KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Colorado

Point-of-Service

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.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

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

If you believe that Kaiser Permanente Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: KPIC Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services: 1-800-632-9700.

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

HELP IN YOUR LANGUAGE

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

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

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

Ɓăsɔ̀ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-632-9700** (TTY: **711**)

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

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

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

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

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY: **711**）まで、お電話にてご連絡ください。

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

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

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंका निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

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

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

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

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

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

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

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Colorado

Point of Service Large Group (*Grandfathered Coverage*)

Certificate of Insurance

TITLE PAGE (Cover Page)

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. The Group Policy is available for inspection at the Policyholder's office.

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 BENEFITS (Who Pays What)** section 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.

Please refer to the LIMITATIONS and EXCLUSIONS (What is Not Covered) section of this Certificate for a description of this health insurance plan's general limitations and exclusions. Likewise, the SCHEDULE OF BENEFITS (Who Pays What) section 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 TERMINATION/NON-RENEWAL/CONTINUATION section.

Colorado state law requires that an Access Plan be available that describes Kaiser Permanente Insurance Company (KPIC) Colorado's network of provider Services. To obtain a copy, please call **Customer Services** at 1-855- 364-3184 or visit https://choiceproducts-colorado.kaiserpermanente.org/3-tier-point-of-service-plan/member-information/.

Grandfathered Coverage

Kaiser Permanente Insurance Company (KPIC) believes this coverage is a ‘‘grandfathered health plan’’ under the Patient Protection and Affordable Care Act (PPACA), as then constituted or later amended. If you have questions about grandfathered health plans, please call: **Customer Services** at 1-855-364-3184 or 711 (TTY) or write to: Customer Service, 2500 South Havana Street Aurora, Colorado 80014.

If your plan is an ERISA plan, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. To determine whether your employee benefit plan is covered by ERISA, check with your employer.

CONTACT US

Please read the HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFIT section carefully. It will help You understand how Pre-certification (prior authorization) requirements and the provider You select can affect the dollar amount You must pay in connection with receiving Covered Services.

This Certificate uses many terms that have very specific definitions for the purpose of the Group Policy. These terms are defined in the **DEFINITIONS** section and are capitalized so that You can easily recognize them. Other parts 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 BENEFITS (Who Pays What)** section 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.

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

1-855-364-3184 (Toll-free)
711 (TTY)

Or You may write to the Administrator:

Kaiser Foundation Health Plan of Colorado PO Box 378397
Denver, CO 80237-0897

For Pre-certification of Covered Services or Utilization Review of medical benefits other than Outpatient Prescription Drugs, please call the number listed on Your ID card or call 1-888-525-1553.

For Prior Authorization of certain Outpatient Prescription Drugs, please call the number listed on Your ID card or call 1-800-788-2949 (Pharmacy Help Desk).

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The sections of the Certificate appear in the order set forth below.

SCHEDULE OF BENEFITS (Who Pays What) section*

***Issued with this Certificate. Please consult Your Group Administrator if You did not receive a SCHEDULE OF BENEFITS (Who Pays What section.**

ELIGIBILITY

The following persons will be eligible for insurance:

All employees of the Policyholder and their Dependents who are eligible for and enrolled under Health Plan as Point-of-Service Members.

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 which shall not exceed 90 days elected by the Policyholder.

Eligibility of an Eligible Employee's Dependent
See the Definition section for the definition of a Dependent.

Age Limits for Dependent Children
The age limit for Dependent children is under **26** years. 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.

Exceptions
The Dependent Age Limit for Dependent Children does not apply to a Dependent child who is unmarried and continues to be both: 1) physically or mentally disabled and 2) dependent upon You for support and maintenance. 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 depends on You for support and maintenance.

The above exception also applies 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 physically or mentally disabled and dependent upon You for support and maintenance.

Proof of such incapacity and dependency must be submitted to KPIC within 60 days of Your receipt of KPIC's notice of the child's attainment of the limiting age and subsequently as may be required by KPIC, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

IMPORTANT:
KPIC will not deny enrollment of a child under the health insurance coverage of a child's parent because:
1. The child was born out of wedlock;
2. The child is not claimed as a Dependent on the parent's federal income tax return; or
3. The child does not reside with the parent or in an applicable service area.

