope of their license or registration.
 - b) Speech therapy rendered by a certified speech therapist or certified speech pathologist.
 - c) Occupational therapy rendered by a certified occupational therapist.
 - d) Pulmonary therapy.
 - e) Multidisciplinary rehabilitation services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program.
28. Respiratory therapy rendered by a certified respiratory therapist
29. Mental Health Services that are Medically Necessary for prevention, diagnosis and treatment of a Mental Health condition are covered under the same terms and conditions applied to other medical conditions under this Plan. This includes all benefits listed elsewhere in this General Benefits section. Covered Services include:
 - a) Outpatient office visit mental health services, including the following:
 - (i) Individual and group mental health evaluation and treatment, including repetitive Transcranial Magnetic Stimulation (rTMS);
 - (ii) Psychological testing when necessary to evaluate a Mental Disorder;
 - (iii) Outpatient Services for the purpose of monitoring drug therapy; and
 - (iv) Gender dysphoria treatment, including diagnostic assessment, psychotherapy, and medication management.
 - b) Outpatient other items and services (other than office visit services) for mental health care, defined as other outpatient intermediate services that fall between inpatient care and regular outpatient office visits, including but not limited to the following:
 - (i) Intensive psychiatric treatment programs, including the following:
 - (1) Hospital-based intensive outpatient care;
 - (2) Multidisciplinary treatment in an intensive outpatient psychiatric treatment program; Mental health partial hospitalization;
 - (3) Electroconvulsive Therapy (ECT), and
 - (4) Psychiatric observation for an acute psychiatric crisis.
 - (ii) Mental health partial hospitalization;
 - (iii) Services that are Medically Necessary of Mental Health and Substance Use Disorder for gender dysphoria, including outpatient reconstructive surgery, administered hormones; and fertility preservation*; and
 - (iv) Behavioral Health Treatment Program for Pervasive Development Disorder or Autism (including treatment provided in the home).
 - c) Inpatient mental health care including the following:
 - (i) Inpatient psychiatric hospitalization, including coverage for room and board, prescription drugs, and services of physicians and providers who are licensed health care professionals acting within the scope of their license; and
 - (ii) Treatment in a psychiatric residential care facility, including treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis.

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*See also "Transgender Surgery and other Medically Necessary treatment of Mental Health and Substance Use Disorder for treatment of gender dysphoria" in this **GENERAL BENEFITS** section.

30. Substance Use Disorder services that are Medically Necessary for prevention, diagnosis, and treatment of a Substance Use Disorder are covered under the same terms and conditions applied to other medical conditions under this Plan. This includes all benefits listed elsewhere in this **GENERAL BENEFITS** section. Covered services include:
- a) Inpatient Substance Use Disorder care:
 - i. Inpatient detoxification: hospitalization only for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling;
 - ii. Treatment in a residential care facility, including transitional residential recovery services for Substance Use Disorder treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.
 - b) Outpatient office visit Substance Use Disorder care:
 - i. Individual and group Substance Use Disorder counseling;
 - ii. Medication-assisted treatment
 - c) Outpatient other items and services other than office visit services for Substance Use Disorder care, defined as other outpatient intermediate services that fall between inpatient care and regular outpatient office visits, including but not limited to the following:
 - i. Day-treatment programs;
 - ii. Intensive outpatient programs;
 - iii. Treatment at a licensed and certified opioid treatment program. Treatment includes delivery or administration of opioid agonist treatment medications, including methadone therapy;
 - iv. Medical treatment for withdrawal symptoms;
 - v. Methadone therapy at a licensed treatment center for treatment of withdrawal symptoms and maintenance treatment.
- Medically Necessary Treatment of Mental Health and Substance Use Disorders are covered under the same terms and conditions applied to other medical conditions under this Plan.
31. Transplant services in connection with an organ or tissue transplant procedure, harvesting the organ, tissue, or bone marrow and treatment of complications, including charges incurred by a donor or prospective donor who is not insured under the plan will be paid as though they were incurred by the insured provided that the services are directly related to the transplant. Coverage for transplant services shall not be denied based upon the Covered Person being infected with the human immunodeficiency virus (HIV).
32. Treatment for breast cancer. Some services may be considered preventive benefits and are covered at no Cost Share. Please refer to Preventive Care Exams and Services in this General Benefits section for coverage of preventive benefits to screen for or diagnose breast cancer.
33. Allergy testing and treatment, services, material and serums.
34. Fertility Services, except in vitro fertilization. Fertility Services are limited to treatment by artificial means for the purpose of causing pregnancy, such as: a) drugs; b) medicines; c) artificial insemination; d) gamete intrafallopian transfer; e) ovum transplants; f) donor eggs; or g) donor sperm. Treatment must be consistent with prevailing standards for efficacy. Benefits payable for diagnosis of infertility will be covered on the same basis as a Sickness.
35. Diagnosis and treatment of covered conditions directly affecting the upper or lower jawbone, or associated bone joints, including craniomandibular and temporomandibular joint disorders limited to Medically Necessary non-dental diagnostic and non-dental surgical treatment only.
36. Reconstructive Surgery. Coverage is limited to a surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function; or 2) to create a normal appearance to the extent possible. Reconstructive Surgery includes, but is not limited to, non-dental jaw surgery, incidental surgery to a covered mastectomy and Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures, or

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other craniofacial conditions, such as Apert, Pfeiffer and Crouzon Syndromes, and hemifacial microsomia. Reconstructive breast surgery following a mastectomy including reconstruction of the healthy breast to produce a symmetrical appearance; prostheses; and treatment of complications at all stages of the mastectomy, including lymphedemas. Please refer to "Prosthetic and Orthotic Devices that are Medically Necessary" in this **GENERAL BENEFITS** section for coverage of breast prostheses needed after a covered mastectomy.

37. General anesthesia and associated facility charges for dental procedures rendered in a Hospital or surgery center setting, when the clinical status or underlying medical condition of the Covered Person requires that the dental procedure be performed while the Covered Person is under general anesthesia in a Hospital or surgery center setting. Coverage shall not be provided unless the Covered Person is:
- a) under seven years of age; or
 - b) developmentally disabled; or
 - c) one whose health is compromised and for whom general anesthesia is medically necessary.

This provision does not apply to treatment rendered for temporal mandibular joint disorders nor does it provide coverage for any dental procedure or the professional fees or services of the dentist.

38. Dental services for radiation treatment. Coverage is limited to dental evaluation, x-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer in Your head or neck.
39. Screening and treatment of Phenylketonuria (PKU), including coverage for medical food products, such as formula that are Medically Necessary for the treatment of PKU. Such coverage for formula and special food products is limited to the extent that the cost of such formulas or special food products exceed the cost of a normal diet.
40. Coverage for a second medical opinion, limited to charges for Physician consultation, and charges for any additional x-rays, laboratory tests and other diagnostic studies. Benefits will not be payable for x-ray, laboratory tests, or diagnostic studies that are repetitive of those obtained as part of the original medical opinion and/or those for which KFFC paid benefits. For benefits to be payable, the second medical opinion must be rendered by a Physician who agrees not to treat the Covered Person's diagnosed condition. The Physician offering the second medical opinion may not be affiliated with the Physician offering the original medical opinion.
41. Behavioral Health Treatment for Pervasive Developmental Disorder or Autism. The treatment must be prescribed by a physician or surgeon; or is developed by a psychologist and provided under the Treatment Plan prescribed by a Qualified Autism Service Provider and administered by one of the following:
- a) A Qualified Autism Service Provider.
 - b) A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
 - c) A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.
42. Bariatric surgery and associated services that are Medically Necessary for the treatment of obesity in adults by modification of the gastrointestinal tract to reduce nutrient intake and absorption. Covered hospital inpatient care related to the bariatric surgical procedures includes room and board, x-ray, imaging, laboratory, and Physician Services. For Medically Necessary associated services related to a covered bariatric surgical procedure that you receive under this Plan, refer to the coverage information in this Certificate for the specific service. Under the Precertification process through the Medical Review Program, the proposed treatment will be evaluated using clinical guidelines on the identification, evaluation, and treatment of obesity in adults. Please refer to the **PRECERTIFICATION** section for information about Precertification through the Medical Review Program.
43. Covered Services in connection with the diagnosis of Obesity. These include Covered Services to diagnose the causes of obesity, for treatment of diseases causing obesity, or resulting from obesity including screening, diagnostic testing and lab services.
44. Special contact lenses for aniridia for adults age 19 and over. Coverage is limited to up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).

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45. Telehealth when used as a mode of delivering otherwise Covered Services via interactive and non-interactive communications methods, including, email or the transmission of data via online technology, telephone and fax.
46. Acupuncture services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain).
47. Habilitative Services. The following services are covered:
 - a) Physical therapy rendered by a certified physical therapist or other provider practicing within the scope of their license or registration.
 - b) Occupational therapy performed by a licensed occupational therapist.
 - c) Speech therapy rendered by a certified speech therapist or certified speech pathologist.
 - d) Pulmonary therapy.
 - e) Multidisciplinary habilitation services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program.
48. Routine Eye Exams for Refraction for adults age 19 and over, including coverage for eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses.
49. Foreign travel immunizations.
50. Covered Services associated with clinical trials, including Routine Patient Care Costs if all of the following requirements are met:
 - a) You are a "qualified insured" eligible to participate in the approved clinical trial, as defined below, according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
 - i. A Participating Provider makes this determination; or
 - ii. A Non-Participating provider makes this determination, including a Non-Participating provider located outside this state, if the clinical trial is not offered or available through a Participating Provider. If any Participating Provider participates in the clinical trial and will accept You as a participant in the clinical trial, You must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where You live; and
 - b) The services would be covered under this Policy if they were not provided in connection with a clinical trial.

For Covered Services related to a clinical trial, You will pay the Cost Sharing You would pay if the Covered Services were not related to a clinical trial. If You participate in the clinical trial offered by a Non-Participating Provider because the clinical trial is not offered or available through a Participating Provider, then the Participating Provider Cost Sharing and Out-of-Pocket Maximum applies.

"Qualified insured" means an insured who meets both of the following conditions:

- A. The Insured is eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition; and
- B. Either of the following applies:
 - (i) The referring health care professional is a Participating Provider and has concluded that the Insured's participation in the clinical trial would be appropriate because the Insured meets the conditions of subparagraph (A); or
 - (ii) The Insured provides medical and scientific information establishing that the Insured's participation in the clinical trial would be appropriate because the Insured meets the conditions of subparagraph (A).

"Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition that meets at least one of the following:

- (A) The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:

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- (i) The National Institutes of Health.
 - (ii) The federal Centers for Disease Control and Prevention.
 - (iii) The Agency for Healthcare Research and Quality.
 - (iv) The federal Centers for Medicare and Medicaid Services.
 - (v) A cooperative group or center of any of the entities described in clauses (i) to (iv), inclusive, the Department of Defense, or the United States Department of Veterans Affairs.
 - (vi) A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - (vii) One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
 - I. The United States Department of Veterans Affairs.
 - II. The United States Department of Defense.
 - III. The United States Department of Energy.
- (B) The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
- (C) The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.
51. Diagnosis, treatment and management of osteoporosis, including but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.
52. Transgender Surgery and other Medically Necessary Treatment of Mental Health and Substance Use Disorders for the treatment of gender dysphoria, including but not limited to gender affirming surgeries that include genital surgery (e.g., hysterectomy, oophorectomy and orchiectomy), breast/chest surgery (e.g., mastectomy and breast augmentation) and aesthetic procedures to change secondary sex characteristics (e.g., tracheal shave and facial feminization surgery) and other services found to be Medically Necessary Treatment of Mental Health and Substance Use Disorders to create an appearance within the range of normal for the gender with which the person identifies. Coverage also includes Medically Necessary Treatment of Mental Health and Substance Use Disorders non-surgical services for treatment of gender dysphoria, such as fertility preservation, speech therapy and administered hormones, including puberty suppressing hormones. Gender dysphoria treatment is covered at the Mental Health Cost Share as shown in the Schedule of Coverage. Medically Necessary treatment of Mental Health and Substance User Disorders are covered under the same terms and conditions applied to other medical conditions under this Plan. Please refer to the **PRECERTIFICATION** section for information about Precertification through the Medical Review Program. See also, "Mental Health Services for diagnosis and Medically Necessary Treatment of a Mental Disorder" in this **GENERAL BENEFITS** section.
53. Medically Necessary fertility preservation services when a covered treatment may directly or indirectly cause Iatrogenic Infertility in accordance with the provisions of California Senate Bill 600 of 2019 and any subsequent implementing regulations and guidance, California Insurance Code section 10112.27, and any other applicable laws as then constituted or later amended in connection with its coverage.
54. COVID-19 screening, testing, and immunizations. In compliance with state and federal law, coverage includes:
- Medically Necessary screening and testing for COVID-19, including a visit to a medical office, emergency room, urgent care setting, hospital, or telehealth visit when the purpose of the visit is screening and/or testing for COVID-19, and associated lab testing and radiology services
 - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), regardless of whether the immunization is recommended for routine use.

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Pediatric Vision (children up to age 19)

The pediatric vision services described below are available to children up to age 19. This means that covered pediatric vision services are provided to a Covered Person until the last day of the month in which the Covered Person turns nineteen years of age. Unless otherwise stated, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to the following Covered Services. Please refer to Your Schedule of Coverage regarding each benefit in this section:

Exams

Routine eye exams including refractive exams to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses. This exam includes dilation if medically indicated.

Eyewear

The following eyewear is covered:

1. Lenses

- a) Single vision
- b) Conventional (Lined) Multifocal
- c) Lenticular
- d) Other optional lenses and treatments
 - i. Ultraviolet Protective Coating
 - ii. Polycarbonate Lenses
 - iii. Gradient tinting
 - iv. Blended Segment Lenses
 - v. Intermediate Vision Lenses
 - vi. Standard Progressives
 - vii. Premium Progressives
 - viii. Photochromic Glass Lenses
 - ix. Plastic Photosensitive Lenses (Transitions®)
 - x. Glass-grey #3 prescription sunglass lenses
 - xi. Polarized Lenses
 - xii. Standard Anti-Reflective (AR) Coating
 - xiii. Premium AR Coating
 - xiv. Ultra-AR Coating
 - xv. Hi-Index Lenses
 - xvi. Oversized

Note: Lenses include choice of glass or plastic lenses. All lenses include scratch resistant coating.

2. Eyeglass frames limited to standard frames (not including designer or deluxe frames). Please request standard, non-deluxe frames from Your optical retailer.
3. Contact lenses including evaluation, fitting, or follow-up care relating to contact lenses
4. Medically Necessary contact lenses in lieu of other eyewear for the following conditions:
 - a. Keratoconus,
 - b. Pathological Myopia,
 - c. Aphakia,
 - d. Anisometropia,
 - e. Aniseikonia,
 - f. Aniridia,
 - g. Corneal Disorders,
 - h. Post-traumatic Disorders,
 - i. Irregular Astigmatism.

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Note: Contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

Other Vision Services

Low Vision services are services provided to children with a significant loss of vision but not total blindness. The goal of services is to maximize the remaining usable vision for children with low vision who have visual impairments not fully treatable by medical, surgical interventions or conventional eyewear or contact lenses. Coverage is limited to the following:

- Comprehensive low vision evaluation
- Low vision aids such as high-power spectacles, magnifiers, and telescopes
- Follow up care

The following vision services are not covered:

All pediatric vision services not listed above including but not limited to:

1. Laser Vision Correction
2. Orthoptics
3. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
4. Replacement of lenses, frames or contacts.
5. Contact lens modification, polishing and cleaning.

Preventive Care

Unless otherwise stated, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to the following Covered Services. Please refer to Your Schedule of Coverage regarding each benefit in this section:

Preventive Care Exams and Services

As shown in the Schedule of Coverage, the following preventive services are not subject to Deductibles, Copayments or Coinsurance when received from a Participating Provider. Consult with Your physician to determine what preventive services are appropriate for You.

I. Exams

- 1) Well-Baby, Child, Adolescent Exam according to the Health Resources and Services Administration (HRSA) guidelines.
- 2) Well woman exam visits including routine prenatal care office visits, according to the Health Resources and Services Administration (HRSA) guidelines.

II. Screenings

- 1) Abdominal aortic aneurysm screening
- 2) Asymptomatic bacteriuria screening
- 3) Anxiety screening in adolescent and adult women, including those who are pregnant or postpartum
- 4) Breast cancer mammography screening
- 5) Cervical cancer and dysplasia screening including Human Papilloma Virus (HPV) screening and Pap test,
- 6) Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy. This includes anesthesia required for colonoscopies, pathology for biopsies resulting from a screening colonoscopy, over the counter and prescriptions drugs necessary to prepare the bowel for the procedure, and a specialist consultation visit prior to the procedure.
- 7) Depression screening
- 8) Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus
- 9) Gestational diabetes screening
- 10) Hepatitis B virus infection screening

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- 11) Hematocrit or Hemoglobin screening in children
- 12) High blood pressure screening
- 13) Lead Screening
- 14) Lipid disorders screening
- 15) Lung cancer screening with low-dose computed tomography including a counseling visit to discuss the screening
- 16) Newborn congenital hypothyroidism screening
- 17) Newborn hearing loss screening
- 18) Newborn metabolic/hemoglobin screening
- 19) Newborn sickle cell disease screening
- 20) Newborn Phenylketonuria screening
- 21) Obesity screening
- 22) Osteoporosis screening
- 23) Pre-eclampsia screening with blood pressure measurements throughout pregnancy
- 24) Rh (D) incompatibility screening for pregnant women
- 25) Sexually transmitted infection screening such as chlamydia, gonorrhea, syphilis and HIV screening
- 26) Type 2 diabetes mellitus screening
- 27) Tuberculin (TB) Testing
- 28) Urinary incontinence screening in women
- 29) Visual impairment in children screening

III. Health Promotion:

- 1) Screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
- 2) Unhealthy Alcohol use and drug misuse assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse
- 3) Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease.
- 4) Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children.
- 5) Tobacco use screening and tobacco-caused disease counseling and interventions. All FDA-approved tobacco cessation prescription or over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs for women who are not pregnant and men. Coverage of FDA-approved tobacco cessation prescription or over-the-counter medications for pregnant women is described below under the "Other Preventive Care" subsection of this General Benefits section.
- 6) Referral for testing for breast and ovarian cancer susceptibility, genetic counseling and BRCA mutation testing.
- 7) Sexually transmitted infections counseling.
- 8) Discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention and when prescribed by a physician for asymptomatic women with an increased risk of breast cancer and no history of breast cancer, risk reducing medication such as aromatase inhibitors, tamoxifen and raloxifene.
- 9) When prescribed by a licensed health care professional authorized to prescribe drugs:
 - a) aspirin in the prevention of cardiovascular disease, preeclampsia in pregnant women and colorectal cancer.
 - b) iron supplementation for children from 6 months to 12 months of age.
 - c) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
 - d) topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.
 - e) folic acid supplementation for women planning or capable of pregnancy for the prevention of neural tube defects.

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- f) vitamin D to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
- 10) Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and counseling by a provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the post-partum period, and the purchase of a breast pump. In lieu of purchase of a breast pump, rental of a hospital-grade electric breast pump (including a hospital-grade double breast pump kit), including any equipment that is required for pump functionality, when prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.
- 11) All prescribed FDA-approved contraceptive methods for women with reproductive capacity, including but not limited to drugs cervical caps, vaginal rings, continuous extended oral contraceptives and patches. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, female sterilization procedures (including follow-up and management of side effects, counseling for continued adherence, and device removal), and patient education and counseling for all women with reproductive capacity. Over the counter FDA approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs. In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, is covered for women desiring an alternative method.
- 12) Screening and counseling for interpersonal and domestic violence.
- 13) Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls.
- 14) Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.
- 15) Counseling of young adults, adolescents, children and parents of young children, adolescents, and young adults aged 6 months to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce their risk for skin cancer.

IV. Disease prevention:

- 1) Immunizations as recommended by the Centers for Disease Control and HRSA. Coverage includes flu shots administered at a Participating Pharmacy.
- 2) Prophylactic gonorrhea medication for newborns to protect against gonococcal ophthalmia neonatorum.
- 3) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met: a) individuals are aged 40-75 years; b) they have one or more cardiovascular risk factors; and c) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.
- 4) Pre exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. In addition, the following related services for HIV PrEP initiation and follow-up care are covered:
 - a. Services for initiation of HIV Prep, including:
 - i. HIV testing
 - ii. Kidney function testing
 - iii. Serologic testing for hepatitis B and C virus
 - iv. Hepatitis B vaccination
 - v. Testing for Sexually Transmitted Infections (STIs)
 - vi. Pregnancy testing (when appropriate)
 - b. Follow-up and monitoring services, including:
 - i. HIV testing every 3 months,
 - ii. Office visits to a primary care provider or specialist for prescribing and medication management,
 - iii. Lab testing to monitor effects of medication

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Covered Services under the Affordable Care Act (ACA) have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations as listed below:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including:
 - a. The American Academy of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care, and
 - b. The Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children.
4. For women, to the extent not described in paragraph (a), evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration Women's Preventive Services Guidelines.

The preventive services listed above may change according to federal guidelines in effect as of January 1 of each year, however, such changes, unless we notify You otherwise, will not be effective until your Group Policy renews in that Calendar Year. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of covered services.

For a complete list of current preventive services required under the Affordable Care Act for which cost share does not apply, please call: 1-800-464-4000. You may also visit:

- U.S. Centers for Medicare & Medicaid Services Preventive Care Benefits.
www.healthcare.gov/center/regulations/prevention.htm
- U.S. Preventive Services Task Force Grade A & B recommendations.
www.uspreventiveservicestaskforce.org/uspstf/uspstf-core.htm
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention.
www.cdc.gov/vaccines/acip/index.html
- Guidelines for women's preventive health care as supported by the Health Resources and Services Administration (HRSA).
www.hrsa.gov/womensguidelines/
- Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.
www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

Please note, however, for recommendations that have been in effect for less than one year, KPIC will have one year from the effective date to comply.