ELIGIBILITY

Eligibility Date of Dependents
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.

Enrollment Rules for Eligible Employee or Dependent
If you are an Eligible Employee, your and your Dependent's effective date of insurance is determined by the Enrollment Rules that follow.

1. **Initial Open Enrollment**
   The Policyholder will offer an initial open enrollment to new 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 (not to exceed 90 days), if required by the Policyholder. In the absence of a waiting period, the enrollment becomes effective according to the eligibility rules established by the Policyholder.

   If You did not enroll Yourself and/or Your Dependents during the initial enrollment period, You will need to wait until the next annual open enrollment period to enroll, during the special enrollment period as described below.

2. **Annual Open Enrollment**
   Annual 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 and Dependents to enroll. During the annual open enrollment period, Eligible Employees and Dependents can apply for or change coverage by submitting an enrollment application to your Group during the annual open enrollment period.

   Effective date. Enrollment is effective on the first day following the end of the prior plan year. Annual open enrollment occurs only once every year. The Policyholder will notify You when the annual open enrollment is available in advance of such period. Your Group will let you know when the annual open enrollment period begins and ends and the effective date.

3. **Special Enrollment**
   You or your Dependent may experience a qualifying event that allows a change in your enrollment. Examples of qualifying events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The qualifying event results in a special enrollment period that usually (but not always) starts on the date of the qualifying event and lasts for sixty (60) days. During the special enrollment period, you may enroll your Dependent(s) in this plan or, in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's qualifying event. To learn more about qualifying events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Kaiser Permanente and other requirements, call **Member Services** at 1-855-364-3184.

   Effective date. In the case of birth, adoption, or placement for adoption, or placement in foster care, enrollment is effective on the date of birth, adoption, or placement for adoption or placement in foster care.

   In the case of any other qualifying event listed above, including marriage, civil union, or loss of coverage, enrollment is effective on the first day of the following month after We receive a fully completed enrollment form.

ELIGIBILITY

If You have Dependent coverage and there would be no extra cost for adding a Dependent to Your coverage, the effective date of insurance for a Dependent will be the date You acquire the Dependent. You must notify KPIC that You have a new Dependent within 31 days so that the Dependent can be added to Your coverage. This will also help avoid delays on any claim You might file on behalf of the Dependent..

If the cost of Your Dependent coverage would increase when You add a Dependent, You must enroll the Dependent for insurance and agree to pay any additional cost in accordance with the Enrollment Rules. The effective date of insurance for that Dependent will be the date determined from the Enrollment Rules. If a Dependent does not enroll when eligible during the special enrollment period he/she may be excluded from all coverage until the next Annual Open Enrollment Period.

Court or Administrative Ordered Coverage for a Dependent Child
If a Covered Person is a non-custodial parent and 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 amount 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 31 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. Coverage will not commence until the enrollment process has been completed.

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 31 days of the Order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

The coverage for any child enrolled under this provision will continue pursuant to the terms of this health insurance plan unless KPIC is provided written evidence that:
1. The Order is no longer in effect;
2. The child is or will be enrolled in comparable health coverage through another insurer which will take effect on or before the requested termination date of the child's coverage under the Group Policy;
3. All family coverage is eliminated for members of the employer group; or
4. Nonpayment of premium.

Newborns
A newborn Dependent child is insured from birth, whether or not You have applied for coverage, for a period of 31 days.

If You are already insured for Dependent coverage, no further application is required to continue the child's coverage. If You are not already insured for Dependent coverage and if an additional premium is required for the child's coverage, You must apply for and pay the additional premium before the expiration of the 31-day period; otherwise the child's coverage will terminate after the 31-day period.

Coverage for newborn children will include coverage for Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If the newborn child is born with cleft lip or cleft palate or both, care and treatment will include to the extent Medically Necessary:
1. Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons;
2. Prosthetic treatment such as obturators, speech appliances, and feeding appliances;
3. Orthodontic treatment;
4. Prosthodontic treatment;
5. Habilitative speech therapy;

6. Otolaryngology treatment; and
7. Audiological assessments and treatment.

Adopted Children
Your adopted child is insured for the period of 31 days after the earlier of the date of adoption or the date of Placement for Adoption, whether or not You have applied for coverage.

If You are already insured for Dependent coverage, no further application is required to continue the child's coverage. If, however, You are not already insured for Dependent coverage and You are required to pay an additional premium for the child's coverage, You must apply for and pay the additional premium before the expiration of the 31-day period: otherwise, the child's coverage will terminate after the 31-day period.

The Health Plan Evidence of Coverage issued to you separately explains more fully the eligibility, effective date, and the termination provisions.

HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

This section describes how to access your services and how to obtain approval of certain benefits that are subject to Pre-certification.

Please read the following information carefully. It will help You understand how the Pre-certification (prior authorization) requirements and the provider You select can affect the dollar amount You must pay in connection with receiving Covered Services.

Under this Point of Service Plan, a Covered Person has access to three (3) tiers of coverage. The level of coverage that is applied to a Covered Service is dependent upon the provider's participating status and prior authorization requirements. Your provider and your provider's adherence to prior authorization requirements pursuant to state law affect whether the HMO Provider or the Participating or Non-Participating Provider tiers applies to a Covered Service.

HMO Tier (Health Plan)
Kaiser Foundation Health Plan of Colorado (hereafter referred to as "Health Plan") provides the HMO coverage, which includes specified medical and Hospital services provided, prescribed, or directed by a Medical Group Physician, Affiliated Physicians and other Plan Providers (hereafter referred to as "Plan Providers") as these terms are defined in the Health Plan Evidence of Coverage. HMO services also include Emergency Care received from non-Plan Providers. These services rendered by Plan Providers are set forth in the Health Plan Evidence of Coverage issued to you separately. When a Plan Provider renders a Covered Service and the Health Plan's prior authorization rules are met, the service will be covered under the HMO Tier coverage. Typically, benefits payable under the Health Plan Evidence of Coverage are greater for Covered Services received from Plan Providers than those benefits payable for Covered Services received from Participating Providers and Non-Participating Providers.

Participating Provider Tier and Non-Participating Provider Tier (KPIC)
Kaiser Permanente Insurance Company (KPIC) provides the Participating Provider and Non-Participating Provider benefit tiers of Your coverage. As reflected in Your **SCHEDULE OF BENEFITS (Who Pays What) and MEMBER PAYMENT RESPONSIBILITY** section, Your coverage also includes Covered Services received from Participating Providers as well as Non-Participating Providers. Generally, benefits payable under the Group Policy are greater for Covered Services received from Participating Providers than those benefits payable for Covered Services received from Non-Participating Providers. In order for benefits to be payable at the Participating Provider level under the Participating Provider Tier, the Covered Person must receive care from a Participating Provider. To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Provider directory is available from Your employer, call the phone number listed on Your ID card or You may visit KPIC's website at https://choiceproducts-colorado.kaiserpermanente.org/3-tier-point-of-service-plan/member-information/. If a Covered Person receives care from a Non-Participating Provider, benefits under the Group Policy will be payable at the Non-Participating Provider level under the Non-Participating Provider Tier. However, if there are no Participating Providers within a reasonable distance per state regulation to provide a covered benefit, and as a result services are provided by a Non-Participating Provider, then the service will be covered at the Participating Provider level. Please notify us by calling **Customer Service** at 1-855-364-3184 if you are unable to locate a Participating Provider for a covered benefit.

In addition to higher Deductibles, Coinsurance or Copayments, a Non-Participating Provider may balance bill you. Balance billing occurs when a Non-Participating Provider bills you for the difference between the billed amount and Maximum Allowable Charge. Non-Participating Providers rendering services in Colorado are not allowed to balance bill You according to state and federal law:

- When You receive Emergency services in a Non-Participating facility or when Emergency services are rendered by physicians and other professionals that are Non-Participating Providers. This includes services You may get after You are in stable condition unless You give written consent and give up Your protections not to be balanced billed for these post-stabilization

services.