Note: Screening colonoscopies or sigmoidoscopies are covered under this section as a preventive benefit. This includes polyp removal during a colonoscopy performed as a screening procedure. However, sigmoidoscopies or colonoscopies that are not screening are not Covered Services under the Preventive Exams and Services benefit but may be Covered Services as Outpatient Care and may affect Your out of pocket costs.

Other Preventive Care

These other preventive care covered under this Policy that are listed below may be subject to Deductibles, Copayments or Coinsurance as described in the Schedule of Coverage. Please refer to the Schedule of Coverage to see how the following Preventive Benefits are covered under this Policy:

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Please refer to Your Schedule of Coverage regarding each benefit in this section.

1. Routine nursery care and Physician charges for a newborn while the mother is confined.
2. Adult preventive screening. Services must meet the prevailing standards. The care will include:
 - a) Screening and diagnosis of prostate cancer, including but not limited to prostate-specific antigen testing and digital rectal examination when Medically Necessary and consistent with good professional practice. This coverage does not cover the surgical and other procedures known as radical prostatectomy, external beam radiation therapy, radiation seed implants, or combined hormonal therapy; and
 - b) All other cancer screening tests not covered under ACA, including any cervical cancer screening test approved by the Federal Food and Drug Administration.
3. Adult routine physical examinations. Services must meet prevailing standards. The care shall include:
 - a) examination; b) history; and c) x-ray and laboratory tests limited to: EKG, chest x-rays, CBC, comprehensive metabolic panel, urinalysis (when performed in conjunction with a routine adult physical examination)
4. Other hearing screenings and hearing exams limited to services to determine the need for a hearing correction
5. Routine Preventive Vision Screenings for adults age 19 and over and routine eye exams for refractions
6. Routine Preventive Retinal Photography Screenings. for adults age 19 and over.
7. Family planning limited to:
 - a) The charge of a Physician for consultation concerning the family planning alternatives available to You and Your spouse or Domestic Partner (except those considered preventive benefits under ACA) including any related diagnostic tests; and
 - b) Charges for the following procedures:
 - i) vasectomy;
 - ii) elective abortion; and
 - iii) fertility testing and counseling.

Family planning charges do not include any charges for the following:

- a) Artificial insemination;
- b) In vitro fertilization and other procedures involving the eggs; and
- c) Implantation of an embryo developed in vitro.
- d) Consultations for insertion of internally implanted time-release contraceptives or intrauterine devices (IUDs);
- e) Consultations for monitoring and management of contraceptive devices;
- f) Reversal of voluntary sterilization

Please refer to Health Promotion under Preventive Care Exams and Services in this General Benefits section for coverage of contraceptive methods.

8. AIDS vaccine limited to those approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service
9. Prenatal alpha-fetoprotein screening including services through participation in the California Prenatal Screening Program.
10. Health education counseling programs and programs for stress management and chronic conditions such as asthma.
11. FDA approved tobacco cessation prescription or over-the-counter medications by a licensed health care professional authorized to prescribe drugs for women who are pregnant.
12. Iron deficiency anemia screening for pregnant women.
13. The following services and items are treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
 - a. Hemoglobin A1C testing for individuals diagnosed with diabetes.
 - b. Retinopathy Screening for individuals diagnosed with diabetes.
 - c. Low Density Lipo-Protein testing for individuals diagnosed with heart disease.

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- d. International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders.
- e. Peak flow meters for individuals diagnosed with asthma.
- f. Glucometers including lancets, test strips, control solution and batteries for individuals diagnosed with diabetes.

Length of Stay for Inpatient Maternity Care

Hospital Confinements in connection with childbirth for the mother or newborn child will not be limited to less than 48 hours following normal vaginal delivery and not less than 96 hours following a Caesarean section, unless, after consultation with the mother, the attending provider discharges the mother or newborn earlier. Your Physician may order a follow-up visit for You and Your newborn to take place within 48 hours after discharge.

A stay longer than the above may be allowed provided the attending provider obtains authorization for an extended confinement through KPIC's Medical Review Program. In no case will KPIC require that a provider reduce the mother's or child's Hospital Confinement below the allowable minimums cited above.

Length of Stay for Mastectomy and Lymph Node Surgical Services

The length of a hospital stay associated with mastectomy or lymph node surgical procedures will be determined by the attending Physician in consultation with the patient, post-surgery, consistent with sound clinical principles and processes. The treating physician and surgeon is not required to receive prior approval from KPIC in determining the length of hospital stay following these procedures.

Benefits for Emergency Services

Emergency Services are covered 24 hours a day, 7 days a week, anywhere in the world. If You have an Emergency Medical Condition, call 911 or go to the nearest emergency room.

If You receive Emergency Care/Services and cannot, at the time of emergency, reasonably reach a Participating Provider, that emergency care rendered during the course of the emergency will be paid for in accordance with the terms of the Group Policy at benefit levels at least equal to those applicable to treatment by a Participating Providers for emergency care in an amount based on the Usual, Customary, and Reasonable charges in the area where the treatment is provided.

Please refer to the definition of "Maximum Allowable Charge" under the **GENERAL DEFINITIONS** section of this Certificate for an explanation of the amount payable by KPIC for Emergency Services rendered by Non-Participating Providers.

Extension of Benefits

Except with regard to any Outpatient Drug Benefit that may be provided under the Group Policy, the benefits for the disabling condition of a Covered Person will be extended if:

1. The Covered Person becomes totally disabled while insured for that insurance under the plan; and
2. The Covered Person is still totally disabled on the date this Plan terminates.

The extended benefits will be paid only for treatment of the Injury or Sickness that causes the total disability. The extension will start on the day that follows the last day for which premiums are paid for the insurance of the Covered Person. It will end on the first of these dates that occur:

1. The date on which the total disability ends;
2. The last day of the 12-month period that follows the date the total disability starts; or
3. The date on which the Covered Person becomes covered under any plan that: a) replaces this insurance; and b) covers the disabling condition so that benefits are not limited due to the total disability having started before that plan was in effect.

For purposes of this Extension of Benefit provision, a Covered Person other than a Dependent minor is totally disabled only if, in the judgment of a Physician, a Sickness or Injury: a) is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and b) makes the

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person unable, even with training, education and experience, to engage in any employment or occupation.

For purposes of this Extension of Benefit provision, a Covered Person who is a Dependent minor is totally disabled only if, in the judgment of a Physician, a Sickness or Injury: a) is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and b) makes the person unable to engage in most of the normal activities of persons in good health of like age.

SAMPLE

PEDIATRIC DENTAL BENEFITS

Pediatric Dental (children up to age 19)

Coverage for Pediatric Dental services is limited only to children up to age 19. This means that covered Pediatric Dental services are provided to a Covered Person until the last day of the month in which the Covered Person turns nineteen years of age. Several categories of benefits are covered, when the services are provided by a licensed Provider, and when they are necessary and customary under the Generally Accepted Standards of Dental Practice. Precertification is not required in order to obtain covered pediatric dental benefits.

Covered Dental Services

Unless otherwise indicated in Your Schedule of Coverage, KPIC will pay the percentage payable of the Maximum Allowable Charge for the following Covered Dental Services:

When a Covered Person is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Covered Person or her Provider when the claim is submitted.

Teledentistry. A Benefit appropriately provided through teledentistry is covered on the same basis and to the same extent that the Benefit is covered when delivered through in-person diagnosis, consultation or treatment. Cost sharing for Benefits delivered through teledentistry will not exceed the cost sharing that applies to the same Benefit when delivered in-person.

Schedule of Covered Services

The codes and nomenclature in this schedule are copyright of the American Dental Association. This table represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT)© in effect at the date of this printing. Our administration of benefits, limitations and exclusions under this plan at all times will be based on the current version of CDT whether or not a revised table is provided.

Code

Procedure

DIAGNOSTIC AND PREVENTIVE

DIAGNOSTIC

Clinical oral examinations

Diagnostic services are the necessary procedures to assist the Provider in evaluating Your dental health and to determine necessary treatments, including x-rays and oral exams. Diagnostic services include:

- D0120 Periodic oral examination - established patient: once every 6 months per provider
- D0140 Limited oral examination - problem focused: once every 6 months per provider
- D0145 Oral examination for a patient under three years of age and counseling with primary caregiver
- D0150 Comprehensive oral examination - new or established patient: once every 6 months per provider
- D0160 Detailed and extensive oral examination - problem focused, by report: once per patient per provider
- D0170 Re-examination - limited, problem focused (established patient; not post-operative visit) 6 in 3 months, not to exceed 12 in 12 months
- D0171 Re-evaluation – post-operative office visit
- D0180 Comprehensive periodontal examination - new or established patient

PEDIATRIC DENTAL BENEFITS

Radiographs/diagnostic imaging (including interpretation)

- D0210 Intraoral - complete series of radiographic images: once per provider every 36 months
- D0220 Intraoral - periapical first radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
- D0230 Intraoral - periapical each additional radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
- D0240 Intraoral - occlusal radiographic image: maximum of 2 in 6 months per provider
- D0250 Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector: once per date of service
- D0251 Extra oral posterior dental radiographic image: 4 per date of service
- D0270 Bitewing - single radiographic image: once per date of service
- D0272 Bitewings - two radiographic images: once every 6 months per provider
- D0273 Bitewings - three radiographic images
- D0274 Bitewings - four radiographic images: once every 6 months per provider, age 10 and over
- D0277 Vertical bitewings - 7 to 8 radiographic images: maximum of 4
- D0310 Sialography
- D0320 Temporomandibular joint arthrogram, including injection: maximum of 3 per date of service
- D0322 Tomographic survey: twice in 12 months per provider
- D0330 Panoramic radiographic image: once in 36 months per provider
- D0340 2D cephalometric radiographic image – acquisition, measurement and analysis: twice in 12 months per provider
- D0350 2D oral/facial photographic image obtained intra-orally or extra-orally: maximum of 4 per date of service
- D0351 3D photographic image: once per date of service
- D0460 Pulp vitality tests
- D0470 Diagnostic casts: once per provider

Oral pathology laboratory

- D0502 Other oral pathology procedures, by report
- D0601 Caries risk assessment and documentation, with a finding of low risk: one procedure (D0601, D0602, D0603) every 12 months per provider
- D0602 Caries risk assessment and documentation, with a finding of moderate risk: one procedure (D0601, D0602, D0603) every 12 months per provider
- D0603 Caries risk assessment and documentation, with a finding of high risk: one procedure (D0601, D0602, D0603) every 12 months per provider
- D0701 Panoramic radiographic image – image capture only
- D0702 2-D cephalometric radiographic image – image capture only
- D0703 2-D oral/facial photographic image obtained intra-orally or extra-orally –image capture only
- D0704 3-D photographic image – image capture only
- D0705 Extra-oral posterior dental radiographic image – image capture only
- D0706 Intraoral – occlusal radiographic image – image capture only
- D0707 Intraoral – periapical radiographic image – image capture only
- D0708 Intraoral – bitewing radiographic image – image capture only
- D0709 Intraoral – complete series of radiographic images –image capture only
- D0999 Unspecified diagnostic procedure, by report

PREVENTIVE

Preventive services are the necessary procedures and techniques to prevent the occurrence of dental abnormalities or diseases. Preventive cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers. Preventive services include:

PEDIATRIC DENTAL BENEFITS

Dental prophylaxis

- D1110 Prophylaxis - adult: once every 6 months
- D1120 Prophylaxis - child: once every 6 months

Topical fluoride treatment

- D1206 Topical application of fluoride varnish: once every 6 months and frequency limitation applies towards D1208
- D1208 Topical application of fluoride – excluding varnish: once every 6 months and frequency limitation applies towards D1206

Other preventive services

- D1310 Nutritional counseling for control of dental disease
- D1320 Tobacco counseling for the control and prevention of oral disease
- D1321 Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
- D1330 Oral hygiene instructions
- D1351 Sealant - per tooth once per permanent molar every 36 months per provider if they are without caries (decay) or restorations on the occlusal surface
- D1352 Preventive resin restoration in a moderate to high caries risk patient – permanent tooth: once per tooth every 36 months per provider
- D1353 Sealant repair – per tooth
- D1354 Interim caries arresting medicament application – per tooth: once every 6 months
- D1355 Caries preventive medicament application – per tooth
- D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician
- D9311 Consultation with a medical health care professional
- D9997 Dental case management – patient with special health care needs

Space maintenance (passive appliances)

- D1510 Space maintainer - fixed - unilateral: once per quadrant per patient through age 17
- D1516 Space maintainer - fixed – bilateral, maxillary: once per arch per patient through age 17
- D1517 Space maintainer - fixed – bilateral, mandibular: once per arch per patient through age 17
- D1520 Space maintainer - removable- unilateral: once per quadrant per patient through age 17
- D1525 Space maintainer - removable - bilateral: once per arch per patient through age 17
- D1526 Space maintainer - removable – bilateral, maxillary: once per arch per patient through age 17
- D1527 Space maintainer - removable – bilateral, mandibular: once per arch per patient through age 17
- D1551 Re-cement or re-bond bilateral space maintainer – maxillary: once per provider per quadrant or arch through age 17
- D1552 Re-cement or re-bond bilateral space maintainer - mandibular: once per provider per quadrant or arch through age 17
- D1553 Re-cement or re-bond bilateral space maintainer - per quadrant: once per provider per quadrant or arch through age 17
- D1556 Removal of fixed unilateral space maintainer - per quadrant
- D1557 Removal of fixed bilateral space maintainer - maxillary
- D1558 Removal of fixed bilateral space maintainer - mandibular
- D1575 Distal shoe space maintainer - fixed – unilateral: once per quadrant per lifetime; under age 9

PEDIATRIC DENTAL BENEFITS

BASIC SERVICES

RESTORATIVE

Restorative services provide the necessary procedures to restore the teeth; other than cast restorations. Restorative services include:

Amalgam restorations (including Polishing)

- D2140 Amalgam - one surface, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2150 Amalgam - two surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2160 Amalgam - three surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2161 Amalgam - four or more surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth

Resin – based composite restorations - direct

- D2330 Resin-based composite - one surface, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2331 Resin-based composite - two surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2332 Resin-based composite - three surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior) : once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2390 Resin-based composite crown, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2391 Resin-based composite - one surface, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2392 Resin-based composite - two surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2393 Resin-based composite - three surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2394 Resin-based composite - four or more surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth

Crowns, Inlays, Onlays and are provided to treat cavities that cannot be restored with amalgam, silicate or direct composite (resin) restorations. Crowns, Inlays, Onlays Services include:

Crowns – single restoration only

- D2710 Crown - resin-based composite (indirect): once in 5 years, age 13+
- D2712 Crown - 3/4 resin-based composite (indirect): once in 5 years, age 13+
- D2721 Crown - resin with predominantly base metal: once in 5 years, age 13+
- D2740 Crown - porcelain/ceramic substrate: once in 5 years, age 13+
- D2751 Crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
- D2781 Crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
- D2783 Crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
- D2791 Crown - full cast predominantly base metal: once in 5 years, age 13+

Other restorative services

- D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration: once in 12 months per provider

PEDIATRIC DENTAL BENEFITS

- D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core: performed in conjunction with recementation of existing or new crown and is not separately payable
- D2920 Re-cement or re-bond crown
- D2921 Reattachment of tooth fragment, incisal edge or cusp: once in 12 months
- D2928 Prefabricated porcelain/ceramic crown – permanent tooth
- D2929 Prefabricated porcelain/ceramic crown – primary tooth: once in 12 months
- D2930 Prefabricated stainless steel crown - primary tooth: once in 12 months
- D2931 Prefabricated stainless steel crown - permanent tooth: once in 36 months
- D2932 Prefabricated resin crown: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2933 Prefabricated stainless steel crown with resin window: once in 12 months for primary teeth, once in 36 months for permanent teeth
- D2940 Protective restoration: once per tooth in 6 months per provider
- D2941 Interim therapeutic restoration - primary dentition: once per tooth in 6 months per provider
- D2949 Restorative foundation for an indirect restoration
- D2950 Core buildup, including any pins when required
- D2951 Pin retention - per tooth, in addition to restoration: once per tooth for permanent teeth
- D2952 Post and core in addition to crown, indirectly fabricated: once per tooth
- D2953 Each additional indirectly fabricated post - same tooth
- D2954 Prefabricated post and core in addition to crown: once per tooth
- D2955 Post removal
- D2957 Each additional prefabricated post - same tooth
- D2971 Additional procedures to construct new crown under existing partial denture framework
- D2980 Crown repair necessitated by restorative material failure
- D2999 Unspecified restorative procedure, by report

OTHER BASIC SERVICES

Unclassified treatment

- D9110 Palliative (emergency) treatment of dental pain – minor procedure : once per date of service per provider regardless of the number of teeth and/or areas treated
- D9120 Fixed partial denture sectioning

Anesthesia

- D9210 Local anesthesia not in conjunction with operative or surgical procedures: once per date of service per provider
- D9211 Regional block anesthesia
- D9212 Trigeminal division block anesthesia
- D9215 Local anesthesia in conjunction with operative or surgical procedures
- D9222 Deep sedation/general anesthesia – first 15 minutes
- D9223 Deep sedation/general anesthesia – each 15-minute increment
- D9230 Inhalation of nitrous oxide / anxiolysis, analgesia
- D9239 Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
- D9243 Intravenous moderate conscious sedation/analgesia – each 15-minute increment
- D9248 Non-intravenous conscious sedation: once per date of service

Professional consultation

- D9310 Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician
- D9410 House/extended care facility call: once per patient per date of service
- D9420 Hospital or ambulatory surgical center call

PEDIATRIC DENTAL BENEFITS

Professional visits

- D9430 Office visit for observation (during regularly scheduled hours) – no other services performed: once per date of service per provider
- D9440 Office visit – after regularly scheduled hours: once per date of service per provider

Drugs

- D9610 Therapeutic parenteral drug, single administration: maximum of 4 injections per date of service
- D9612 Therapeutic parenteral drugs, two or more administrations, different medications
- D9910 Application of desensitizing medicament: once in 12 months per provider for permanent teeth

Miscellaneous

- D9930 Treatment of complications (post-surgical) – unusual circumstances, by report: once per date of service per provider
- D9950 Occlusion analysis – mounted case: once in 12 months, age 13+
- D9951 Occlusal adjustment – limited: once in 12 months, age 13+
- D9952 Occlusal adjustment – complete: once in 12 months, age 13+
- D9999 Unspecified adjunctive procedure, by report

MAJOR SERVICES

ENDODONTICS

Endodontic services provide the procedures for the treatment of tooth pulp. Endodontic services include:

Pulpotomy

- D3110 Pulp cap – direct (excluding final restoration)
- D3120 Pulp cap – indirect (excluding final restoration)
- D3220 Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction, and application of medicament: once per primary tooth
- D3221 Pulpal debridement, primary and permanent teeth: once per tooth
- D3222 Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development: once per permanent tooth
- D3230 Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration): once per primary tooth
- D3240 Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration): once per primary tooth

Endodontic therapy

- D3310 Endodontic therapy, anterior tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3346)
- D3320 Endodontic therapy, bicuspid tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3347)
- D3330 Endodontic therapy, molar (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3348)
- D3331 Treatment of root canal obstruction; non-surgical access
- D3333 Internal root repair of perforation defects

Endodontic retreatment

- D3346 Retreatment of previous root canal therapy – anterior
- D3347 Retreatment of previous root canal therapy – bicuspid

PEDIATRIC DENTAL BENEFITS

D3348 Retreatment of previous root canal therapy – molar

Apexification/recalcification procedures

- D3351 Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.): once per permanent tooth
- D3352 Apexification/recalcification – interim medication replacement once per permanent tooth

Apicoectomy / periradicular services

- D3410 Apicoectomy – anterior
- D3421 Apicoectomy – bicuspid (first root)
- D3425 Apicoectomy – molar (first root)
- D3426 Apicoectomy (each additional root)
- D3430 Retrograde filling – per root

Other endodontic services

- D3471 Surgical repair of root resorption – anterior
- D3472 Surgical repair of root resorption – premolar
- D3473 Surgical repair of root resorption – molar
- D3910 Surgical procedure for isolation of tooth with rubber dam
- D3999 Unspecified endodontic procedure, by report

PERIODONTICS

Periodontic services provide the procedures for the treatment of gums and bones that support the teeth. Periodontic services include:

Surgical Services

- D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
- D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
- D4249 Clinical crown lengthening – hard tissue
- D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
- D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
- D4265 Biologic materials to aid in soft and osseous tissue regeneration

Non-surgical periodontal services

- D4341 Periodontal scaling and root planing - four or more teeth per quadrant: once per quadrant in 24 months, age 13+
- D4342 Periodontal scaling and root planing - one to three teeth per quadrant: once per quadrant in 24 months, age 13+
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation: once every 6 months
- D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis.
- D4381 Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth

PEDIATRIC DENTAL BENEFITS

Other periodontal services

- D4910 Periodontal maintenance: once in a calendar quarter and only in the 24 months following the last scaling and root planing, age 13+
- D4920 Unscheduled dressing change (by someone other than treating dentist or their staff): included in fee for completed service (D4210, D4211, D4260, D4261) if same provider. Once per patient to different provider.
- D4999 Unspecified periodontal procedure, by report age 13+

Note: on Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Administration of this plan design must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

PROSTHODONTICS, REMOVABLE

Removable Prosthetic Benefits are provided to replace missing, natural teeth. Removable Prosthetic Benefits include:

Complete dentures

- D5110 Complete denture – maxillary: once in 5 years
- D5120 Complete denture – mandibular: once in 5 years
- D5130 Immediate denture – maxillary: once per patient
- D5140 Immediate denture – mandibular: once per patient