- When You receive Non-Emergency Services rendered in Participating facilities by physicians and other professionals that are Non-Participating Providers . unless You give written consent and give up Your protections.

- When You receive Emergency Ambulance Services from ambulance service providers that are private companies (not publicly funded).

- When You receive Air Ambulance Services subject to federal law.

When balance billing is not allowed, You are only responsible for paying Your share of the cost (like the copayments, coinsurance, and deductibles that You would pay if the provider or facility was a Participating Provider or facility). KPIC will count any amount You pay for Emergency Services or Non-Participating Provider services toward your Deductible and Out-of-Pocket Maximum.

KPIC will pay Non-Participating Providers and facilities directly.

IMPORTANT NOTE:
- If a Covered Service is provided, arranged, paid for or payable by the Health Plan, no payment will be made by KPIC.
- Payments will be made by either Health Plan or KPIC but not both.
- The benefits provided by Health Plan under the HMO level and by KPIC under the Participating Provider and Non-Participating Provider Tiers are not the same. Some services are covered by both Health Plan and KPIC, and others are covered only by Health Plan or KPIC.
- In cases where a provider is contracted with both Health Plan and KPIC and the Health Plan's prior authorization requirements are met, pursuant to state law, the HMO level of coverage is applied to the treatment and services. If the Covered Service is not payable under the HMO coverage, it may be considered for payment under the Participating Provider level.
- Neither Health Plan nor KPIC is responsible for any Covered Person's decision to receive treatment, services or supplies by HMO Providers (Plan Providers) or by Participating Providers and Non-Participating Providers.
- Neither Health Plan nor KPIC is liable for the qualifications of providers or treatment, services or supplies provided under the policy's coverage.
- KPIC is not liable for the qualifications of providers or treatment, services or supplies provided by Participating or Non-Participating Providers.
- For any questions regarding provider network participation please call **Customer Service** at 1-855-364-3184 (Toll free) or 711 (TTY).

Pre-certification through the Medical Review Program
This sub-section under the **HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS** section describes:
1. The Medical Review Program and Pre-certification procedures for medical benefits other than Outpatient Prescription Drugs;
2. How failure to obtain Pre-certification affects coverage;
3. Pre-certification administrative procedures; and
4. Which clinical procedures require Pre-certification.

If Pre-certification is not obtained, benefits payable by KPIC will be reduced by twenty percent (20%) each time Pre-certification is required. This 20% reduction will not count toward any Deductible, Coinsurance, or Out-of-Pocket Maximum applicable under the Group Policy. Such reduction only applies if You receive services, which have not been pre-certified, from a Non-Participating Provider, subject to the **IMPORTANT** note stated below.

IMPORTANT: Consistent with applicable Colorado law, the sole responsibility for obtaining any necessary Pre-certification regarding the utilization of the Participating Provider level of benefits rests with

the Participating Provider, who recommends or orders Covered Services, and not with the Covered Person.

If You, however, received services from a Non-Participating Provider, and Pre-certification is not obtained, benefits payable by KPIC will be reduced by twenty percent (20%) each time Pre-certification is required 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 pre-certified without further Pre-certification, benefits for the extra days: (1) will similarly be reduced; or (2) will not be covered, if deemed not to be Medically Necessary.

Medical Review Program means the organization or program that evaluates proposed treatments and/or items to determine they are Covered Services and Medical Necessary. If the Medical Review Program determines that such services and/or items are not Covered Services and/or not Medical Necessary Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours a day, seven (7) days a week.

Medical Review Program for providers accessed via the Cigna PPO Network outside the KP states will be performed by the Cigna Payer Solutions. CIGNA PPO Network Providers will obtain any necessary Pre-certification on Your behalf. Providers may contact them at 1-888-801-0761.