Partial dentures

- D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth) once in 5 years
- D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth) once in 5 years
- D5213 Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) once in 5 years
- D5214 Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth) once in 5 years
- D5221 Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
- D5222 Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
- D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
- D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years

Adjustment to dentures

- D5410 Adjust complete denture – maxillary: per provider, once per date of service and twice in 12 months
- D5411 Adjust complete denture – mandibular: per provider, once per date of service and twice in 12 months
- D5421 Adjust partial denture – maxillary: per provider, once per date of service and twice in 12 months

PEDIATRIC DENTAL BENEFITS

D5422 Adjust partial denture – mandibular: per provider, once per date of service and twice in 12 months

Repairs to complete dentures

D5511 Repair broken complete denture base: mandibular: per provider, once per arch per date of service and twice in 12 months

D5512 Repair broken complete denture base, maxillary: per provider, once per arch per date of service and twice in 12 months

D5520 Replace missing or broken teeth – complete denture (each tooth): per provider, 4 per arch per date of service and twice in 12 months

D5611 Repair resin denture base: mandibular per provider, once per arch per date of service and twice in 12 months

D5612 Repair resin denture base, maxillary: per provider, once per arch per date of service and twice per arch in 12 months

D5621 Repair cast framework: mandibular: per provider, once per arch per date of service and twice per arch in 12 months

D5622 Repair cast partial framework, maxillary: per provider, once per arch per date of service and twice per arch in 12 months

D5630 Repair or replace broken clasp – per tooth: per provider, 1 per date of service and twice per arch in 12 months

D5640 Replace broken teeth – per tooth: per provider, 4 per arch per date of service and twice per arch in 12 months

D5650 Add tooth to existing partial denture: per provider, 3 per date of service and once per tooth

D5660 Add clasp to existing partial denture – per tooth: per provider, 3 per date of service and twice per arch in 12 months

Denture reline procedures

D5730 Reline complete maxillary denture (chairside): once in 12 months

D5731 Reline complete mandibular denture (chairside): once in 12 months

D5740 Reline maxillary partial denture (chairside): once in 12 months

D5741 Reline mandibular partial denture (chairside): once in 12 months

D5750 Reline complete maxillary denture (laboratory): once in 12 months

D5751 Reline complete mandibular denture (laboratory): once in 12 months

D5760 Reline maxillary partial denture (laboratory): once in 12 months

D5761 Reline mandibular partial denture (laboratory): once in 12 months

Other removable prosthetic services

D5850 Tissue conditioning, maxillary: twice per prosthesis in 36 months

D5851 Tissue conditioning, mandibular: twice per prosthesis in 36 months

D5862 Precision attachment, by report: included in fee for prosthetic and restorative procedure and not separately payable

D5863 Overdenture – complete maxillary: once in 5 years

D5865 Overdenture – complete mandibular: once in 5 years

D5866 Overdenture - partial mandibular: once in 5 years

D5899 Unspecified removable prosthodontic procedure, by report

Maxillofacial Prosthetics

D5911 Facial moulage (sectional)

D5912 Facial moulage (complete)

D5913 Nasal prosthesis

D5914 Auricular prosthesis

D5915 Orbital prosthesis

PEDIATRIC DENTAL BENEFITS

D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive
D5933	Obturator prosthesis, modification: twice in 12 months
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5952	Speech aid prosthesis, pediatric
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification: twice in 12 months
D5960	Speech aid prosthesis, modification: twice in 12 months
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5991	Vesiculobullous disease medicament carrier
D5999	Unspecified maxillofacial prosthesis, by report

PROSTHODONTICS, FIXED

Fixed Prosthetic Benefits are provided to replace missing, natural teeth. Fixed Prosthetic Benefits include:

Implant services

D6010	Surgical placement of implant body: endosteal implant
D6011	Surgical access to an implant body (second stage implant surgery)
D6013	Surgical placement of mini implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6055	Connecting bar – implant supported, or abutment supported
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)
D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)

PEDIATRIC DENTAL BENEFITS

D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown- porcelain fused to high noble alloys
D6067	Implant supported crown - high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer FPD - porcelain fused to high noble alloys
D6077	Implant supported retainer for metal FPD- high noble alloys
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure: once per tooth in 24 months
D6082	Implant supported crown - porcelain fused to predominantly base alloys
D6083	Implant supported crown - porcelain fused to noble alloys
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys
D6085	Provisional implant crown: included in fee for implant services and not separately payable
D6086	Implant supported crown - predominantly base alloys
D6087	Implant supported crown - noble alloys
D6088	Implant supported crown - titanium and titanium alloys
D6090	Repair implant supported prosthesis, by report
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6092	Re-cement or re-bond implant/abutment supported crown: once in 12 months per provider
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture: once in 12 months per provider
D6094	Abutment supported crown – titanium and titanium alloys
D6095	Repair implant abutment, by report
D6096	Remove broken implant retaining screw
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer - porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys
D6100	Implant removal, by report
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD - predominantly base alloys
D6122	Implant supported retainer for metal FPD - noble alloys
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys
D6190	Radiographic/surgical implant index, by report
D6191	Semi-precision abutment – placement
D6192	Semi-precision attachment – placement
D6194	Abutment supported retainer crown for FPD – titanium and titanium alloys
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys
D6199	Unspecified implant procedure, by report

PEDIATRIC DENTAL BENEFITS

Fixed partial pontics

- D6211 Pontic - cast predominantly base metal: once in 5 years, age 13+
- D6241 Pontic - porcelain fused to predominantly base metal: once in 5 years, age 13+
- D6245 Pontic - porcelain/ceramic: once in 5 years, age 13+
- D6251 Pontic - resin with predominantly base metal: once in 5 years, age 13+

Fixed partial denture retainers - crowns

- D6721 Retainer crown - resin with predominantly base metal: once in 5 years, age 13+
- D6740 Retainer crown - porcelain/ceramic: once in 5 years, age 13+
- D6751 Retainer crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
- D6781 Retainer crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
- D6783 Retainer crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
- D6784 Retainer crown - 3/4 titanium and titanium alloys: once in 5 years, age 13+
- D6791 Retainer crown - full cast predominantly base metal: once in 5 years, age 13+

Other fixed partial denture services

- D6930 Re-cement or re-bond fixed partial denture: once in 12 months, per same provider
- D6980 Fixed partial denture repair necessitated by restorative material failure: once in 12 months of initial placement or previous repair by same provider
- D6999 Unspecified fixed prosthodontic procedure, by report: once in 12 months of initial placement by same provider

ORAL AND MAXILLOFACIAL SURGERY

Extractions (including local anesthesia, suturing, if needed, and routine postoperative care)

- D7111 Extraction, coronal remnants - deciduous tooth
- D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical extractions (including local anesthesia, suturing, if needed, and routine postoperative care)

- D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
- D7220 Removal of impacted tooth – soft tissue
- D7230 Removal of impacted tooth – partially bony
- D7240 Removal of impacted tooth – completely bony
- D7241 Removal of impacted tooth – completely bony, with unusual surgical complications
- D7250 Surgical removal of residual tooth roots (cutting procedure)

Other surgical procedures

- D7260 Oroantral fistula closure
- D7261 Primary closure of a sinus perforation
- D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth; once per arch regardless of the number of teeth involved for permanent anterior teeth
- D7280 Surgical access of an unerupted tooth
- D7283 Placement of device to facilitate eruption of impacted tooth
- D7285 Incisional biopsy of oral tissue -hard (bone, tooth): once per arch per date of service
- D7286 Incisional biopsy of oral tissue -soft: maximum of 3 per date of service
- D7290 Surgical repositioning of teeth: once per arch for permanent teeth for patients in active orthodontic treatment
- D7291 Transseptal fiberotomy/supra crestal fiberotomy, by report: once per arch

PEDIATRIC DENTAL BENEFITS

Alveoloplasty – surgical preparation of ridge for dentures

- D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
- D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
- D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
- D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant

Vestibuloplasty

- D7340 Vestibuloplasty - ridge extension (secondary epithelialization): once per arch in 5 years
- D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue): once per arch

Surgical excision of lesions

- D7410 Excision of benign lesion up to 1.25 cm
- D7411 Excision of benign lesion greater than 1.25 cm
- D7412 Excision of benign lesion, complicated
- D7413 Excision of malignant lesion up to 1.25 cm
- D7414 Excision of malignant lesion greater than 1.25 cm
- D7415 Excision of malignant lesion, complicated
- D7440 Excision of malignant tumor – lesion diameter up to 1.25 cm
- D7441 Excision of malignant tumor – lesion diameter greater than 1.25 cm
- D7450 Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
- D7451 Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
- D7460 Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
- D7461 Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
- D7465 Destruction of lesion(s) by physical or chemical method, by report

Excision of bone tissue

- D7471 Removal of lateral exostosis (maxilla or mandible): once per quadrant
- D7472 Removal of torus palatinus: once in the patient's lifetime
- D7473 Removal of torus mandibularis: once per quadrant
- D7485 Surgical reduction of osseous tuberosity: once per quadrant
- D7490 Radical resection of maxilla or mandible

Surgical incision

- D7510 Incision and drainage of abscess - intraoral soft tissue: once per quadrant per same date service
- D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces): once per quadrant per same date service
- D7520 Incision and drainage of abscess - extraoral soft tissue
- D7521 Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
- D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue: once per date of service
- D7540 Removal of reaction producing foreign bodies, musculoskeletal system: once per date of service
- D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone: once per quadrant per date of service

PEDIATRIC DENTAL BENEFITS

D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of fracture - simple

D7610 Maxilla - open reduction (teeth immobilized, if present)
D7620 Maxilla - closed reduction (teeth immobilized, if present)
D7630 Mandible - open reduction (teeth immobilized, if present)
D7640 Mandible - closed reduction (teeth immobilized, if present)
D7650 Malar and/or zygomatic arch - open reduction
D7660 Malar and/or zygomatic arch - closed reduction
D7670 Alveolus closed reduction may include stabilization of teeth
D7671 Alveolus, open reduction may include stabilization of teeth
D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches

Treatment of fracture – compound

D7710 Maxilla open reduction
D7720 Maxilla – closed reduction
D7730 Mandible – open reduction
D7740 Mandible – closed reduction
D7750 Malar and/or zygomatic arch – open reduction
D7760 Malar and/or zygomatic arch – closed reduction
D7770 Alveolus – open reduction stabilization of teeth
D7771 Alveolus, closed reduction stabilization of teeth
D7780 Facial bones – complicated reduction with fixation and multiple surgical approaches

Reduction of dislocation and management of other temporomandibular joint dysfunctions

D7810 Open reduction of dislocation
D7820 Closed reduction of dislocation
D7830 Manipulation under anesthesia
D7840 Condylectomy
D7850 Surgical discectomy, with/without implant
D7852 Disc repair
D7854 Synovectomy
D7856 Myotomy
D7858 Joint reconstruction
D7860 Arthrotomy
D7865 Arthroplasty
D7870 Arthrocentesis
D7871 Non-arthroscopic lysis and lavage
D7872 Arthroscopy - diagnosis, with or without biopsy
D7873 Arthroscopy - surgical: lavage and lysis of adhesions
D7874 Arthroscopy - surgical: disc repositioning and stabilization
D7875 Arthroscopy - surgical: synovectomy
D7876 Arthroscopy - surgical: discectomy
D7877 Arthroscopy - surgical: debridement
D7880 Occlusal orthotic device, by report
D7881 Occlusal orthotic device adjustment: once per date of service per provider, two in 12 months per provider
D7899 Unspecified TMD therapy, by report

Repair of traumatic wounds

D7910 Suture of recent small wounds up to 5 cm

PEDIATRIC DENTAL BENEFITS

Complicated suturing

- D7911 Complicated suture - up to 5 cm
- D7912 Complicated suture - greater than 5 cm

Other repair procedures

- D7920 Skin graft (identify defect covered, location and type of graft)
- D7922 Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
- D7940 Osteoplasty - for orthognathic deformities
- D7941 Osteotomy - mandibular rami
- D7943 Osteotomy - mandibular rami with bone graft; includes obtaining the graft
- D7944 Osteotomy - segmented or subapical
- D7945 Osteotomy - body of mandible
- D7946 Lefort I (maxilla - total)
- D7947 Lefort I (maxilla - segmented)
- D7948 Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
- D7949 Lefort II or lefort III - with bone graft
- D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
- D7951 Sinus augmentation with bone or bone substitute via a lateral open approach
- D7952 Sinus augmentation via a vertical approach
- D7955 Repair of maxillofacial soft and/or hard tissue defect
- D7961 Buccal / labial frenectomy (frenulectomy)
- D7962 Lingual frenectomy (frenulectomy)
- D7963 Frenuloplasty: once per arch per date of service
- D7970 Excision of hyperplastic tissue - per arch: once per arch per date of service
- D7971 Excision of pericoronal gingiva
- D7972 Surgical reduction of fibrous tubercle: once per quadrant per date of service
- D7979 Non-surgical sialolithotomy
- D7980 Sialolithotomy
- D7981 Excision of salivary gland, by report
- D7982 Sialodochoplasty
- D7983 Closure of salivary fistula
- D7990 Emergency tracheotomy
- D7991 Coronoectomy
- D7995 Synthetic graft - mandible or facial bones, by report
- D7997 Appliance removal (not by dentist who placed appliance), includes removal of archbar: once per arch per date of service
- D7999 Unspecified oral surgery procedure, by report
- D9950 Occlusion analysis - mounted case: once in 12 months, age 13+
- D9952 Occlusal adjustment - complete: once in 12 months, age 13+

ORTHODONTICS

Orthodontic treatment is a benefit of this dental plan only when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

- D8080 Comprehensive orthodontic treatment of the adolescent dentition: once per patient per phase of treatment
- D8210 Removable appliance therapy: once per patient, ages 6 through 12
- D8220 Fixed appliance therapy: once per patient, ages 6 through 12
- D8660 Pre-orthodontic treatment examination to monitor growth and development: once every 3 months for a maximum of 6 during patient's lifetime
- D8670 Periodic orthodontic treatment visit: once per calendar quarter

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D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) once per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment. Included in fee for complete orthodontic service and not separately payable.
D8696	Repair of orthodontic appliance – maxillary: once per appliance
D8697	Repair of orthodontic appliance – mandibular: once per appliance
D8698	Re-cement or re-bond fixed retainer – maxillary: once per provider
D8699	Re-cement or re-bond fixed retainer – mandibular: once per provider
D8701	Repair of fixed retainer, includes reattachment – maxillary: Included in fee for complete orthodontic service and not separately payable.
D8702	Repair of fixed retainer, includes reattachment – mandibular: Included in fee for complete orthodontic service and not separately payable.
D8703	Replacement of lost or broken retainer – maxillary: once per arch
D8704	Replacement of lost or broken retainer – mandibular: once per arch
D8999	Unspecified orthodontic procedure, by report

Note: The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.

Limitations

- All Services

Services that are more expensive than the form of treatment customarily provided under Generally Accepted Dental Practice Standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means KPIC will base Benefits on the lower cost of the customary service or standard procedure instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

If the Provider discounts, waives, or rebates any portion of Your co-insurance amount, KPIC only provides as benefits the applicable allowances reduced by the amount that such fees, or allowances are discounted, waived or rebated.

Claims shall be processed in accordance with Our standard processing policies. The processing policies may be revised from time to time; therefore, We shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (Dental Consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine Generally Accepted Dental Practice Standards and to determine if treatment has a favorable prognosis.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

- Diagnostic and Preventive Services:

1. Roentgenology (x-rays) is limited as follows:

- a. We will limit the total reimbursable amount to the Providers Contracted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Providers Contracted Fee for a complete intraoral series.
- b. When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Providers Contracted Fee for a complete intraoral series

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- c. If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
- d. Complete intraoral and panoramic film x-rays are limited to once every thirty-six (36) consecutive months per provider. Additional panoramic films may be allowed when documented as essential for a follow up/post-operative exam (such as oral surgery).
- e. Bitewing x-rays of two or more radiographic images, are limited to once every six (6) months per provider Bitewing x-rays of four radiographic images are limited to Covered Persons under the age of 10. Bitewings x-rays of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances. Isolated bitewing or periapical films are allowed on an emergency or episodic basis. Image capture procedures are not separately allowable services.
- f. Cephalometric x-rays and tomographic surveys are covered twice (2) in any 12-month period. Diagnostic casts are covered once per provider and only for the evaluation of Orthodontic Services when covered. are - provided once per provider unless special circumstances are documented (such as trauma or pathology which as affected the course of orthodontic treatment). Orthodontic Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.
- g. The fee for pulp vitality tests is included in the fees for diagnostic, restorative, endodontic and emergency procedures and is not payable separately.
- 2. Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period.
- 3. Sealants are limited as follows:
 - a. Once per tooth per provider every 36 months and only to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
 - b. Repair or replacement of a sealant on any tooth within 24 months of its application is included in the fee for the original placement by the original provider.
- 4. Intraoral - periapical radiographic images are limited to a maximum of 20 in any 12-month period.
- 5. Intraoral – occlusal radiographic images are limited to two (2) in any six (6) month period.
- 6. Topical application of fluoride solutions is limited to twice in a Calendar Year.
- 7. KPIC will cover oral examinations (except after hours exams and exams for observation) no more than once every six (6) months per provider and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than once every six (6) months
- 8. Limited comprehensive oral examinations are covered once per patient per provider. Re-evaluation – limited problem focused exams (established patient; not post-operative visits) are covered up to six (6) times in a three (3) month period and up to a maximum of 12 in a 12-month period. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation.
- 9. Space maintainer limitations:
 - a. Except for distal shoe space maintainers, space maintainers are limited to the initial appliance for a Covered Person under age 18 and covered once per quadrant in a lifetime, except bilateral fixed space maintainers which are covered once per arch in a lifetime.
 - b. Distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
 - c. Recementation of space maintainer is limited to once per lifetime per applicable arch or quadrant.
 - d. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

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- Basic Services:

1. Restorative Services are limited as follows:

- a. Treatment of caries for a tooth that can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations. Any other restoration such as a crown or jacket is considered an Optional Service.
- b. Composite resin or acrylic restorations in posterior teeth are Optional Services.
- c. Replacement of a restoration is covered only when it is defective (as evidenced by conditions such as recurrent caries or fracture) and replacement is dentally necessary.

- Major Services:

1. Oral Surgery benefit is limited as follows:

- a. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
- b. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth are covered once per arch regardless of number of teeth involved for permanent, anterior teeth only.
- c. Surgical repositioning of teeth and transseptal fiberotomy/supra crestal fiberotomy, by report procedures are covered once per arch for permanent teeth for patients in active orthodontic treatment.
- d. Vestibuloplasty Limitations
 - i. Ridge extension (secondary epithelialization) is covered once per arch in a (5) five-year period.
 - ii. Ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of overtopped and hyperplastic tissue) is covered once per arch in a lifetime.
- e. Removal of lateral exostosis (maxilla or mandible) and of torus mandibularis, as well as the surgical reduction of osseous tuberosity, are limited to once per quadrant per lifetime.
- f. Removal of torus palatinus is limited to once per lifetime.
- g. Incision and drainage of abscess – intraoral soft tissue is limited to one (1) per quadrant on the same date of service.
- h. Partial osteotomy/sequestrectomy for removal of non-vital bone is limited to one (1) per quadrant on the same date of service.

2. Endodontics – Root canal therapy, including culture canal, is limited as follows:

- a. Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- b. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
- c. We will not cover replacement of an amalgam, prefabricated crown or resin-based composite restorations (fillings) within 12 months of treatment for primary teeth or 24 months of treatment for permanent teeth. Replacement restorations performed within 12 months for primary teeth and within 36 months for permanent teeth are included in the fee for the original restoration.
- d. Protective restorations (sedative fillings) are allowed once per tooth per provider in a six (6) month period when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.
- e. Therapeutic pulpotomy is limited to once per tooth per lifetime for baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.

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- f. Pulpal therapy (resorbable filling) for anterior primary teeth and pulpal debridement for primary and permanent teeth are limited to once per tooth per lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 12 months is considered part of the original procedure.
 - g. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth with the fee for the final visit included in the fee for the final root canal.
 - h. Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
 - i. Pin retention is covered once per tooth per lifetime for permanent teeth. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
 - j. Palliative treatment is allowed once per date of service, per provider regardless of the number of teeth and/or areas treated, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment.
3. Periodontics benefit is limited as follows:
- a. Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period for a Covered Person age 13 and older.
 - b. Periodontal surgery in the same quadrant is limited to once in every 36-month period for a Covered Person age 13 and older and includes any surgical re-entry or scaling and root planing.
 - c. Periodontal services, including covered graft procedure, are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
 - d. Periodontal surgery is subject to a 30-day wait following periodontal scaling and root planing in the same quadrant.
 - e. Periodontal maintenance is limited to Enrollees age 13 and older once in a calendar quarter and only in the 24 months following the last scaling and root planing. A full mouth debridement is included in the fee for other periodontal procedures and is not payable separately.
 - f. Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
 - g. Caries risk assessments are allowed once in 36 months.
 - h. Interim caries arresting medicament applications are covered once per tooth every six (6) months when Enrollee has a caries risk assessment and documentation with a finding of high risk.
 - i. When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic benefit and are limited to once in a 24-month period.

Note that procedure codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in the presence of generalized of moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

4. Crowns benefit is limited as follows:
- a. Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional. Only acrylic crowns and stainless-steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown.

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- b. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
 - c. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
 - d. Crowns, excluding prefabricated crowns, are limited to a Covered Personage 13 and older and are covered not more often than once in any five (5) year period except when We determine the existing Crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.
 - e. Post and core services are covered once in a lifetime on permanent teeth.
 - f. Crown repairs are covered not more than once in any 12 months of initial crown placement of previous repair for the same provider.
 - g. When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
 - h. Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within 12 months of the initial placement. After 12 months, payment will be limited to one (1) recementation in a 12-month period by the same Provider/Provider office.
5. Fixed Bridge benefit is limited as follows:
- a. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an Optional Service.
 - b. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person thirteen (13) years of age or older and the patient's oral health and general dental condition permits. For children under the age of thirteen (13), it is considered an Optional Service. If performed on an Enrollee under the age of thirteen (13), the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
 - c. Fixed bridges used to replace missing posterior teeth are considered an Optional Service when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
 - d. Fixed bridges are an Optional Service when provided in connection with a partial denture on the same arch. However, when a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
 - e. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
 - f. The Plan allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction. Full mouth reconstruction is considered an Optional Service.
6. Removable Prosthetic benefit is limited as follows:
- a. Partial dentures will not be replaced within thirty-six (36) consecutive months, unless:
 - i. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
 - ii. The denture is unsatisfactory and cannot be made satisfactory
 - b. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. Removable Denture Repairs are covered once per arch per date of service per provider and not more than twice per arch in any twelve (12) month period per provider. Adding teeth to an existing partial denture covered once per tooth and is limited to a maximum of three (3) per date of service per provider. However more elaborate or precision appliances, if chosen by the patient and the Provider, and are not necessary to satisfactorily restore an arch are considered Optional Services. A removable partial denture is considered an adequate restoration of a case when teeth are

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missing on both sides of the dental arch. Other treatments of such cases are considered Optional Services.

- c. Fixed partial dentures (bridgework) are not generally covered but shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. The Enrollee shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered. Approved fixed partial dentures are a benefit once in a 60-month period and only for a Covered Person age 13 and older.

Medical conditions, which preclude the use of a removable partial denture, include:

- i. the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,
- ii. the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,
- iii. patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

- d. Tissue conditioning is limited to two (2) per denture.
- e. Implants are considered an Optional Service. However, Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Us for medical necessity for prior authorization. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Exceptional medical conditions include, but are not limited to:
 - i. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
 - ii. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedure or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
 - iii. Skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
 - iv. Traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.
- f. Palatal lift prosthesis modification and speech aid prosthesis modification are limited to twice in a 12-month period.
- g. Prosthodontics that were provided under any program will be replaced only after five (5) years have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Implant dentures are a benefit once per patient per lifetime. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a program will be made if We determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature.
- h. The initial installation of a prosthodontic appliance is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under Our plan.
- i. TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.
- j. Occlusion analysis – mounted case, and occlusal adjustments, limited and complete, are limited to one (1) in 12 months for diagnosed TMJ dysfunction for permanent dentition and only for a Covered Person age 13 and older.
- k. Application of desensitizing medicament is limited to once in a 12-month period for permanent teeth only.
- l. We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and

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includes routine post-delivery care including any adjustments for the first six (6) months after placement and relines for the first 12 months after placement.

- i. Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment, adjustments are limited to twice in a 12-month period per provider and relining is limited to once in a 12-month period.
- ii. Tissue conditioning is limited to two (2) per prosthesis in a 36-month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline service.
- m. Recementation of fixed partial dentures is not a benefit within 12 months of a previous recementation by the same provider.

7. Orthodontic Services are limited as follows:

- a. We will pay or otherwise discharge the Cost Share shown in Our Schedule of Coverage for Essential Health Benefits when provided by a Provider and when necessary and customary under Generally Accepted Dental Practice Standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.
- b. Cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- c. Services are limited to medically necessary orthodontics when provided by a Provider. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.
- d. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
- e. The automatic qualifying conditions are:
 - i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - ii. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - iii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
 - iv. A crossbite of individual anterior teeth causing destruction of soft tissue,
 - v. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
 - vi. Severe traumatic deviation.

The following documentation must be submitted with the request for prior authorization of services by the Provider:

- a) The following documentation must be submitted with the request for prior authorization of services by the Provider:
 - i. ADA 2006 or newer Claim Form with service code(s) requested;
 - ii. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
 - iii. Cephalometric radiographic image or panoramic radiographic image;
 - iv. HLD score sheet completed and signed by the Orthodontist; and
 - v. Treatment plan.

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- b) The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.
- c) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
- d) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for a Covered Person under the age of 19 and shall be prior authorized.
- e) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
- f) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
- g) Pre-orthodontic treatment visits are allowed once every three (3) months up to a maximum of six (6) per Enrollee.
- h) Removable and fixed appliance therapy are allowed once per Enrollee age six (6) to 12.
- i) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, We will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
- j) Repair of an orthodontic appliance inserted under this dental plan is covered once per appliance per lifetime. The replacement of an orthodontic appliance inserted under this dental plan is covered once per arch per lifetime.
- k) Replacement of a lost or broken retainer is a benefit once per arch in a lifetime and only within 24 months following date of service of orthodontic retention.
- l) Orthodontic, including oral evaluations and all treatment must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. Self-administered orthodontics are not covered.
- m) The removal of fixed orthodontics appliances for reasons other than completion of treatment is not a covered benefit.

EXCLUSIONS

The following items are excluded from the Pediatric Dental Benefits coverage and are in addition to those exclusions set forth in the General Limitations and Exclusions section and in the Outpatient Prescription Drug Benefits section:

- 1. Any service not specifically listed as a Covered Service under this Pediatric Dental Benefits section.
- 2. Services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
- 3. Cosmetic surgery or procedures for purely cosmetic reasons.
- 4. Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
- 5. Treatment that increases the vertical dimension of an Occlusion, replaces tooth structure lost by Attrition or erosion or otherwise unless it is part of a treatment dentally necessary due to accident or injury.
 - a. Occlusion means the way the teeth meet when the lower jaw (mandible) and upper jaw (maxilla) come together.
 - b. Attrition means the wearing down of the surface of a tooth from chewing or grinding teeth.

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6. Any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
7. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesics, separate charges for local anesthetics, general anesthesia except as a Benefit in conjunction with a covered Oral Surgery procedure. Prescription drugs are medications provided after treatment (e.g. pain relief medication). Please refer to the **Outpatient Prescription Drug Benefits** section of this Certificate for coverage of prescription drugs.
8. Experimental/investigational procedures.
9. Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
10. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
11. Laboratory processed crowns for a Covered Person under age 13.
12. Interim implants and endodontic endosseous implants.
13. Indirectly fabricated resin-based Inlays/Onlays.
14. Charges for hospitalization or any other surgical treatment facility, including hospital visits.
15. Treatment by a person who is not licensed as a Dentist or authorized to perform or deliver services in the state in which such services were delivered or performed.
16. Preventive plaque control programs, including oral hygiene instruction programs.
17. Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
18. Procedures that are determined not to be Medically Necessary based on the professional review of the submitted documentation by a Dental Consultant We designate.
19. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
20. Treatment or materials for which no charge is made, for which the Covered Person is not legally obligated to pay or for which no charge would be made in the absence of coverage under this Plan.
21. Services covered under the dental plan but exceed Benefit limitations.
22. The initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Us. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
23. Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.
24. Missed and/or cancelled appointments.
25. Action taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
26. The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
27. Dental case management motivational interviewing and patient education to improve oral health literacy.
28. Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
29. Corticotomy (specialized oral surgery procedures associated with orthodontics).
30. The fee for teledentistry services are considered inclusive in overall patient management and are not a separately payable service.
31. Antigen and antibody testing.

Your Choice of Dental Providers

Please read the following information carefully. It will help You understand how the provider You select can affect the dollar amount You must pay.

PEDIATRIC DENTAL BENEFITS

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support Your right to freedom of choice regarding Your Provider. This assures that You have full access to the dental treatment You need from the dental office of Your choice. You may see any Provider for Your covered treatment, whether the Provider is a PPO, Premier or a Non-Delta Dental Provider. In addition, You and Your family members can see different Providers.

Participating or Premier Provider

When You choose a PPO or Premier Provider, Your out-of-pocket costs may be less. To take full advantage of Your benefits, we highly recommend You verify a dentist's participation status within with Your dental office before each appointment. Review the "**CLAIM and APPEALS PROCEDURES**" section for an explanation of payment procedures to understand the method of payments applicable to Your dentist selection and how that may impact Your out-of-pocket costs.

Locating a Delta Dental PPO or Premier Provider

There are two ways in which You can locate a PPO or Premier Provider near you:

- You may access information through our web site at: www.deltadentalinc.com. This web site includes a Provider search function allowing You to locate PPO Provider or Premier Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at 1-800-835-2244 and one of our representatives will assist You. We can provide You with information regarding a Provider's network, specialty and office location.

IMPORTANT: If You receive dental services that are not covered services under this policy, a participating provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call KPIC or its Administrator Delta Dental at 1-800-835-2244. To fully understand Your coverage, You may wish to carefully review this Certificate of Insurance.

Predetermination of Your Dental Benefits

After an examination, Your Provider will talk to You about treatment You may need. The cost of treatment is something You may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than \$300, we encourage You to ask Your Provider to request for a Predetermination of Benefits.

A Predetermination of Benefits does not guarantee payment. It is an estimate of the amount KPIC will pay if You are eligible and meet all the requirements of the Group Policy at the time the treatment You have planned is completed.

In order to receive Pre-determination of Benefits, Your Provider must send a statement of proposed treatment to our Administrator, Delta Dental listing the proposed treatment. Delta Dental will send Your Provider a Notice of Predetermination of Benefits which estimates how much of the treatment costs KPIC will pay and how much You will have to pay. After You review the estimate with Your Provider and You decide to go ahead with the treatment plan, Your Provider returns the statement to the following address for payment after treatment has been completed.

**Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330**

PEDIATRIC DENTAL BENEFITS

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination of Benefit is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual maximum when completed services are submitted to KPIC or to Delta Dental.

Pre-determination of Benefits help prevent any misunderstanding about Your financial responsibilities.

Definitions:

The following definitions apply to the Pediatric Dental coverage:

Benefit means those Covered Dental Services which are made available to Covered Persons under the terms of this Group Policy and which are listed as part of the Group Policy.

Covered Dental Services means those dental services set forth in the Benefits and Limitations section of this Certificate.

Delta Dental Premier® Provider (Premier Provider) means a Participating Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to:

1. accept the Premier Provider's Contracted Fee as payment in full for services provided under this dental insurance plan; and
2. complies with Delta Dental's administrative guidelines.

Delta Dental PPOSM Provider (PPO Provider) means a Participating Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to:

1. accept the PPO Provider's Contracted Fee as payment in full for services provided under this dental insurance plan; and
2. complies with Delta Dental's administrative guidelines.

Maximum Allowable Charge means the lesser of:

1. **The Usual and Customary Charge (U&C):**

The usual and customary charge is the lesser of: (a) the charge generally made by a Dentist; or (b) the general level of charge made by Dentists within an area in which the charge is incurred comparable in severity and nature to the service or treatment being performed. The general level of charges is determined by KPIC in accord with schedules on file with the authorized Administrator. For charges not listed in the schedules, KPIC will establish the U&C. KPIC reserves the right to periodically adjust the charges listed in the schedules.

The term "area" as it would apply to any particular service means a city or such greater area as is necessary to obtain a representative cross section of level of charges.

If the Maximum Allowable Charge is the U&C Charge, the Covered Person will be responsible for payment to the provider of any amounts in excess of the U&C Charge for a Covered Service when the U&C Charge is less than the actual billed charges for the Covered Service.

2. **Premier or PPO Provider's Contracted Fee**

Delta Dental Premier Provider's Contracted Fee (Premier Provider's Contracted Fee) means the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for treating a Covered Person.

Delta Dental PPO Provider's Contracted Fee (PPO Provider's Contracted Fee) means the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for treating a Covered Person.

3. **Actual Billed Charges:**

The actual charges billed by the Dentist for Covered Dental Services.

PEDIATRIC DENTAL BENEFITS

Non-Delta Dental Provider means a licensed Provider who:

1. does not have Filed Fees/Negotiated Fees on file with Delta Dental; or
2. does not accept the Premier Provider's Contracted Fee or the PPO Provider's Contracted Fee as payment in full for services provided under this dental insurance plan; or
3. does not comply with Delta Dental's administrative guidelines.

Participating Dentist means a licensed Delta Dental Premier® Provider (Premier Provider) or Delta Dental PPOSM Provider (PPO Provider) who:

1. accepts the Premier Provider's Contracted Fee or the PPO Provider's Contracted Fee as payment in full for services provided under this dental insurance plan; or
2. complies with Delta Dental's administrative guidelines.

Provider means a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Single Procedure means a dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

Submitted Fee means the amount that the Provider bills and enters on a claim for a specific procedure.

IMPORTANT: If You receive dental services that are **not** covered services under this policy, a participating provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, You may call KPIC or its Administrator Delta Dental at 1(800)-765-6007. To fully understand your coverage, you may wish to carefully review this Certificate of Insurance.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Prescribed drugs, medicines and supplies purchased from a licensed pharmacy on an outpatient basis are covered provided they: a) can be lawfully obtained only with the written prescription of a Physician or dentist; b) are purchased by Covered Persons on an outpatient basis; c) are covered under the Group Plan; d) do not require administration by medical personnel; and e) do not exceed the maximum daily supply shown in the Schedule of Coverage, except that in no case may the supply be larger than that normally prescribed by a Physician or dentist.

Open drug formulary

This Outpatient Prescription Drug Benefit uses an open formulary. Unless specifically excluded under the Plan, all FDA-approved drugs are part of this Plan's open formulary. The formulary consists of generic and preferred and non-preferred brand drugs including specialty drugs.

All Medically Necessary outpatient prescription drugs are covered, including disposable devices for the administration of a covered outpatient prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs, and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. Please see the "Exception Requests for a drug not on the formulary" subsection below for information on the exception process. To access the Outpatient Prescription Drug Formulary online, please visit <http://info.kaiserpermanente.org/html/kpic/formulary.html>.

Prior Authorization

Outpatient Prescription Drug Prior authorization is a procedure that is used to encourage safe and cost-effective medication use. Prior authorization is generally applied to drugs that have multiple indications, are high in cost, or have a significant safety concern.

The purpose of prior authorization is to ensure that a Covered Person gets the right medication. This means that when Your licensed prescribing provider prescribes a drug that has been identified as subject to prior authorization, the medication needs to be reviewed by Us to determine Medical Necessity before the prescription is filled. Prior authorization edits address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.

If a drug requires prior authorization, your licensed prescribing provider will need to work with Us to pre-approve the drug. Prior authorized drugs have specific clinical criteria that You must meet in order to obtain coverage. Refer to the formulary for a complete list of medications requiring prior authorization. The most current formulary can be obtained by visiting kp.org/kpic/ppo. If you have questions about prior authorization or about drugs covered You can call 24 hours a day, 7 days a week (closed holidays), at 1-800-788-2949 or 711 (TTY).

The Covered Person or the licensed prescribing provider must notify the Prescription Drug Review Program as follows:

1. The Covered Person or the licensed prescribing provider can obtain a copy of the request form by calling 1-800-788-2949. Prior authorization requests not made on the prescribed request form shall not be accepted;
2. We will accept the request form through any reasonable means of transmission, including, but not limited to, paper, electronic, or any other mutually accessible method of transmission;
3. Upon receipt of a completed request form, We will notify the licensed prescribing provider within 72 hours for non-urgent requests and within 24 hours if exigent circumstances exist from receipt of a request form, that:
 - a. The request is approved; or

OUTPATIENT PRESCRIPTION DRUG BENEFITS

- b. The request is disapproved due to:
 - i. Not Medically Necessary; or
 - ii. Missing material information necessary to determine Medical Necessity; or
 - iii. The patient is no longer eligible for coverage; or
 - iv. The request is not submitted on the prescribed Request Form and must be resubmitted using the prescribed request form.
4. If We fail to respond within 72 hours for non-urgent requests and within 24 hours if exigent circumstances exist from receipt of a request form from a licensed prescribing provider; the request shall be deemed to have been approved.
5. In the event, the licensed prescribing provider's prior authorization request is disapproved:
 - a. The notice of disapproval must contain an accurate and clear written explanation of the specific reasons for disapproving the request.
 - b. If the request is disapproved due to missing material information necessary to determine Medical Necessity, the notice of disapproval must contain an accurate and clear explanation that specifically identifies the missing material information.
6. The prescription drug prior authorization request shall be deemed approved in the event that:
 - a. The notice of disapproval is not sent to the licensed prescribing provider within 72 hours of receipt of a non-urgent request and within 24 hours for exigent circumstances; or
 - b. We accept any prescription drug prior authorization form other than the prescribed request form and We did not send timely disapproval.
7. Notices required to be sent to the Covered Person or to his/her designee or the licensed prescribing provider shall be delivered by Us in the same manner as the request form was submitted to Us, or any other mutually agreeable accessible method of notification.
8. Prescription drug prior authorization procedures conducted electronically through a web portal, or any other manner of transmission mutually agreeable, shall not require the licensed prescribing provider to provide more information than is required by the request form.

Step therapy process

Selected prescription drugs require step therapy. The step therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain high-cost medications. Refer to the formulary for a complete list of medications requiring step therapy. This means that to receive coverage You may first need to try a proven, cost-effective medication before using a more costly treatment. Treatment decisions are always between You and Your Provider.

The step therapy program is a process that defines how and when a particular drug can be dispensed by requiring the use of one or more prerequisite drugs (1st line agents), as identified through the Covered Person's drug history, prior to the use of another drug (2nd line agent).

Your licensed prescribing provider should prescribe a first-line medication appropriate for Your condition. If Your licensed prescribing provider determines that a first-line drug is not appropriate or effective for You, a second-line drug, may be covered after meeting certain conditions.

Definitions specific to the Prior Authorization of Outpatient Prescription Drug and Step Therapy provisions:

Exigent circumstances exists when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when a Covered Person is using a drug while undergoing a current course of treatment.

Request form means the prescription drug prior authorization form prescribed by KPIC as set forth under applicable California state law.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Licensed prescribing provider shall include a provider authorized to write a prescription pursuant to subdivision (a) of the Business and Professional Code section 4040, to treat a medical condition of a Covered Person.

There are no precertification requirements for outpatient prescription drugs under the open formulary. As such, there are no prior authorization or exception request processes for outpatient prescription drugs under this coverage.

Exception Requests

You or Your designated assignee or the licensed prescribing provider may request an exception to the Outpatient Prior Authorization Request and Step Therapy process described above if You are already being treated for a medical condition and currently under medication of a drug subject to prior authorization or step therapy, provided the drug is appropriately prescribed and is considered safe and effective for your condition.

However, further prior authorization may be required for the continued coverage of a prescription drug prescribed pursuant to a prior authorization or step therapy process imposed from a prior insurance policy.

To request a waiver please call: 1-800-788-2949 (MedImpact).

If Your request for a waiver of Outpatient Prescription Drug Prior Authorization or of the step therapy process is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Exception Requests for a drug not on the Formulary

You can request an exception to obtain coverage of a drug that is not listed on the formulary by calling MedImpact, KPIC's Pharmacy Benefit Manager ("PBM") at 1-800-788-2949. Upon receipt of Your request, MedImpact will notify You within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist, of the request approval or other outcome. (Urgent circumstances exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health or ability to regain maximum function or when an insured is using a drug while undergoing a current course of treatment.) If a standard exception request is granted, coverage of the requested drug, including refills, will be granted for the duration of the prescription. If an exception based on urgent circumstances is granted, coverage of the drug will be granted for the duration of the urgency.

If Your request for an exception for coverage of a drug not listed on the formulary is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Outpatient Prescription Drug Benefits

Covered Charges for outpatient prescription drugs are limited to charges from a licensed pharmacy for:

1. Legend Drugs. Legend Drugs means drugs that are approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state law to be dispensed to the public only by prescription from a licensed Physician or other licensed provider;
2. Experimental drugs and Medicines, if such Experimental drugs that are used to treat cancer if one or more of the following conditions is met:
 - a. the drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information publication: or

OUTPATIENT PRESCRIPTION DRUG BENEFITS

- b. the drug is recommended for treatment of the Covered Person's particular type of cancer and has been found to be safe and effective in formal clinical studies, the result of which have been published in either the United States or Great Britain;
- 3. Off-label use of covered prescription drugs;
- 4. Insulin;
- 5. The following other pharmacy items:
 - a. Disposable blood glucose and ketone urine test strips;
 - b. Blood glucose monitors;
 - c. Lancets and lancet puncture devices;
 - d. Pen delivery systems for the administration of insulin;
 - e. Visual aids excluding eyewear to assist in insulin dosing; and,
 - f. Peak flow meters.

Please refer to "Management and treatment of diabetes" under the GENERAL BENEFITS section of this Certificate for a list of diabetic equipment and supplies covered under the medical benefit portion of this Plan.

- 6. Prescriptive medications for the treatment of diabetes;
- 7. Glucagon;
- 8. Episodic drugs prescribed for the treatment of sexual dysfunction disorders;
- 9. Disposable devices that are Medically Necessary for the use of covered outpatient prescription drugs, including disposable needles and syringes needed for injecting covered drugs and supplements;
- 10. Contraceptive drugs and devices. These drugs and devices are covered as preventive services under the Preventive Care and Services header in the General Benefits section;
- 11. Drugs or devices that do not require a prescription by law (over the counter drugs). These drugs are limited to over the counter contraceptive and other oral over the counter drugs which are covered as preventive services under the Preventive Care and Services header in the General Benefits section;
- 12. Weight loss drugs when Medically Necessary for the treatment of morbid obesity;
- 13. Continuity drugs. If this Plan is amended to exclude a drug that we had previously been covering and providing to You under this Plan we will continue to be provided if a Your Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.
- 14. All Medically Necessary outpatient prescription drugs pursuant to California Insurance Code section 10112.27 and California Code of Regulations Title 28 section 1300.67.24(a).
- 15. Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells.
- 16. Pain management medications prescribed for a terminally ill patient when Medically Necessary and in accordance with our formulary guidelines. For purposes hereof, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 12 months.

If a Physician prescribes a Brand Name, Generic or over the counter Prescription Drug and the pharmacy's retail price for the prescription drug is less than the applicable copayment, the insured is not required to pay any more than the retail price.

Limitations

- 1. Mail Order Service: A Covered Person may use the contracted mail order service if the Covered Person takes maintenance medications to treat an acute or chronic health condition, such as high blood pressure, ulcers or diabetes. Benefits are subject to any limitations, Copayments and deductibles shown in the Schedule of Coverage.

The prescription drug mail order service is administered by the Mail Order Pharmacy ("Pharmacy") contracted by KPIC's Pharmacy Benefit Manager ("PBM").

The contracted mail order service can give You more information about obtaining refills. For example, not all drugs can be mailed through our mail-order service. Some drugs (for example, drugs that are extremely high cost or require special handling) may not be eligible for mailing. Drugs cannot be mailed outside the United States. Please check with the contracted mail order service if You have a question about whether or not Your prescription is available to be mailed. Items available through our mail-order service are subject to change at any time without notice.

OUTPATIENT PRESCRIPTION DRUG BENEFITS

Any prescriptions that are delayed greater than 4 days in facility have upgraded/expedited shipping placed on them at Pharmacy's expense. If at any point the patient states that they are out of medication or running out of medication, Pharmacy may upgrade shipping to Overnight, arrange for short term supply at a local store, or both. Some exclusions may apply depending on medication type (ex. Controlled medications).

2. Episodic drugs prescribed for the treatment of sexual dysfunction disorders are limited to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period.

Brand Name Prescription Drug and Generic Prescription Drug Rules. (These rules do not apply to FDA-approved contraceptive drugs.)

1. If the drug prescribed by the Physician is a Generic Prescription Drug – Copayment due for the prescription is that of the Generic Prescription Drug, as shown in the Schedule of Coverage.
2. If the drug prescribed by the Physician is a Generic Drug and the Covered Person prefers a Brand Name Prescription Drug – Copayment due for the prescription is the Brand Name Prescription Drug Copayment as shown in the Schedule of Coverage, plus the cost difference between the Brand Name Prescription Drug and the Generic Prescription Drug.
3. If a Physician prescribes a Brand Name Prescription Drug and orders such prescription as "DISPENSED AS WRITTEN", the copayment due for such prescription is the applicable copayment for a Brand Name Prescription Drug, as shown in the Schedule of Coverage.
4. If a Physician prescribes a Brand Name Prescription Drug and did not order such prescription as "DISPENSED AS WRITTEN", and a Generic Prescription Drug is available, but the Covered Person prefers a Generic Prescription Drug, the copayment due for such prescription is the applicable copayment for a Generic Prescription Drug, as shown in the Schedule of Coverage.
5. If a Physician prescribes a Brand Name Prescription Drug and did not order such prescription as "DISPENSED AS WRITTEN", and a Generic Prescription Drug is available, but the Covered Person prefers a Brand Name Prescription Drug, the copayment due for such prescription is the applicable copayment for a Brand Name Prescription Drug as shown in the Schedule of Coverage, plus the cost difference between the Brand Name Prescription Drug and the Generic Prescription Drug.
6. If a Physician prescribes a Brand Name Prescription Drug and did not order such prescription as "DISPENSED AS WRITTEN", and a Generic Prescription Drug is not available, the copayment due for such prescription is the applicable copayment for a Brand Name Prescription Drug, as shown in the Schedule of Coverage.

Exclusions

The following items are excluded from Outpatient Prescription Drug coverage in addition to those set forth in the General Limitations and Exclusions section:

1. Experimental Drugs and Medicines not listed as covered.
2. Drugs or devices that do not require a prescription by law except when over the counter drug coverage is required by law.
3. Weight loss drugs not used for the treatment of morbid obesity.
4. Charges for the administration of any drug when the drug does not require administration by medical personnel.
5. Contraceptive drugs and devices, except that contraceptive supplies prescribed for reasons other than contraceptive purposes are covered, such as a) decreasing the risk of ovarian cancer; b) eliminating symptoms of menopause; or c) when it is necessary to preserve the life or health of an insured.

GENERAL LIMITATIONS AND EXCLUSIONS

Unless specifically stated otherwise in the Group Policy or elsewhere in this Certificate, no payment will be made under any benefit of the plan for Expenses Incurred in connection with the following:

1. Charges in excess of the Maximum Allowable Charge.
2. Services or supplies other than Emergency Services received outside the United States.
3. Treatment, services, or supplies provided by any of the following:
 - a) The Covered Person;
 - b) The Covered Person's Spouse;
 - c) The Covered Person's child, sibling or parent;
 - d) The child, sibling or parent of the Covered Person's Spouse; or
 - e) Any person who resides in the Covered Person's home.
4. Confinement, treatment, services or supplies received where care is provided at government expense. This exclusion does not apply if: a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or b) payment is required by law.
5. Dental care including dental x-rays; dental appliances; orthodontia; and dental services resulting from medical treatment. This exclusion does not include: a) visits for repairs or treatment of accidental injury to a jaw or sound natural teeth when performed or rendered within 12 months following an accident, when the accident is sustained while covered under the Group Policy; b) service that is for an Insured Dependent child because of congenital disease or anomaly; c) the removal of impacted wisdom teeth when imbedded in bone; d) Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; e) dental services necessary to prepare your jaw for radiation therapy for cancer in Your head or neck; or f) dental care for children under the age of 18.
6. Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance. This exclusion does not apply to covered Reconstructive services including services related to mastectomy, testicular implants, or prosthetics to replace all or part of an external facial body part or to covered transgender surgery services that are described under the General Benefits section.
7. Nonprescription drugs or medicines, vitamins, nutrients and food supplements, even if prescribed or administered by a Physician, except for: 1) formulas and special food products for treatment of Phenylketonuria (PKU); and, 2) Preventive Care; as described in the **GENERAL BENEFITS** section.
8. Any treatment, procedure, drug or equipment, or device which is experimental or investigational. This means that one of the following is true:
 - the service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or
 - the service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

As described under the Outpatient Prescription Drug Benefits section, this exclusion will not apply to experimental drugs and medicines that are used to treat cancer if one or more of the following conditions is met:

- the drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information publication; or
- the drug is recommended for treatment of the Covered Person's particular type of cancer and has been found to be safe and effective in formal clinical studies, the result of which have been published in either the United States or Great Britain.

Please refer to the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section of this Certificate for information about Independent Medical Review related to denied requests for experimental or investigational services

GENERAL LIMITATIONS AND EXCLUSIONS

9. Clinical Trial services that are provided solely to satisfy data collection and analysis needs and are not used in Your clinical management, and services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial. In addition, this condition will not apply to Routine Patient Care Costs related to clinical trial if the Covered Person's treating Physician recommends participation in the clinical trial after determining that participation in such clinical trial has a meaningful potential to benefit the Covered Person.
10. Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems, except as otherwise provided for the treatment of Mental Health and Substance Use Disorders. This exclusion does not apply to covered Habilitative Services as described in the **GENERAL BENEFITS** section.
11. Weight loss programs (such as Weight Watchers and OPTIFAST), fitness programs and gym memberships rendered for the treatment of obesity or weight management.
12. Recreational therapy. This exclusion does not apply to Covered Services that are part of a Behavioral Health Therapy treatment plan and covered under "Mental Health Services" or to covered Habilitative Services as described in the **GENERAL BENEFITS** section.
13. Items and services that are not health care items and services, including those listed below. This exclusion does not apply to Covered Services that are part of a Behavioral Health Therapy treatment plan and covered under "Mental Health Services" or to covered Habilitative Services as described in the **GENERAL BENEFITS** section:
 - a) Teaching manners and etiquette
 - b) Teaching and support services to develop planning skills such as daily activity planning and project or task planning
 - c) Items and services that increase academic knowledge or skills
 - d) Teaching and support services to increase intelligence
 - e) Academic coaching or tutoring for skills such as grammar, math, and time management
 - f) Teaching You how to read, whether or not You have dyslexia
 - g) Educational testing
 - h) Testing for aptitude, intelligence or interest, except this exclusion does not apply to psychological testing to evaluate a Mental Disorder
 - i) Teaching art, dance, horse riding, music, play or swimming, except that this exclusion for "teaching play" does not apply to Covered Services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the **GENERAL BENEFITS** section
 - j) Teaching skills for employment or vocational purposes
 - k) Vocational training or teaching vocational skills
 - l) Professional growth courses
 - m) Training for a specific job or employment counseling
 - n) Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to covered physical therapy services that are part of a physical therapy treatment plan and covered under the **GENERAL BENEFITS** section.
14. Non-surgical treatment of craniomandibular and temporomandibular joint disorders.
15. Personal comfort items such as telephone, radio, television, or grooming services.
16. Custodial care. **Custodial Care** is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse. This exclusion does not apply to assistance with activities of daily living that is provided as part of covered home health care, hospice care, skilled nursing facility care, or inpatient hospital care.
17. Care in an intermediate care facility. This is a level of care for which a Physician determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary. This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
18. Routine foot care such as trimming of corns and calluses
19. Services of a private duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility.

GENERAL LIMITATIONS AND EXCLUSIONS

20. Medical social services except those services related to discharge planning in connection with a) a covered Hospital Confinement; b) covered Home Health Care Services; or c) covered Hospice Care.
21. Living expenses or transportation, except as provided under Covered Services.
22. Reversal of sterilization.
23. Services provided in the home other than 1) Covered Services provided through a Home Health Agency; or 2). house calls when care can best be provided in your home, as determined by the Physician
24. The following Home Health Care Services:
 - a) meals,
 - b) personal comfort items,
 - c) housekeeping services.
25. Services received in connection with a surrogacy arrangement, except for otherwise Covered Services provided to a Covered Person who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies)child to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Please refer to the "Surrogacy Arrangement" provision under the **GENERAL PROVISIONS** section for information about Your obligations to Us in connection with a surrogacy arrangement, including Your obligation to reimburse Us for any services We cover and to provide information about anyone who may be financially responsible for Covered Services the baby (or babies) receive.
26. Computed tomographic colonography screening (virtual colonoscopy) except when endoscopic colonoscopy screening cannot be safely performed, such as in anatomical blockage of the colon.
27. Biofeedback or hypnotherapy.
28. Hearing aids.
29. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye
30. Eyeglasses and contact lenses for adults age 18 or older, except for the following:
 - a) Special contacts for aniridia as described under the **GENERAL BENEFITS** section;
 - b) Eyewear following cataract surgery or eyewear to correct aphakia as described under the **GENERAL BENEFITS** section; and
 - c) Benefits provided under the Adult Vision Care Optional Benefit, if so elected by your Group. Please refer to the **Schedule of Benefits** to determine if Your Group elected the Adult Vision Care Optional Benefit. Services for which no charge is normally made in the absence of insurance.
31. Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases.

OPTIONAL BENEFITS, LIMITATIONS, AND EXCLUSIONS

To determine if You are covered for the following optional benefits You must refer to the Schedule of Coverage. If the treatment or service is not listed as covered under Your Schedule of Coverage, then the treatment or service is excluded from coverage as provided under the General Exclusions and Limitations section of this certificate.

Adult Vision Care. This benefit covers the cost of a refraction vision exam, prescription lenses, and prescription contact lenses. This benefit does not cover plain sunglasses, plastic lenses that are not medically indicated, contact lenses for cosmetic purposes, replacement of lost or broken frames or lenses, or athletic or industrial frames or lenses.

SAMPLE

CALIFORNIA CONTINUATION OF MEDICAL BENEFIT (CAL-COBRA)

This section only applies to small employer groups with 2-19 eligible employees who are subject to California COBRA (Cal COBRA) and who are not offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as then constituted or later amended (COBRA).

Eligibility

A Covered Person may have a right to continue coverage when coverage terminates under the provisions of the Policy. Continued coverage will be: (A) available only to those Covered Persons who qualify at the time a qualifying event occurs; and (B) subject to the terms and conditions of the Policy.

A child that is born to or placed with a Covered Person during a period of Cal-COBRA coverage is eligible for coverage as a Dependent provided proper written notice and election takes place.

Individuals Not Eligible for Cal-COBRA Continuation

Continuation of coverage under this provision is not available to and will not be provided for the following individuals:

1. Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as then constituted or later amended.
2. Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan that provides coverage to individuals and that does not impose any exclusion or limitation with respect to any preexisting condition, other than a preexisting condition limitation or exclusion that does not apply to or has been satisfied due to prior creditable coverage;
3. Individuals who are covered, become covered, or are eligible for federal COBRA coverage, except those individuals, who under applicable California law, are eligible for an extension of COBRA coverage.
4. Individuals who are covered, become covered, or are eligible for coverage pursuant to chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1;
5. Individuals who do not meet the notice requirements of this State Continuation of Coverage provision or fail to make the election in a timely manner;
6. Individuals who do not submit the correct premium amount for the continuation coverage as required by the Group Policy or who fail to satisfy other terms and conditions of the Group Policy.

Qualifying Events

Individuals will qualify for Cal-COBRA as follows:

- A) If Your health insurance coverage ends due to: (1) termination of employment; or (2) reduction in your employment hours, You may continue health coverage under the Group Policy for the continuation of coverage period. The right to continue coverage under this provision will not be allowed if Your employment was terminated due to gross misconduct.
- B) If Your Dependent's insurance coverage ends due to: (1) Your death; (2) Your divorce or legal separation from Your spouse or Domestic Partner; or (3) Your Dependent reaching the limiting age for a Dependent.
- C) If You become entitled to Medicare benefits under Title XVIII of the Social Security Act, as the constituted or later amended, Your Medicare ineligible spouse and Dependent eligible children may continue health coverage under the policy for the continuation of coverage period.

CALIFORNIA CONTINUATION OF MEDICAL BENEFIT (CAL-COBRA)

Termination of Cal-COBRA Continuation Coverage

Cal-COBRA coverage continues only upon timely payment of applicable monthly premiums to KPIC. Coverage will terminate on the earliest of:

1. the date the Covered Person requests coverage be terminated;
2. 36 months after the date the Covered Person's benefits under the Policy would have terminated because of the qualifying events set forth under (A) above;
3. the end of the grace period for which premium payments were made if the Covered Person ceases or fails to make timely premium (The grace period is 30-days after the date that notice of nonreceipt of payment is sent to the Insured's address of record.);
4. 36 months after the date the Covered Person's benefits under the Policy would have terminated because of the qualifying events set forth under (B) and (C) above.
5. the date the individual is no longer eligible for continuation coverage as set forth under the **Individuals Not Eligible for Cal-COBRA Continuation** provision above;
6. the date the employer or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees;
7. the date the Covered Person moves out of KPIC's service area;
8. the date the Covered Person, or their representative, commits fraud or deception in using or obtaining the benefits provided under the Group Policy.

If a Covered Person's continuation coverage under the Group Policy is going to terminate earlier than specified by the Group Policy, the employer must notify the person of their right to obtain continuation coverage under the employer's new group coverage for the remainder of the continuation period. The employer must provide this notice to persons insured under the continuation of coverage provision on the later of:

1. 30 days prior to the termination of the Group Policy; or
2. at the same time all Insured Employees are notified of the termination of the Group Policy.

The employer must also notify the succeeding carrier in writing, of all individuals who are receiving continuation coverage so that necessary continuation election information can be forwarded to those individuals.

Extension for Disabled Covered Persons

A Covered Person may be eligible for an extension of Cal-COBRA continuation if all the following apply:

1. the Covered Person is:
 - a. a former employee who has Cal-COBRA continuation because of the occurrence of event (A) listed under the Qualifying Events section of this provision; or
 - b. a Dependent of the former employee and elected continuation coverage because of event (A) listed under the Qualifying Events section of this provision; and
2. Social Security determines under Title II or Title XVI of the Social Security Act that the Covered Person is disabled within the first 60 days of coverage under the Cal-COBRA continuation.

For those Covered Persons, the 18-month maximum period of continued health coverage for qualifying event (A) may be extended 11 months for a total continuation period of 29 months. To obtain the extension, the Covered Person must notify the employer or KPIC of Social Security's determination within 60 days of the date of the determination letter and prior to the end of the original 18-month continuation of coverage period.

If Social Security subsequently determines that the Covered Person is no longer disabled, coverage will terminate on the later of:

1. the end of the original 18-month continuation of coverage period; or
2. the first day of the month that begins more than 31 days after Social Security determines the Covered Person is no longer disabled.

CALIFORNIA CONTINUATION OF MEDICAL BENEFIT (CAL-COBRA)

The Covered Person must notify the employer or KPIC that he or she is no longer disabled within 30 days of the date of Social Security determination.

For the continued health coverage of disabled Covered Persons that exceeds 18 months, KPIC may increase the premium it charges by as much as 50%. The employer may require the disabled Covered Persons to pay all or part of that total increased premium.

Notice Requirements and Requests for Continuation Coverage

Notice of Event

You or Your Dependent must notify KPIC of the following qualifying events:

1. the death of the Covered Person;
2. Your legal divorce or legal separation from Your spouse or Domestic Partner;
3. Your child reaching the limiting age for a Dependent or otherwise becoming ineligible for coverage under the Policy;
4. Your becoming entitled to Medicare benefits under Title XVIII of the United States Social Security Act (Medicare).

The notice must be given to KPIC within 60 days after the date the event occurs. If You or Your Dependent fails to give KPIC notice within the 60-day period, You and Your Dependent will not qualify for continuation of coverage under this Cal-COBRA provision. You or Your Dependent must also still send KPIC a written request for continuation of coverage within the time limits set forth below in the Request for Continuation of Coverage section.

Notice Required of Employer

The employer must notify KPIC of the following events within 30 days of the date of the event:

1. The termination of the employee;
2. A reduction in hours of employment of the Insured Employee's employment;
3. The employer becoming subject to the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, as then constituted or later amended.

If the employer fails to provide KPIC with the required notice, KPIC will not be obligated to provide Cal-COBRA coverage to the affected employee or their dependents.

Notice to You and Your Dependent of Right of Continuation

Within 14 days of receiving a notice of a qualifying event, KPIC will provide You or Your Dependent the necessary premium information, enrollment forms and disclosures needed to allow You or Your Dependent to formally make the election of continuation coverage.

Request for Continuation of Coverage and Payment of Premium

Continuation of coverage under the Group Policy must be requested in writing and be delivered to KPIC by first-class mail or other reliable means of delivery, including personal delivery, express mail or private courier, within the 60-day period following the later of:

- A. The date the Covered Person's coverage under the Group Policy terminated or will terminate by reason of a qualifying event; or
- B. The date the Covered Person was sent notice of the right to continuation of coverage.

Payment of the first premium must be received by KPIC within 45 days of the date the Covered Person provided the written request to continue coverage under the Group Policy. The premium must be sent by first class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier. The first premium payment must equal an amount sufficient to pay all required premiums and all premiums due. If You or Your Dependent fails to submit the required premium amount within the 45-day period, the You and Your Dependent will not be eligible for continuation coverage under Cal-COBRA.

CALIFORNIA CONTINUATION OF MEDICAL BENEFIT (CAL-COBRA)

Premiums will be due monthly and will not exceed 110 percent of the applicable rate charged for a Covered Person, or if the continuation is for a covered Dependent, not more than the 110 percent of the rate charged for a similarly situated Insured Dependent under the Policy. However, If the Covered Person is determined to be disabled under Title II or Title XVI of the United States Social Security Act, premiums may be increased to up to 150 percent of the group rate after the first 18 months of continuation coverage.

SAMPLE

FEDERAL CONTINUATION OF HEALTH INSURANCE

This section only applies to Participating Employers who are subject to Public Law 99-271 (COBRA)

You or a covered Dependent may have a right to have health coverage continued under the Policy when coverage terminates under the provisions of the Policy. Continued coverage will be: (A) available only to those Covered Persons who qualify at the time a qualifying event occurs; and (B) subject to the terms and conditions of the Policy.

A child that is born to or placed with an Insured Employee during a period of COBRA coverage is eligible for coverage as a Dependent provided proper written notice and election takes place.

Qualifying Events

- (A) If Your health insurance coverage ends due to (1) termination of employment; or (2) a reduction in hours, You may continue health coverage under the policy for the continuation of coverage period. The right to continue coverage under this provision will not be allowed if H.P.I.C. is informed by the employer that Your employment was terminated due to gross misconduct.
- (B) If Your Dependent's insurance coverage ends due to: (1) Your death; (2) Your legal divorce or legal separation from Your spouse; or (3) Your child reaching the limiting age for a Dependent, the terminated Dependent has the option to continue health coverage under the policy for the continuation of coverage period.
- (C) If You retired from employment with the employer and Your health insurance coverage, or the health insurance coverage of Your Dependents, including Your surviving spouse:
 - (1) is substantially eliminated as a result of the employer's filing of a Title XI bankruptcy; or
 - (2) was substantially eliminated during the calendar year preceding the employer's filing of a Title XI bankruptcy,You and Your Dependents may continue health coverage under the policy for the continuation of coverage period.
- (D) If You become entitled to Medicare benefits under Title XVIII of the Social Security Act, Your Medicare ineligible spouse and Dependent eligible children may continue health coverage under the policy for the continuation of coverage period.

Continuation of Coverage Period

"Continuation of Coverage Period," as used in this provision, means the period of time ending on the earlier of:

1. 18 months following qualifying event (A) except if a qualifying event (B) occurs during these 18 months, the continuation of coverage period will be extended an additional 18 months for a total period of 36 months.
2. 36 months following qualifying event (B);
3. for a qualifying event (C):
 - a) the date of Your death, at which time Your dependents (other than Your surviving spouse in (i) below) will be entitled to continue coverage on the same basis as if a qualifying event (B) had occurred.
 - b) if You died before the occurrence of a qualifying event (C), Your surviving spouse is entitled to lifetime coverage.
4. the end of a 36-month period following an event described in qualifying event (D), without regard to whether that occurrence is a qualifying event, or for any subsequent qualifying event;

FEDERAL CONTINUATION OF HEALTH INSURANCE

5. the date You or Your dependents become covered under any other group coverage providing hospital, surgical or medical benefits, insured or self-insured, which does not contain any limitation with respect to any preexisting condition;
6. the date a Covered Person, other than those provided continuation of coverage under qualifying event (C) becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
7. the date the employer ceases to provide any group health coverage for its employees; or
8. the date any premium for continuation of coverage is not timely paid.

Requirements

You or Your Dependent must notify the employer within 60-days of the following qualifying events:

1. the date You and Your spouse were legally divorced or legally separated; or
2. the date the coverage for Your Dependent child ceases due to reaching the limiting age.

The option of electing continuation of coverage lasts for a 60-day period which begins to run at the later of either the date of the qualifying event or the date the Covered Person who would lose coverage due to the qualifying event receives notice of his or her rights to continuation of coverage.

If You or Your Dependent elects to continue coverage for the continuation of coverage period, it will be Your duty to pay each monthly premium, after the initial payment, to the employer one month in advance. The premium amount will include that part of premium formerly paid by Your employer prior to termination. Premiums for each subsequent month will be paid by You or Your Dependent without further notice from the employer.

In any event, KPIC will not be required to provide a continuation of coverage under this provision unless KPIC has received:

1. a written request for continuation, signed by You or Your Dependent; and
2. the premium for the period from the termination date to the end of the last month for which Your employer has paid the group premium.

If Your Employer Group's size changes to 19 or fewer employees and Your employer is required to comply with Cal-COBRA, this will not affect You and Your coverage if You were already enrolled in Federal COBRA.

If You (i) have elected COBRA coverage through another health plan available through Your Employer Group, and (ii) elect to receive COBRA coverage through KPIC during an Open Enrollment, You will be entitled to COBRA coverage only for the remainder, if any, of the maximum coverage period permitted by COBRA, subject to the termination provisions described above.

Extension for Disabled Covered Persons

If Social Security, under its rules, determines that a Covered Person was disabled when a qualifying event set forth in "B" occurred, the 18-month maximum period of continued health coverage for such a qualifying event may be extended 11 months for a total period of 29 months. To obtain that extension, the Covered Person must notify the employer of Social Security's determination before the initial 18-month maximum period ends.

For the continued health coverage of disabled Covered Persons that exceeds 18 months, KPIC may increase the premium it charges by as much as 50%. The employer may require the disabled Covered Persons to pay all or part of that total increased premium.

In no event will continued health coverage extend beyond the first month to begin more than 30 days after Social Security determines that the Covered Person is no longer disabled. The Covered Person must notify the employer within 30 days of the date of such a Social Security determination.

FEDERAL CONTINUATION OF HEALTH INSURANCE

Extension of Coverage After Exhaustion of COBRA

If a Covered Person has exhausted continuation of coverage under COBRA and or Cal COBRA (if applicable) and the Covered Person was entitled to less than 36 months of COBRA and or Cal COBRA (if applicable) coverage, such continuation of coverage may be extended to a maximum of 36 months from the effective date of the COBRA coverage.

Continued Health Coverage from a Prior Plan

Continued health coverage will also be provided if: a) The Policy replaced a prior benefit plan of Your employer or an associated company; and b) a person's continued health coverage under a provision of that prior plan similar to this ended due to the replacement of that prior plan. In such case, that person may obtain continued health coverage under this provision. It will be as though the Policy had been in effect when the qualifying event occurred. But no benefits will be paid under the Policy for health care expenses incurred before its effective date.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If You are called to active duty in the uniformed services, You may be able to continue Your coverage under this Policy for a limited time after You would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to Your Employer within 60 days after Your call to active duty. Please contact Your Employer to find out how to elect USERRA coverage and how much You must pay Your Employer.

CALIFORNIA REPLACEMENT AND DISCONTINUANCE

Insurance Continued from a Replaced Plan

Replaced Plan as used in this section means a Policyholder's health benefit plan which the Policyholder has replaced, not more than 60 days after its termination with This Plan.

Continued Insurance means the insurance of a Covered Person whose medical coverage under a Replaced Plan has ceased:

1. due to the Replaced Plan's termination; or
2. due to a Policyholder's termination of medical coverage under a Replaced Plan.

Continued Insurance

The effective date of a Covered Person's continued insurance will not be deferred because:

1. an Insured Employee is not actively at work on that date; or
2. a Dependent is confined in a health care facility on that date;

The Insured Employee's insurance under the plan will be the same as they would have had under the Replaced Plan until the date on which that Covered Person is: a) an Insured Employee who is actively at work; or b) a Dependent who is not confined in a health care facility.

Termination of Continued Insurance during Total Disability

The Continued Insurance of a Covered Person who became totally disabled while covered under a Replaced Plan will terminate on the earlier of these dates:

1. the date the Covered Person is no longer totally disabled; or
2. the last date of the 12-month period that follows the last day for which premiums were paid for the Covered Person's medical coverage under the replaced plan;

Unless the Covered Person is insured as otherwise provided under This Plan.

Limitations and Reductions

1. No benefits will be paid under the plan for Expenses Incurred due to an Injury or Sickness for which a Covered Person is entitled to an extension of benefits under the Replaced Plan.
2. Benefits paid under this provision will not be more than the benefits of the Replaced Plan as they would be paid if the plan had not been replaced.
3. The Continued Insurance benefits will be reduced by the amounts that are paid under a Replaced Plan for the same loss or expense.

Policy Termination during Total Disability - Extension of Benefits

The insurance of a Covered Person will be extended if:

1. the Covered Person becomes totally disabled while insured for that insurance under the plan; and
2. the Covered Person is still totally disabled on the date This Plan terminates or on the date the Covered Group ceases to be a Policyholder.

A Covered Person other than a Dependent minor is "**totally disabled**" only if in the judgment of a Physician, an illness or injury is:

1. expected to result in: death or has lasted or is expected to last for a continuous period of at least 12 months; and
2. makes the person unable, even with training, education and experience, to engage in any employment or occupation.

CALIFORNIA REPLACEMENT AND DISCONTINUANCE

A Covered Person, who is a Dependent minor, is totally disabled only if, in the judgment of a Physician, an illness or injury:

1. is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and
2. makes the person unable to engage in most of the normal activities of persons in good health of like age.

SAMPLE

COORDINATION OF BENEFITS

Application

This Coordination of Benefits provision applies when the Covered Person has coverage under more than one Plan. If this provision applies, the benefit determination rules state whether this Plan pays before or after another Plan.

The benefits of this Plan:

1. will not be reduced when this Plan is primary;
2. may be reduced when another Plan is primary and this Plan is secondary. The benefits of This Plan are reduced so that they and the benefits payable under all other Plans do not total more than 100% of the Allowable Expenses during any Calendar Year; and
3. will not exceed the benefits payable in the absence of other coverage

Order of Benefit Determination Rules

This Plan determines its order of benefits by using the first of the following that applies:

1. General: A Plan that does not coordinate with other Plans is always the primary Plan.
2. Non-dependent\Dependent: The benefits of the Plan which covers the person as a Covered Person, or subscriber (other than a Dependent) is the primary Plan; the Plan which covers the person as a Dependent is the secondary Plan.
3. Dependent Child--Parents Not Separated or Divorced: When This Plan and another Plan cover the same child as a Dependent of different parents, benefits for the child are determined as follows:
 - a) the primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The secondary Plan is the Plan of the parent whose birthday falls later in the year.
 - b) if both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the primary Plan; the Plan which covered the parent the shorter time is the secondary Plan.
 - c) if the other Plan does not have the birthday rule, but has the male\female rule and if, as a result, the Plans do not agree on an order of benefits, the rule in the other Plan will determine the order of benefits.
4. Dependent Child: Separated or Divorced Parents: If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined as follows:
 - a) first, the Plan of the parent with custody of the child;
 - b) then, the Plan of the spouse or Domestic Partner of the parent with custody of the child; and
 - c) finally, the Plan of the parent without custody of the child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the primary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the provider, if the custodial parent so requests.

5. Active/Inactive Service: The primary Plan is the Plan which covers the person as a Covered Person who is neither laid off or retired (or as that employee's Dependent). The secondary Plan is the Plan which covers that person as a laid off or retired Covered Person (or as that Covered Person's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
6. Longer\Shorter Length Of Coverage: If none of the above rules determines the order of benefits, the primary Plan is the Plan which covered a Covered Person, or subscriber the longer time. The secondary Plan is the Plan which covered that person the shorter time.

COORDINATION OF BENEFITS

Effect of Medicare

This Plan will be primary to Medicare for an active employee and Dependent spouse or Domestic Partner of such active employee. This Plan will not be primary to Medicare if the Covered Person is eligible for Medicare as primary. Any such Covered Person may not continue enrollment under This Plan. Medicare is primary for an insured retiree or the Dependent spouse or Domestic Partner of a retiree age 65 or over; this applies whether or not the retiree or spouse is enrolled in Medicare.

Members with Medicare and Retirees

This plan is not intended for retirees and most Medicare beneficiaries. If, during the term of this Group Policy, You are or become eligible for Medicare or you retire, the following will apply:

- If You are the Insured Employee and You retire, Your coverage under this Policy will be terminated and You may be eligible to continue membership as described in Your Group Policy or in the Termination of Membership section of This Plan.
- If federal law requires that Your Group's health care plan be primary and Medicare coverage be secondary, Your coverage under this Policy will be the same as it would be if You had not become eligible for Medicare.
- If none of the above applies to You and You are eligible for Medicare, please ask your Group's benefits administrator about Your membership options.

Reduction in this Plan's Benefits

When the benefits of This Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable Benefit Maximum of This Plan.

Any benefit amount not paid under This Plan because of coordinating benefits becomes a benefit credit under This Plan. This amount can be used to pay any added Allowable Expenses the Covered Person may incur during the remainder of the Calendar Year, including any coinsurance payable under This Plan.

Right to Receive and Release Information

Certain facts are needed to coordinate benefits. KPIC may get needed facts from or give them to any other organization or person. KPIC need not tell or get the consent of any person to do this. Each person claiming benefits under This Plan must give KPIC any facts it needs to pay the claim.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by KPIC is more than it should have paid, KPIC may recover the excess from one or more of the following:

1. the persons KPIC has paid or for whom it has paid.
2. insurance companies.
3. other organizations.

The "**amount of payments made**" includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION OF BENEFITS

When a Covered Person's Injury appears to be someone else's fault, benefits otherwise payable under the policy for Covered Expense incurred as a result of that Injury will not be paid unless the Covered Person or his legal representative agrees:

- a) to repay KPIC for such benefits to the extent they are for losses for which compensation is paid to the Covered Person by or on behalf of the person at fault;
- b) to allow KPIC a lien on such compensation and to hold such compensation in trust for KPIC; and
- c) to execute and give to KPIC any instruments needed to secure the rights under a) and b).

Definitions Related to Coordination of Benefits

Active Service means that a Covered Person: 1) is present at work with the intent and ability to work the scheduled hours; and 2) is performing in the customary manner the regular duties of his or her employment.

Allowable Expenses means the Maximum Allowable Charge for medical or dental care or treatment. Part of the expenses must be covered under at least one of the Plans covering the Covered Person.

Coordination of Benefits means the way benefits are payable under more than one medical or dental plan. Under Coordination of Benefits, the Covered Person will not receive more than the Allowable Expenses for a loss.

Plan means any of the following which provides medical or dental benefits or services:

1. This Plan.
2. any group, blanket, or franchise health insurance.
3. a group contractual prepayment or indemnity plan.
4. a health maintenance organization (HMO), whether a group practice or individual practice association.
5. a labor-management trustee plan or a union welfare plan.
6. an employer or multi-employer plan or employee benefit plan.
7. any government program, including Medicare, as long as benefits under such program are not, by law, excess to this Plan; and they do not expand the definition of "Allowable Expenses, as set forth above.
8. insurance required or provided by statute.

Plan does not include any:

1. individual or family policies or contracts.
2. public medical assistance programs, including benefits under Medi-Cal or California Crippled Children Services program or any other coverage provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.
3. group or group-type Hospital indemnity benefits of \$100 per day or less.
4. school accident-type coverages.
5. traditional fault automobile or no-fault automobile policies.

The benefits provided by a Plan include those that would have been provided if a claim had been duly made.

Primary Plan\Secondary Plan means that when This Plan is primary, its benefits are determined before those of the other Plan; the benefits of the other Plan are not considered. When This Plan is secondary, its benefits are determined after those of the other Plan; its benefits may be reduced because of the other Plan's benefits. When there are more than two Plans, This Plan may be primary as to one and may be secondary as to another.

CLAIM AND APPEALS PROCEDURES

This section explains provisions for filing Claims and Appeals arising from decisions made regarding benefit Claims under Your Group Policy.

This section contains the following:

- Definitions of Terms unique to this section
- General Claims and Appeals Provisions
- Internal Claims and Appeals Procedures
 - ♦ The Claims Process
 - ♦ The Internal Appeals Process
 - ♦ Providing Additional Information Regarding Your Claim
 - ♦ Pre-service Claims and Appeals
 - Pre-service Claim
 - Non-urgent pre-service Appeal
 - Urgent pre-service Appeal
 - ♦ Concurrent Care Claims and Appeals
 - Concurrent-care Claim
 - Non-urgent concurrent care Appeal
 - Urgent concurrent care Appeal
 - ♦ Post-Service Claims and Appeals
 - Post-service Claim
 - Post-service Appeal
 - ♦ Appeals of retroactive coverage termination (rescission)
 - Help With Your Appeal
- External Review

A. Definitions Related to Claims and Appeals Procedures

NOTE: For purposes of this **CLAIMS AND APPEALS PROCEDURES** section, the term “Medically Necessary” refers to both “Medically Necessary” and “Medically Necessary Treatment of Mental Health and Substance Use Disorders” as these terms are defined under the **GENERAL DEFINITIONS** section.

The following terms have the following meanings when used in this **CLAIMS AND APPEALS PROCEDURES** section:

Claim means a request for us to:

1. provide or pay for a Covered Service that You have not received (pre-service claim);
2. continue to provide or pay for a Covered Service that You are currently receiving (concurrent care claim); or
3. pay for a Covered Service that You have already received (post-service claim).

Appeal means a request for us to review our initial Adverse Benefit Determination.

Adverse Benefit Determination means our decision to do any of the following:

1. deny Your Claim, in whole or in part, including but not limited to, reduction of benefits or a failure or refusal to cover an item or service resulting from a determination that an expense is:
 - a. experimental or investigational;
 - b. not Medically Necessary or appropriate.

CLAIM AND APPEALS PROCEDURES

2. terminate Your coverage retroactively except as the result of non-payment of premiums (also known as rescission),
3. deny Your (or, if applicable, Your dependent's) application for individual plan coverage, or
4. uphold our previous Adverse Benefit Determination when You Appeal.

If You miss a deadline for making a Claim or Appeal, we may decline to review it. Except when simultaneous external review can occur, You must exhaust the internal claims and appeals procedure (as described below in this CLAIMS AND APPEALS PROCEDURES section) for Your Claim before You can request external review or seek judicial relief.

B. General Claims and Appeals Provisions

Questions about claims: For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when You call toll free number: 1-800-392-8649 or You may write to the address listed above. Claim forms are available upon request from the Administrator.

Claims related to your medical coverage under this Policy will be administered by:

NTT DATA Services
P.O. Box 261130
Plano, TX 75026

Claims related to Your dental benefits under this Policy will be administered by:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

Participating Provider Claims

If You receive services from a Participating Provider, that provider will file the claims on Your behalf. Benefits will be paid to the provider. You need to pay only Your Deductible, if any, and any Coinsurance or Copayment.

Upon receipt of due written Proof of Loss, unless the Covered Person has asked Us not to do so, KPIC may pay all or any part of the benefits provided by the Group Policy directly to the service provider. Any such payment made by KPIC in good faith will fully discharge KPIC's obligation to the extent of the payment.

Any benefits for health expenses for covered medical transportation services are payable to the provider of these services. No benefits are payable to the Covered Person to the extent benefits for the same expenses are paid to the provider.

Notice of Claim

You must give us written notice of claim within 20 days after the occurrence or commencement of any loss covered by this Policy, or as soon as reasonably possible. You may give notice or may have someone do it for You. The notice should give Your name and Your Medical Record Number shown in Your Schedule of Coverage. The notice should be mailed to our Administrator at:

NTT DATA Services
P.O. Box 261130
Plano, TX 75026

For Claims related to Your dental benefits under this Policy:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

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Claim Forms

When we receive Your notice of claim, we will send You forms for filing Proof of Loss. If we do not send You these forms within 15 days after receipt of Your notice of claim, You shall be deemed to have complied with the Proof of Loss requirements by submitting written proof covering the occurrence, character and extent of the loss, within the time limit stated in the Proof of Loss section.

Proof of Loss

You must give us written Proof of Loss, in the case of a claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which we are liable. For any other loss, You must furnish written proof within 90 days after the date of such loss. If it is not reasonably possible to give us this timely proof, we will not reduce or deny Your claim if proof is filed with us as soon as reasonably possible. In any event, proof must be furnished within 12 months from the time proof is otherwise required, unless legal capacity is absent.

"Proof of Loss" means sufficient information to allow KPIC or its Administrator to decide if a claim is payable under the terms of the Policy. The information needed to make this determination may include but is not limited to: reports of investigations concerning fraud and misrepresentation, necessary consent forms, releases and assignments, medical records, information regarding provider services, information regarding medical necessity or other necessary information requested by KPIC.

Time for Payment of Claims

Subject to due written Proof of Loss, all indemnities for loss for which this policy provides payment will be paid to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Insured Employee immediately, but no later than 30 days upon receipt of due written proof.

Payment of Claims

Subject to any written direction of the Covered Person, an application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical service may, at the Covered Person's option, and unless the Covered Person requests otherwise in writing not later than the time for filing Proof of Loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Contested Claims

If KPIC is unable to pay Your claim after receiving proper Proof of Loss, KPIC will notify You of any contest to or denial of the claim within 30 working days of the date the Proof of Loss was received by KPIC. The written notice will specify:

1. the parts of the claim that are being contested or denied;
2. the reasons the claim is being contested or denied; and
3. the pertinent provisions of the Group Policy on which the contest or denial is based.

If the Covered Person is dissatisfied with the result of the review, the Covered Person may file an appeal.

Please refer to the **Internal Claims and Appeals Procedures** subsection under this section for specific provisions for filing an appeal for each type of Claim (Pre-service; Concurrent, and Post Service) in cases of any Adverse Benefit Determination.

Right of Recovery for Overpayment

KPIC will not withhold any portion of a claim payment on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim unless:

1. KPIC's files contain clear, documented evidence of an overpayment and written authorization from the claimant or assignee, if applicable, permitting such withholding procedure; or
2. KPIC's files contain clear, documented evidence of all of the following:
 - a. The overpayment was erroneous under the provisions of the Policy;

CLAIM AND APPEALS PROCEDURES

- b. The error which resulted in the payment is not a mistake of the law;
- c. KPIC notifies the claimant within 6 months of the date of the error, except that in instances of errors prompted by representations or nondisclosure of claimants or third parties, KPIC notifies the claimant within 15 calendar days after the date of discover of such error. For the purpose of this provision, the date of the error is the day on which the draft for benefits is issued; and
- d. Such notice states clearly the cause of the error and the amount of the overpayment; however,
- e. The procedure set forth above will not be used if the overpayment is the subject of reasonable dispute as to facts.

With each payment, KPIC will provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the provider's name or service covered, dates of service, and a clear explanation of the computation of benefits. In the case of an Adverse Benefit Determination, it will also include a notice that will tell You why We denied Your claim and will include information regarding the mandatory appeals rights, including external review, that may be available to You.

NTT DATA Services

**P.O. Box 261130
Plano, TX 75026**

For claims related to Your dental benefits under this Policy:

**Delta Dental of California
P.O. Box 99733
Sacramento, CA 95899-0930**

Time Limitations

If any time limitation provided in the plan for giving notice of claims, or for bringing any action at law or in equity, is less than that permitted by the applicable law, the time limitation provided in the plan is extended to agree with the minimum permitted by the applicable law.

Legal Action

No legal action may be brought to recover on this Policy before 60 days from the date written Proof of Loss has been given to us as required under the Proof of Loss section. No such action may be brought more than 3 years after the date written proof of loss is given to us. KPIC will review Claims and Appeals, and we may use medical experts to help us review them.

Language and Translation Assistance

If we send You an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then Your notice of Adverse Benefit Determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request language assistance with Your Claim and/or Appeal by calling the number on Your ID card or 1-800-464-4000.

If we send You an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then You may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request translation of the notice by calling the number on Your ID card or 1-800-464-4000.

Appointing a Representative

If You would like someone to act on Your behalf regarding Your Claim or Appeal, You may appoint an authorized representative. You must make this appointment in writing. Please include Your representative's name, address and telephone contact information with Your Appeal or You can call 1-

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866-213-3062 to request an Authorized Representative Form. You must pay the cost of anyone You hire to represent or help You.

Kaiser Permanente Insurance Company
Appeals Department
P.O. Box 939001
San Diego, CA 92193-9001
Phone: 1-800-788-0710
Fax: 1-855-414-2318

Help with Your Claim and/or Appeal

You may also contact the:

California Department of Insurance
Office of the Ombudsman
300 Capitol Mall, Suite 1600
Sacramento, CA 95814
Consumer Phone: (916) 492-3545
E-mail: Ombudsman@insurance.ca.gov

Reviewing Information Regarding Your Claim

If You want to review the information that we have collected regarding Your Claim, You may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of Your Claim. If You have questions about the codes contained in the Explanation of Benefits and how the claims were paid with respect to those codes, You may call 1-800-392-8649.

Sharing Additional Information That We Collect

We will send You any additional information that we collect in the course of Your Appeal. If we believe that Your Appeal of our initial Adverse Benefit Determination will be denied, then before we issue our final Adverse Benefit Determination we will also share with You any new or additional reasons for that decision. We will send You a letter explaining the new or additional information and/or reasons and inform You how You can respond to the information in the letter if You choose to do so. If You do not respond before we must make our final decision, that decision will be based on the information already in Your Claim file.

C. Internal Claims and Appeals Procedures

The Claims Process

There are several types of Claims, and each has a different procedure for sending Your Claim to us as described below in this Internal Claims and Appeals Procedures subsection:

- Pre-service Claims (urgent and non-urgent)
- Concurrent care Claims (urgent and non-urgent)
- Post-service Claims

The Internal Appeals Process

In order to afford You the opportunity for a full and fair review of an Adverse Benefit Determination, the Policyholder has designated KPIC as the “named fiduciary” for appeals arising under the Group Policy. In addition, there are separate Appeals procedures for Adverse Benefit Determinations due to a retroactive termination of coverage (rescission).

If We deny Your Claim (Post Service, Pre-service or Concurrent Claims), in whole or in part, You have the right to request an Appeal of such decision. The internal Appeals process is described below. Additionally, our Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding the mandatory appeal rights, including external review, that may be available to You. We must receive Your review request within 180 days of Your receiving Our Adverse Benefit Determination. Please note that We will count the 180 days starting 5 business days from the date

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of the notice to allow for delivery time, unless You can prove that You received the notice after that 5 business day period.

Providing Additional Information Regarding Your Claim

When You Appeal, You may send us additional information including comments, documents, and additional medical records that You believe support Your Claim. If we asked for additional information and You did not provide it before we made our initial decision about Your Claim, then You may still send us the additional information so that we may include it as part of our review of Your Appeal. Please send all additional information to:

Kaiser Permanente Insurance Company (KPIC)
Appeals Department
P.O. Box 939001
San Diego, CA 92193-9001
Phone: 1-800-788-0710
Fax: 1-855-414-2318

When You Appeal, You may give testimony in writing or by telephone. Please send Your written testimony to:

Kaiser Permanente Insurance Company (KPIC)
Appeals Department
P.O. Box 939001
San Diego, CA 92193-9001
Phone: 1-800-788-0710
Fax: 1-855-414-2318

You may also fax this information to: KPIC Attn: KPIC Operations Grievance and Appeals Coordinator at (877) 727-9664

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

Pre-service Claims and Appeals. Pre-service Claims are requests that we provide or pay for a Service that You have not yet received. Failure to receive authorization before receiving a service that must be authorized or precertified in order to be a covered benefit may be the basis of reduction of Your benefits or for our denial of Your pre-service Claim or a post-service Claim for payment. If You receive any of the Covered Services You are requesting before we make our decision, Your pre-service Claim or Appeal will become a post-service Claim or Appeal with respect to those services. If You have any general questions about pre-service Claims or Appeals, please call 1-888-567-6847. Following are the procedures for filing a pre-service Claim, a non-urgent pre-service Appeal, and an urgent pre-service Appeal.

- **Pre-service Claim**

- Send Your request in writing to us that You want to make a Claim for us to provide or pay for a Covered Service You have not yet received. Your request and any related documents You give us constitute Your Claim. You must either mail Your Claim to us or, fax Your Claim to Us at:

Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Phone: 1-888-567-6847
Fax: 1-866-338-0266

- If You want us to consider Your pre-service Claim on an urgent basis, Your request should tell us that. We will decide whether Your Claim is urgent or non-urgent unless Your attending health

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care provider tells us Your Claim is urgent. If we determine that Your Claim is not urgent, we will treat Your Claim as non-urgent. Generally, a Claim is urgent only if using the procedure for non-urgent Claims (a) could seriously jeopardize Your life, health, or ability to regain maximum function, or (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 Covered Services You are requesting.

- We will review Your Claim and, if we have all the information we need, we will make a decision within a reasonable period of time but not later than 5 days after we receive Your Claim. We may extend the time for making a decision for an additional 5 days if circumstances beyond our control delay our decision, if we notify You prior to the expiration of the initial 5 day period. If we tell You we need more information, we will ask You for the information within the initial 5 day decision period, and we will give You 45 days to send the information. We will make a decision within 5 days after we receive the first piece of information (including documents) we requested. We encourage You to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 5 days following the end of the 45 day period. We will send written notice of our decision to You and, if applicable to Your provider.
 - If Your pre-service Claim was considered on an urgent basis, we will notify You of our decision orally or in writing within a timeframe appropriate to Your clinical condition but not later than 72 hours after we receive Your Claim. Within 24 hours after we receive Your Claim, we may ask You for more information. We will notify You of our decision within 48 hours of receiving the first piece of requested information. If we do not receive any of the requested information, then we will notify You of our decision within 48 hours after making our request. If we notify You of our decision orally, we will send You written confirmation within 3 days after that.
 - If we deny Your Claim (if we do not agree to provide or pay for all the Covered Services You requested), our Adverse Benefit Determination notice will tell You why we denied Your Claim and how You can Appeal.
- **Non-urgent pre-service Appeal**
 - Within 180 days after You receive our Adverse Benefit Determination notice, You must tell us in writing that You want to Appeal our denial of Your pre-service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) the specific Service that You are requesting, (4) all of the reasons why You disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute Your Appeal. You must either mail Your Appeal to:

**Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Phone: 1-888-567-6847
Fax: 1-866-338-0266**

- Or, Fax Your Claim to : KPIC Attn: KPIC Operations Grievance and Appeals Coordinator at (877) 727-9664.
- We will review Your Appeal and send You a written decision within 30 days after we receive Your Appeal.

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- If we deny Your Appeal, our Adverse Benefit Determination notice will tell You why we denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.
- **Urgent pre-service Appeal**
 - Tell us that You want to urgently Appeal our Adverse Benefit Determination regarding Your pre-service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) the specific Service that You are requesting, (4) all of the reasons why You disagree with our Adverse Benefit Determination, and (5) all supporting documents. Your request and the supporting documents constitute Your Appeal. You must send Your appeal to:

**Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Fax: 1-866-338-0266**

To file an oral appeal, call: 1-888-567-6847

- When You send Your Appeal, You may also request simultaneous external review of our initial Adverse Benefit Determination. If You want simultaneous external review, Your Appeal must tell us this. You will be eligible for the simultaneous external review only if Your pre-service Appeal qualifies as urgent. If You do not request simultaneous external review in Your Appeal, then You may be able to request external review after we make our decision regarding Your Appeal (see “**External Review**” provision under in this **CLAIMS AND APPEALS PROCEDURES** section), if our internal appeal decision is not in Your favor.
- We will decide whether Your Appeal is urgent or non-urgent unless Your attending health care provider tells us Your Appeal is urgent. If we determine that Your Appeal is not urgent, we will treat Your Appeal as non-urgent. Generally, an Appeal is urgent only if using the procedure for non-urgent Claims or Appeals (a) could seriously jeopardize Your life, health, or ability to regain maximum function, or (b) could, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the Services You are requesting.
- We will review Your appeal and give You oral or written notice of our decision as soon as Your clinical condition requires, but not later than 72 hours after we received Your Appeal. If we notify You of our decision orally, we will send You a written confirmation within 3 days after that.
- If we deny Your Appeal, our Adverse Benefit Determination notice will tell You why we denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.

Concurrent Care Claims and Appeals. Concurrent care Claims are requests that KPIC continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If You have any general questions about concurrent care Claims or Appeals, please call 1-888-567-6847.

If we either (a) deny Your request to extend Your current authorized ongoing care (Your concurrent care Claim) or (b) inform You that authorized care that You are currently receiving is going to end early and You Appeal our Adverse Benefit Determination at least 24 hours before Your ongoing course of covered treatment will end, then during the time that we are considering Your Appeal, You may continue to receive the authorized Covered Services. If You continue to receive these Covered Services while we consider

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Your Appeal and Your Appeal does not result in our approval of Your concurrent care Claim, then You will have to pay for the Services that we decide are not covered.

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

- **Concurrent care Claim**

- Tell us in writing that You want to make a concurrent care Claim for an ongoing course of covered treatment. Inform us in detail of the reasons that Your authorized ongoing care should be continued or extended. Your request and any related documents You give us constitute Your Claim. You must mail Your Claim to us at:

**Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Fax: 1-866-338-0266
Phone: 1-888-567-6847**

- If You want us to consider Your Claim on an urgent basis and You contact us at least 24 hours before Your care ends, You may request that we review Your concurrent Claim on an urgent basis. We will decide whether Your Claim is urgent or non-urgent unless Your attending health care provider tells us Your Claim is urgent. If we determine that Your Claim is not urgent, we will treat Your Claim as non-urgent. Generally, a Claim is urgent only if using the procedure for non-urgent Claims (a) could seriously jeopardize Your life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without extending Your course of covered treatment.
- We will review Your Claim, and if we have all the information we need we will make a decision within a reasonable period of time. If You submitted Your Claim 24 hours or more before Your care is ending, we will make our decision before Your authorized care actually ends. If Your authorized care ended before You submitted Your Claim, we will make our decision but no later than 5 days after we receive Your Claim. We may extend the time for making a decision for an additional 5 days if circumstances beyond our control delay our decision, if we send You notice before the initial 5 day decision period ends. If we tell You we need more information, we will ask You for the information before the initial decision period ends, and we will give You until Your care is ending or, if Your care has ended, 45 days to send us the information. We will make our decision as soon as possible, if Your care has not ended, or within 5 days after we first receive any information (including documents) we requested. We encourage You to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within the stated timeframe after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 5 days following the end of the timeframe we gave You for sending the additional information.
- We will send written notice of our decision to You and, if applicable to Your provider.
- If we consider Your concurrent Claim on an urgent basis, we will notify You of our decision orally or in writing as soon as Your clinical condition requires, but not later than 24 hours after we received Your Appeal. If we notify You of our decision orally, we will send You written confirmation within 3 days after receiving Your Claim.

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- If we deny Your Claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our Adverse Benefit Determination notice will tell You why we denied Your Claim and how You can Appeal.
- **Non-urgent concurrent care Appeal**
 - Within 180 days after You receive our Adverse Benefit Determination notice, You must tell us in writing that You want to Appeal our Adverse Benefit Determination. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) the ongoing course of covered treatment that You want to continue or extend, (4) all of the reasons why You disagree with our Adverse Benefit Determination, and (5) all supporting documents. Your request and all supporting documents constitute Your Appeal. You must mail Your Appeal to:

**Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Fax: 1-866-338-0266
Phone: 1-888-567-6847**

- We will review Your Appeal and send You a written decision as soon as possible if Your care has not ended but not later than 30 days after we receive Your Appeal.
- If we deny Your Appeal, our Adverse Benefit Determination decision will tell You why we denied Your Appeal and will include information about any further process, including external review, that may be available to You.
- **Urgent concurrent care Appeal**
 - Tell us that You want to urgently Appeal our Adverse Benefit Determination regarding Your urgent concurrent Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) the ongoing course of covered treatment that You want to continue or extend, (4) all of the reasons why You disagree with our Adverse Benefit Determination, and (5) all supporting documents. Your request and the supporting documents constitute Your Appeal.
 - Call our Expedited Review Unit toll free at 1-888-987-7247 (TTY users call [1-800-777-1370]), which is available Monday through Saturday from 8:30 a.m. to 5 p.m. After hours, You may leave a message and a representative will return Your call the next business day

Send Your written request to:

**Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Fax: 1-866-338-0266**

To file an oral appeal, call: 1-888-567-6847

- When You send Your Appeal, You may also request simultaneous external review of our Adverse Benefit Determination. If You want simultaneous external review, Your Appeal must tell us this. You will be eligible for the simultaneous external review only if Your concurrent care Claim qualifies as urgent. If You do not request simultaneous external review in Your Appeal, then You

CLAIM AND APPEALS PROCEDURES

may be able to request external review after we make our decision regarding Your Appeal (see External Review provision under this **CLAIMS AND APPEALS PROCEDURES** section).

- We will decide whether Your Appeal is urgent or non-urgent unless Your attending health care provider tells us Your Appeal is urgent. If we determine that Your Appeal is not urgent, we will treat Your Appeal as non-urgent. Generally, an Appeal is urgent only if using the procedure for non-urgent Appeals (a) could seriously jeopardize Your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without continuing Your course of covered treatment.
- We will review Your Appeal and notify You of our decision orally or in writing as soon as Your clinical condition requires, but no later than 72 hours after we receive Your Appeal. If we notify You of our decision orally, we will send You a written confirmation within 3 days after that.
- If we deny Your Appeal, our Adverse Benefit Determination notice will tell You why we denied Your Appeal and will include information about any further process, including external review, that may be available to You.

Post-Service Claims and Appeals. Post-service Claims are requests that we pay for services You already received. If You have any general questions about post-service Claims or Appeals, please call 1-866-213-3062.

Here are the procedures for filing a post-service Claim and a post-service Appeal:

- **Post-service Claim**

- In accordance with the provisions of the **Notice of Claim** subsection of this **CLAIMS AND APPEALS PROCEDURES** section of this Certificate, Within 20 days after the date You received or paid for the Services, or as soon as reasonably possible, You must mail Us a Notice of Claim for the Covered Services for which You are requesting payment. The Notice should contain the following: (1) the date You received the Covered Services, (2) where You received them, (3) who provided them, and (4) why You think we should pay for the Covered Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute Your Claim. You must mail the Notice to our Administrator at:

**NTT DATA Services
11830 Webb Chapel
Dallas, TX 75234**

For claims related to Your dental benefits under this Policy:

**Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330**

- We will review Your Claim, and if we have all the information we need we will send You a written decision within 30 days after we receive Your Claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify You within 30 days after we receive Your Claim. If we tell You we need more information, we will ask You for the information before the end of the initial 30 day decision period ends, and we will give You 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage You to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents)

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within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45 day period.

- If we deny Your Claim (if we do not pay for all the Services You requested), our Adverse Benefit Determination notice will tell You why we denied Your Claim and how You can Appeal.

- **Post-service Appeal**

- Within 180 days after You receive our Adverse Benefit Determination, tell us in writing that You want to Appeal our denial of Your post-service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) the specific Covered Services that You want us to pay for, (4) all of the reasons why You disagree with our Adverse Benefit Determination, and (5) include all your supporting documents. Your request and the supporting documents constitute Your Appeal. You must either mail Your Appeal to:

Kaiser Permanente Insurance Company (KPIC)
Appeals Department
P.O. Box 939001
San Diego, CA 92193-9001
Phone: 1-800-788-0710
Fax: 1-855-414-2318

- We will review Your Appeal and send You a written decision within 60 days after we receive Your Appeal.
- If we deny Your Appeal, our Adverse Benefit Determination will tell You why we denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.

Appeals of retroactive coverage termination (rescission). We may terminate Your coverage retroactively (see D. **Rescission for Fraud or Intentional Misrepresentation** provision under the **ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE** section). We will send You written notice at least 30 days prior to the termination. If You have general questions about retroactive coverage terminations or Appeals, please write us.

Kaiser Permanente
P.O. Box 41912
Los Angeles, CA 90041-1912

Here is the procedure for filing an Appeal of a retroactive coverage termination:

- **Appeal of retroactive coverage termination**

- Within 180 days after You receive our Adverse Benefit Determination that Your coverage will be terminated retroactively, You must tell us in writing that You want to Appeal our termination of Your coverage retroactively. Please include the following: (1) Your name and Medical Record Number, (2) all of the reasons why You disagree with our retroactive coverage termination, and (3) all supporting documents. Your request and the supporting documents constitute Your Appeal. You must either mail Your Appeal to:

Kaiser Permanente
P.O. Box 41912
Los Angeles, CA 90041-1912

- We will review Your Appeal and send You a written decision within 60 days after we receive Your Appeal.

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- If we deny Your Appeal, our Adverse Benefit Determination notice will tell You why we denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.

- **Help With Your Appeal.**

You may contact the state ombudsman:

**California Department of Insurance
Office of the Ombudsman
300 Capitol Mall, Suite 1600
Sacramento, CA 95814
Consumer Phone: (916) 492-3545
E-mail: ombudsman@insurance.ca.gov**

D. External Review

If You are dissatisfied with Our final Adverse Benefit Determination, You may have a right to request an external review. For more information about how to obtain this review, please call KPIC toll free number at: 1-800-464-4000 or call the:

**California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-927-4TDD
(1-800-482-4333)**

The Covered Person may write the California Department of Insurance at:

**California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013**

Or You can log in to the California Department of Insurance website at:
www.insurance.ca.gov

Except when external review is permitted to occur simultaneously with Your urgent pre-service Appeal or urgent concurrent care Appeal, You must exhaust Our internal claims and Appeals procedure for Your Claim before You may request external review unless We have failed to comply with federal requirements regarding Our Claims and Appeals procedures.

If the external reviewer overturns Our decision with respect to any Covered Service, We will provide coverage or payment for that Covered Service as directed.

Please refer to the **INDEPENDENT MEDICAL REVIEW IMPORTANT NOTICE** section for a more detailed explanation of Your right to an External Review.

If You miss a deadline for making a Claim or Appeal, We may decline to review it.

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. To understand these rights, You should check with Your benefits office or contact the

CLAIM AND APPEALS PROCEDURES

Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if Your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), You may have a right to request review in state court. The state ombudsman listed below should be able to help You understand any further review rights available to You.

SAMPLE

CLAIMS DISPUTE IMPORTANT NOTICE

If a Covered Person believes a claim has been wrongfully denied or rejected, the Covered Person may have the matter reviewed by the California Department of Insurance. However, the Covered Person should first contact KPIC to try and resolve the dispute. If the dispute is not resolved, the Covered Person may contact the California Department of Insurance. The Department of Insurance should be contacted only after discussions with KPIC, or its agent or other representative.

The Covered Person may call KPIC to make a complaint concerning a claim at the following number:

(800) 392-8649

The Covered Person may also write to KPIC at:

**Kaiser Permanente Insurance Company
P.O. Box 261155
Plano, TX. 75026**

The Covered Person may contact the California Department of Insurance to obtain information on companies, coverage, rights or complaints at:

**1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4839)**

The Covered Person may write the California Department of Insurance at:

**California Department of Insurance
Consumer Communications Bureau
100 S. Spring Street
Los Angeles, CA 90013**

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW

If You believe that health care services have been improperly denied, modified, or delayed, You may have the right to an independent medical review. For more information about how to obtain this review, please call KPIC toll free number at 1-800-392-8649 or call the California Department of Insurance at:

**1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)**

The Covered Person may write the California Department of Insurance at:

**California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013**

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

You have the right to an independent medical review upon the concurrence of the following:

1. You believe that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers;
2. You have a Life-threatening or Seriously Debilitating Condition;
 - a) Duly certified by Your Physician, for which:
 - i. standard therapies have not been effective in improving Your condition; or
 - ii. standard therapies would not be Medically Necessary or Medically Necessary Treatment of Mental Health and Substance Use Disorders; or
 - iii. there is other beneficial therapy covered under this Group Policy other than the proposed experimental or investigational therapy; and
 - b) Your contracting Physician has recommended a drug, device, procedure or therapy duly certified by him in writing that it is likely to be more beneficial than any available standard therapy; or You or Your Physician duly licensed and board certified to practice in the area of practice appropriate for Your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial to You than any other available therapy.
 - c) The Physician's certification shall contain a statement of the evidence relied upon by him in making the above recommendation;
 - d) Such recommendation or request as stated in item number 3 above has been denied, delayed or modified by us based on Medical Necessity;
 - e) The therapy, drug, device or procedure would otherwise be covered under the Group Policy were it not determined by us that such therapy, drug, device or procedure is experimental or investigational.
 - f) Upon denial of coverage as stated in item c) above, a notice shall be sent to You, explaining in detail Your rights under this process.
3. Your membership was terminated retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.
4. If we continue to deny the payment, coverage or service requested or You do not receive a timely decision.

YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW

The external independent review is conducted by an independent third party which may be one of the following:

1. An independent review organization (IRO) selected from a list of randomly assigned Independent Review Organizations (IROs) provided by the California Department of Insurance; or
2. An entity contracted directly with the California Department of Insurance to conduct external reviews.

If Your coverage is through an employer group subject to the Employee Retirement Security Income Act of 1974 (ERISA), You may also have the right to bring a civil action under section 502(a) of ERISA, as then constituted or later amended. To determine if Your plan is covered by ERISA, please check with Your employer.

Definitions

For the purpose of this Section of the Certificate, the following definitions apply:

"Life-threatening" means either or both of the following:

1. Sickness or Injury where the likelihood of death is high unless the course of the Sickness is interrupted.
2. Sickness or Injury with potentially fatal outcomes, where the end point of clinical intervention is survival.

"Seriously Debilitating Condition" means Sickness or Injury that causes major irreversible morbidity.

NOTE: Notwithstanding the foregoing, the effective date of implementation by KPIC of the above requirements are subject to the provisions under ACA, as then constituted or later amended, or subject to the provisions under any interim final regulations promulgated by any government agency in the implementation of the provisions of the ACA.

GENERAL PROVISIONS

Time Effective

The effective time for any dates used is 12:01 AM. at the address of the Policyholder.

Time Limit on Certain Defenses

After two years from the date of issue of this Group Policy, no misstatements, made by the Policyholder in the application for the Group Policy shall be used to void the Group Policy, or to deny, contest or reduce a claim.

Misstatement of Age

If the age of any person insured under This Plan has been misstated: 1) premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

Physical Examination and Autopsy

KPIC, at its own expense, shall have the right and opportunity to examine the person of any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

Assignment

Payment of benefits under this Group Policy for treatment or services that are not provided, prescribed or directed by Participating Providers are not assignable and thereby not binding on KPIC, unless previously approved by KPIC in writing.

Payment of benefits shall be made by KPIC directly to the provider, including medical transportation providers (ambulance), certified nurse-midwives, nurse practitioners and licensed midwives, or to the Insured or Dependent or, in the case of the Insured's death, to his or her executor, administrator, provider, spouse or relative.

Surrogacy Arrangement

If You enter into a surrogacy arrangement and You or any other payee are entitled to receive payments or other compensation under the surrogacy arrangement, You must reimburse Us for Covered Services You receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. A "surrogacy arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.

Note: This "Surrogacy Arrangements" provision does not affect Your obligation to pay Your Cost Share for these Covered Services. After You surrender a baby to the legal parents, You are not obligated to reimburse Us for any Covered Services that the baby receives after the date of surrender (the legal parents are financially responsible for any services that the baby receives).

GENERAL PROVISIONS

By accepting Surrogacy Health Services, You automatically assign to Us Your right to receive payments that are payable to You or any other payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure Our rights, We will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy Our lien. The assignment and Our lien will not exceed the total amount of Your obligation to Us under the preceding paragraph.

Within 30 days after entering into a surrogacy arrangement, You must send written notice of the arrangement, including all of the following information:

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

You must send this information to:

Kaiser Permanente Insurance Company
P.O. Box 261155
Plano, TX 75026

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

If Your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, Your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if You had asserted the claim against the third party. We may assign Our rights to enforce Our liens and other rights.

If You have questions about Your obligations under this provision, please contact Us by calling the phone number listed on Your ID card.

Money Payable

All sums payable by or to KPIC or its Administrator must be paid in the lawful currency of the United States.

Notice of Termination of Provider

KPIC will provide written notice to the Group Policyholder of any termination, permanent breach of contract by, or permanent inability to perform of any Participating Provider, if the termination, breach or inability would materially and adversely affect the Covered Person. The Group Policyholder shall distribute to the Insured Employee the substance of such notice within 30 days of receipt.

GENERAL PROVISIONS

Rights of a Custodial Parent

If the parents of a covered Dependent child are:

1. divorced or legally separated; and
2. subject to the same Order,

The custodial parent will have the rights stated below without the approval of the non-custodial parent. However, for this provision to apply the non-custodial parent must be a Covered Person approved for family health coverage under the Policy, and KPIC must receive:

1. a request from the custodial parent who is not a Covered Person under the policy; and
2. a copy of the Order.

If all of these conditions have been met, KPIC will:

- A. provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Policy;
- B. accept claim forms and requests for claim payment from the custodial parent; and
- C. make claim payments directly to the custodial parent for claims submitted by the custodial parent, subject to all the provisions stated in the Policy. Payment of claims to the custodial parent, which are made in good faith under this provision, will fully discharge KPIC's obligations under the Policy to the extent of the payment.

KPIC will continue to comply with the terms of the Order until We determine that:

- A. the Order is no longer valid;
- B. the Dependent child has become covered under other health insurance or health coverage;
- C. in the case of employer-provided coverage, the employer has stopped providing family coverage for all employees; or
- D. the Dependent child is no longer a Covered Person under the Policy.

"Order" means a valid court or administrative order that:

1. determines custody of a minor child; and
2. requires a non-custodial parent to provide the child's medical insurance coverage or to pay any portion of the medical expenses resulting from medical treatment of the child.

Completion of Covered Services by Terminated Provider

If You or Your Dependent are currently receiving Covered Services with a Terminated Participating Provider, You or Your Dependent may be eligible to continue receiving benefits at the Participating Provider tier, if You or Your Dependent is undergoing a course of treatment for any of the following conditions:

1. Acute Condition;
2. Serious Chronic Condition;
3. Pregnancy and immediate postpartum care;
4. Maternal Mental Health;
5. Terminal illness;
6. Care of children under age 3; or
7. Surgery or other procedure duly recommended and documented by the Terminated Participating Provider to occur within 180 days of the termination of the contract with the Participating Provider.

Duration of completion of Covered Services shall be provided as follows:

1. For Acute Condition – completion of Covered Services shall be provided until the Acute Condition ends.
2. For Serious Chronic condition – completion of Covered Services shall be provided until the earlier of:
 - a. twelve (12) months from the contract termination date with the Participating Provider; or

GENERAL PROVISIONS

- b. the first day when it would be safe to transfer Your care to a Participating Provider.
3. For Pregnancy and immediate postpartum care – completion of Covered Services shall be provided until the duration of the pregnancy and immediate postpartum care.
4. For Maternal Mental Health Condition - completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
5. For Terminal illness – completion of Covered Services shall be provided until the duration of the illness
6. For Care of children under age 3 – completion of Covered Services shall be provided until the earlier of:
 - a. twelve months from the termination date of the Terminated Participating Provider; or
 - b. the child's third birthday

To continue receiving benefits at the Participating Provider tier, all the following requirements must be met:

1. You must make the request for completion of a Covered Service within a reasonable time from the termination date of the Terminated Provider;
2. You or Your Dependent must be undergoing treatment with a Terminated Participating Provider under any of the above conditions;
3. The treatment must be for Medically Necessary Covered Services that are Medically Necessary or Medically Necessary Treatment of Mental Health and Substance Use Disorders;
4. You or Your Dependent are eligible to receive benefits under the Group Policy at the time of receipt of the service; and
5. The terminated Participating Provider agrees in writing to the same contractual terms and conditions that were imposed upon the Terminated Participating Provider by KPIC or KPIC's provider network prior to the termination of the contract.

For purposes of this subsection, the following definitions apply:

Acute Condition means medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration.

Maternal Mental Health Condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

Pregnancy means the three trimesters of pregnancy.

Serious Chronic Condition means an illness or other medical condition that is serious, if one of the following is applicable about the condition:

- 1) it persists without full cure;
- 2) it worsens over an extended period of time; or
- 3) it requires ongoing treatment to maintain remission or prevent deterioration.

Terminal Illness means an incurable or irreversible illness that has a high probability of causing death within a year or less.

Terminated Participating Provider means a provider whose written contract with KPIC or KPIC's contracted provider network has been terminated. A Terminated Participating Provider is not a provider who voluntarily leaves KPIC or KPIC's contracted provider network.

Continuity of Care for New Covered Persons by Non-Participating Providers

If You are a new Covered Person and currently receiving Covered Services from a Non-Participating Provider, benefits under the Group Policy are payable at the Non-Participating Provider tier. In order for

GENERAL PROVISIONS

benefits to be payable at the Participating Provider tier, You must receive care from a Participating Provider.

A current copy of KPIC's directory of Participating Providers is available from Your employer. To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory.

Value-Added Services

Voluntary health promotion programs may be available to You. These value-added services are offered in conjunction with this Plan and are not Covered Services under the Group Policy. Please call KPIC at the number on Your ID card to learn more about the value-added services which may be available to You.

For purposes of this section, "health promotion programs" means value-added services offered to Covered Persons that do not constitute Covered Services under the Group Policy. These services may be discontinued at any time without prior notice.

SAMPLE

SAMPLE

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, California 94612

PPO-COI-SG-Std (2022)

Additional Information and Forms Applicable to Your Insurance Coverage

Please note the following pages are not part of the employer group insurance policy.

The following pages contain information we are required to provide you.

SAMPLE

HIPAA Notice of Privacy Practices

KAISER PERMANENTE INSURANCE COMPANY ("KPIC")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In this Notice we use the terms "we," "us" and "our" to describe KPIC.

I. WHAT IS "PROTECTED HEALTH INFORMATION"?

Your protected health information ("PHI") is individually identifiable health information, including demographic information, about your past, present or future physical or mental health or condition, health care services you receive, and past, present or future payment for your health care. Demographic information means information such as your name, social security number, address, and date of birth.

PHI may be in oral, written or electronic form. Examples of PHI include your medical record, claims record, enrollment or disenrollment information, and communication between you and your health care provider about your care.

With the exception of those insured in California, your individually identifiable health information ceases to be PHI 50 years after your death.

II. ABOUT OUR RESPONSIBILITY TO PROTECT YOUR PHI

By law, we must

1. protect the privacy of your PHI;
2. tell you about your rights and our legal duties with respect to your PHI;
3. notify you if there is a breach of your unsecured PHI; and
4. tell you about our privacy practices and follow our Notice currently in effect.

We take these responsibilities seriously, and have put in place administrative safeguards (such as security awareness training and policies and procedures), technical safeguards (such as encryption and passwords), and physical safeguards (such as locked areas and requiring badges) to protect your PHI and, as in the past, we will continue to take appropriate steps to safeguard the privacy of your PHI.

III. YOUR RIGHTS REGARDING YOUR PHI

This section tells you about your rights regarding your PHI, and describes how you can exercise these rights.

Your right to access and amend your PHI

Subject to certain exceptions, you have the right to view or get a copy of your PHI that we maintain in records relating to your care or decisions about your care or payment for your care. Requests must be in writing.

After we receive your written request, we will let you know when and how you can see or obtain a copy of your record. If you agree, we will give you a summary or explanation of your PHI instead of providing copies. We may charge you a fee for the copies, summary or explanation.

If we do not have the record you asked for but we know who does, we will tell you who to contact to request it. In limited situations, we may deny some or all of your request to see or receive copies of your records, but if we do, we will tell you why in writing and explain your right, if any, to have our denial reviewed.

If you believe there is a mistake in your PHI or that important information is missing, you may request that we correct or add to the record. Requests must be in writing, telling us what corrections or additions you are requesting, and why the corrections or additions should be made. We will respond in writing after reviewing your request. If we approve your request, we will make the correction or addition to your PHI. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement.

Submit all written requests to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

Your right to choose how we send PHI to you or someone else
You may ask us to send your PHI to you at a different address (for example, your work address) or by different means (for example, fax instead of regular mail).

If your PHI is stored electronically, you may request a copy of the records in an electronic format offered by KPIC. You may also make a specific written request to KPIC to transmit the electronic copy to a designated third party.

If the cost of meeting your request involves more than a reasonable amount, we are permitted to charge you our costs that exceeds that amount.

Your right to an accounting of disclosures of PHI
You may ask us for a list of our disclosures of your PHI. Write to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional accountings less than 12 months later, we may charge a fee.

An accounting does not include certain disclosures, for example, disclosures:

- to carry out treatment, payment and health care operations;
- for which KPIC had a signed authorization;
- of your PHI to you;
- for notifications for disaster relief purposes;
- to persons involved in your care and persons acting on your behalf; or
- not covered by the right to an accounting.

Your right to request limits on uses and disclosures of your PHI

You may request that we limit our uses and disclosures of your PHI for treatment, payment and health

care operations purposes. We will review and consider your request. You may write to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

Your right to receive a paper copy of this Notice

You have a right to receive a paper copy of this Notice upon request.

IV. HOW WE MAY USE AND DISCLOSE YOUR PHI

Your confidentiality is important to us. Our employees are required to maintain the confidentiality of the PHI of our insureds and we have policies and procedures and other safeguards to help protect your PHI from improper use and disclosure. Sometimes we are allowed by law to use and disclose certain PHI without your written permission. We briefly describe these uses and disclosures below and give you some examples.

How much PHI is used or disclosed without your written permission will vary depending, for example, on the intended purpose of the use or disclosure. Sometimes we may only need to use or disclose a limited amount of PHI, such as to confirm that you are KPIC-insured. At other times, we may need to use or disclose more PHI such as when we assist in resolving an appeal or grievance.

- **Payment:** Your PHI may be needed to determine our responsibility to pay for, or to permit us to bill and collect payment for, treatment and health-related services that you receive. When you or a provider sends us the bill for health care services, we use and disclose your PHI to determine how much, if any, of the bill you are responsible for paying.
- **Health care operations:** We may use and disclose your PHI for certain health care operations, for example, quality assessment and improvement, licensing, accreditation, activities relating to the creation, renewal or replacement of health insurance or health benefits; conducting medical review, legal services; auditing functions, including fraud and abuse detection and compliance programs; customer service, underwriting, and determining premiums and other aspects of providing health care.
- **Business associates:** We may contract with business associates to perform certain functions or activities on our behalf, such as payment and health care operations. These business associates must agree to safeguard your PHI.
- **Specific types of PHI:** There are stricter requirements for use and disclosure of some types of PHI, for example, mental health and drug and alcohol abuse patient information, mental health records, and HIV tests, and genetic testing information. However, there are still circumstances in which these types of information may be used or disclosed without your authorization.
- **Underwriting:** We may use and disclose your PHI, to the extent permitted under applicable law, for underwriting purposes, including the determination of benefit eligibility and costs of coverage and to perform other activities related to issuing a benefit policy. However, we are prohibited from using or disclosing your genetic information for underwriting purposes. Your genetic information includes information about your genetic tests, your family members' genetic tests, and requests for or receipt of genetic services by you or any family members.
- **Communications with family and others when you are present:** Sometimes a family member or other person involved in your care will be present when we are discussing your PHI with you. If you object, please tell us and we won't discuss your PHI or we will ask the person to leave.

- **Communications with family and others when you are not present:** There may be times when it is necessary to disclose your PHI to a family member or other person involved in your care because there is an emergency, you are not present, or you lack the decision-making capacity to agree or object. In those instances, we will use our professional judgment to determine if it's in your best interest to disclose your PHI. If so, we will limit the disclosure to the PHI that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.
- **Disclosure in case of disaster relief:** We may disclose your name, city of residence, age, gender, and general condition to a public or private disaster relief organization to assist disaster relief efforts, unless you object at the time.
- **Disclosures to parents as personal representatives of minors:** In most cases, we may disclose your minor child's PHI to you. In some situations, however, we are permitted or even required by law to deny your access to your minor child's PHI. Examples of when we must deny such access include your minor child's PHI regarding drug or addiction, certain mental health services, and venereal disease.
- **Public health activities:** Public health activities cover many functions performed or authorized by government agencies to promote and protect the public's health and may require us to disclose your PHI.
 - For example, we may disclose your PHI as part of our obligation to report to public health authorities certain diseases, injuries, conditions, and vital events such as births. Sometimes we may disclose your PHI to someone you may have exposed to a communicable disease or who may otherwise be at risk of getting or spreading the disease.
 - The Food and Drug Administration (FDA) is responsible for tracking and monitoring certain medical products, such as pacemakers and hip replacements, to identify product problems and failures and injuries they may have caused. If you have received one of these products, we may use and disclose your PHI to the FDA or other authorized persons or organizations, such as the maker of the product.
 - We may use and disclose your PHI as necessary to comply with federal and state laws that govern workplace safety.
- **Health oversight:** As a health insurer, we are subject to oversight conducted by federal and state agencies. These agencies may conduct audits of our operations and activities and in that process, they may review your PHI.
- **Disclosures to your employer or your employee organization:** If you are enrolled in a KPIC health insurance plan through your employer or employee organization, we may share certain PHI with them without your authorization, but only when allowed by law. For example, we may disclose your PHI for a workers' compensation claim or to determine whether you are enrolled in the plan or whether premiums have been paid on your behalf. For other purposes, such as for inquiries by your employer or employee organization on your behalf, we will obtain your authorization when necessary under applicable law.
- **Workers' compensation:** We may use and disclose your PHI in order to comply with workers' compensation laws. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers' compensation benefits.
- **Military activity and national security:** We may sometimes use or disclose the PHI of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your PHI to authorized federal

officials as necessary for national security and intelligence activities or for protection of the President and other government officials and dignitaries.

- **Required by law:** In some circumstances federal or state law requires that we disclose your PHI to others. For example, the Secretary of the Department of Health and Human Services may review our compliance efforts, which may include seeing your PHI.
- **Lawsuits and other legal disputes:** We may use and disclose PHI in responding to a court or administrative order, a subpoena, or a discovery request. We may also use and disclose PHI to the extent permitted by law without your authorization, for example, to defend a lawsuit or arbitration.
- **Law enforcement:** We may disclose PHI to authorized officials for law enforcement purposes, for example, to respond to a search warrant, report a crime on our premises, or help identify or locate someone.
- **Abuse or neglect:** By law, we may disclose PHI to the appropriate authority to report suspected child abuse or neglect or to identify suspected victims of abuse, neglect, or domestic violence.
- **Coroners and funeral directors:** We may disclose PHI to a coroner or medical examiner to permit identification of a body, determine cause of death, or for other official duties. We may also disclose PHI to funeral directors.
- **Inmates:** Under the federal law that requires us to give you this Notice, inmates do not have the same rights to control their PHI as other individuals. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your PHI to the correctional institution or the law enforcement official for certain purposes, for example, to protect your health or safety or someone else's.

V. ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

Except for those uses and disclosures described above, we will not use or disclose your PHI without your written authorization. Some instances in which we may request your authorization for use or disclosure of PHI are:

- **Marketing:** We may ask for your authorization in order to provide information about products and services that you may be interested in purchasing or using. Note that marketing communications do not include our contacting you with information about treatment alternatives, prescription drugs you are taking or health-related products or services that we offer or that are available only to our health plan enrollees. Marketing also does not include any face-to-face discussions you may have with your providers about products or services.
- **Sale of PHI:** We may only sell your PHI if we received your prior written authorization to do so.

When your authorization is required and you authorize us to use or disclose your PHI for some purpose, you may revoke that authorization by notifying us in writing at any time. Please note that the revocation will not apply to any authorized use or disclosure of your PHI that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health insurance from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

VI. HOW TO CONTACT US ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice, or want to lodge a complaint about our privacy practices, please let us know by calling or writing to:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

You also may notify the Secretary of the Department of Health and Human Services (HHS).

We will not take retaliatory action against you if you file a complaint about our privacy practices.

VII. CHANGES TO THIS NOTICE

We may change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. If we make an important change to our privacy practices, we will promptly change this Notice and notify you via the U.S. Postal Service that the change has been made along with instructions for obtaining the new notice.

Except for changes required by law, we will not implement an important change to our privacy practices before we revise this Notice.

VIII. EFFECTIVE DATE OF THIS NOTICE

This Notice is effective on September 23, 2013.



PRIVACY NOTICE

Privacy Policy and Practices

This notice describes the privacy policy and practices regarding non-public personal information followed by Kaiser Permanente Insurance Company (herein referred to as "KPIC", "we", "us", and "our"). This notice is provided to you in compliance with the Gramm-Leach-Bliley Financial Services Modernization Act.

Collection of Non-public Personal Information

The types of non-public personal information that we may collect includes, but are not limited to:

- Information we receive from you as part of application forms, enrollment forms, claims forms, pre-certification/utilization reviews, etc, including, but not limited to, your name, address, sex, date of birth, Social Security number, marital status, dependents, and the identity of your employer.
- Information otherwise legally obtained by us, including information you authorize us to receive and/or resulting from your transactions with us, our affiliates, or non-affiliated third parties, including, but not limited to, medical information and claims history.

Disclosure of Non-public Personal Information

Unless otherwise authorized by you, KPIC will not disclose your non-public personal information except to affiliates and non-affiliated third parties as necessary to administer, underwrite, process, service, reinsure or market its own insurance products, or as necessary to effect, administer, or enforce a transaction authorized by you. When KPIC must release non-public personal information to non-affiliated third parties, as noted above, such third parties will subject to contractual agreements that require the third parties to maintain the confidentiality of such non-public personal information. If, at a future date, KPIC determines there is a need to share your non-public personal information with a non-affiliated third party, other than as described above, we will provide you with an advance opportunity to direct us not share such information.

KPIC may also disclose non-public personal information to authorized persons or entities to comply with: federal, state, or local laws, including any properly authorized civil, criminal, or regulatory investigation or subpoena or summons; or respond to judicial process or government regulatory authorities having jurisdiction over us for examination, compliance, or other purposes as authorized by law

Non-public Personal Information Regarding Former Customers

Any non-public personal information KPIC maintains on former customers will be maintained on a confidential and secure basis. Any disclosure of that information will only be made in keeping with the privacy policy and practices described in this notice or as otherwise permitted or required by law.

Confidentiality and Security of Non-public Personal Information

KPIC is committed to protecting the confidentiality and security of non-public personal information. In collaboration with our affiliates, we maintain physical, electronic, and procedural safeguards that comply with federal and state standards regarding the protection of such information. To insure that your information is not misused and is properly protected, KPIC has instituted the following:

- Employees are required to comply with our policies and procedures that exist to protect the confidentiality of customer information. Any employee who violates our privacy policy and practices is subject to a disciplinary process. Our policy requires medical records to be maintained in secure areas not accessible to the public.
- Employee access to information is provided on a business need-to-know basis such as: to facilitate administration, make benefit determinations, pay claims, managed care, underwrite coverage, or provide customer service.
- Mail and electronic security procedures to maintain confidentiality of the information we collect and to guard against its unauthorized access. Such methods include locked files, user authentication, encryption, and firewall technology.
- Contractual agreements with its non-affiliated third parties that require such third parties to maintain the confidentiality of non-public personal information.

Where to Write For More Information

If you have any questions about KPIC's privacy policy and practices, please write to the address listed below:

Kaiser Permanente Insurance Company
Attention: President
One Kaiser Plaza, 25 B
Oakland, California 946

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KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, CA 94612

Employers: Please provide a copy of this notice to all certificate holders

**IMPORTANT NOTICE REGARDING
YOUR HEALTH INSURANCE COVERAGE**

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (the Act) was passed into law on October 21, 1998. The law requires group and individual health plans that provide mastectomy coverage, such as your plan coverage, to also provide coverage for:

1. reconstruction of both the diseased and non-diseased breast to produce symmetrical appearance; and
2. prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

The Kaiser Permanente Insurance Company plan under which you are insured provides coverage for mastectomy and includes the services listed above when performed following a covered mastectomy.

If you have any questions about the coverage provided under the Act and your plan of insurance, please do not hesitate to contact us at the number listed on your insurance card.

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