The following Covered Services must be pre-certified by the Medical Review Program when identified as a Covered Service subject to all exclusion and limitations as set forth in the Certificate (See the **SCHEDULE OF BENEFITS (Who Pays What)** section) under you plan:

1. All Inpatient admissions* and services including:
   a. Inpatient Rehabilitation Therapy Admissions including Comprehensive Rehabilitation Facility admissions related to services provided under an inpatient multidisciplinary rehabilitation program;
   b. Inpatient Mental Health and Substance Use Disorder admissions and services including Residential/Treatment Services;
   c. Long Term Acute Care and Sub-acute admissions
2. Skilled Nursing Facility
3. Partial Hospitalization
4. Non-Emergent Air or Ground Ambulance Transport
5. Amino Acid-Based Elemental Formulas
6. Clinical Trial Services
7. Medical Foods
8. Dental and Endoscopic Anesthesia
9. Durable Medical Equipment
10. Genetic and Biomarker Testing
11. Home Health and Home Infusion Services
12. Hospice Care
13. Imaging Services (Magnetic Resonance Imaging or MRI, Magnetic Resonance Angiography or MRA, Computerized Tomography or CT, Computerized Tomography Angiography or CTA, Positron Emission Tomography or PET, Electron Beam Computerized Tomography or EBCT, Single Photon Emission Computerized Tomography or SPECT)
14. Infertility Services
15. Observation stay except with respect to Emergency Services
16. Outpatient Injectable Drugs
17. Outpatient Procedures
18. Outpatient Surgery
19. Pain Management Services
20. Prosthetic and Orthotic Devices
21. Radiation Therapy Services
22. Reconstructive Surgery
23. TMJ/Orthognathic Surgery
24. Transplant Services including pre-transplant and post-transplant services

*Precertification is not required for Emergency Services. You or Your attending Provider should notify the Medical Review Program of the admission not later than twenty-four (24) hours following an emergency admission or as soon as reasonably possible.

NOTE: The above list is subject to change. For the most current information, please call the Medical Review Program at 1-888-525-1553 or 711 (TTY).

Pregnancy Pre-certification: When a Covered Person is admitted to a Hospital for delivery of a child, the Covered Person is authorized to stay in the hospital not less than:
1. Forty-eight (48) hours for a normal vaginal delivery; or
2. Ninety-six (96) hours for a Cesarean section delivery.

A stay longer than the above may be allowed provided the attending Provider obtain Pre-certification for an extended confinement through the 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. Treatment for Complications of Pregnancy is subject to the same Pre-certification requirements as any other Sickness.

Pre-certification Procedures
The Covered Person or the attending Provider must notify the Medical Review Program as follows:
1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of the scheduled (planned) Hospital Confinement, but at least three days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally pre-certified.
3. Other Covered Services requiring Pre-certification - as soon as reasonably possible after the Covered Person learns of the need for any outpatient Covered Services requiring Pre-certification but at least three (3) days prior to performance of any outpatient Covered Service requiring Pre-certification.
4. During the first trimester of pregnancy if the Covered Person intends to have Birth Services covered under this health insurance plan.
5. Hospital Confinement - as soon as reasonably possible upon stabilization following any emergency admission, if Pre-certification of the post-stabilization service(s) is permitted under applicable law.

A Covered Person or the attending Provider must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person may be required to
1. 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;
2. Participate in the Medical Review Program's case management, Hospital discharge planning, and long-term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the service or item.

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

If the Covered Person or the attending Physician does not provide the necessary information or will not release the necessary information, within the prescribed period as provided in the **APPEALS and COMPLAINTS** section on Pre-service Claim, We will make a decision based on the information We have,

Please refer to the **APPEALS AND COMPLAINTS** section on Pre-service claim of this Certificate of Insurance for Pre-certification request process. Also, refer to the same section where a benefit is denied, in whole or in part, due to a failure to obtain Pre-certification for services rendered by a Non-Participating Provider.

If Your claim is denied, the Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding the mandatory internal appeal process and Your appeal rights, including external review, that may be available to You.

For prior authorization of certain Outpatient Prescription Drugs, please refer to the **BENEFITS/COVERAGE (What is Covered**) section under the Outpatient Prescription Drugs subsection.

If this Plan has been designated a Secondary Plan as defined in the **COORDINATION OF BENEFITS** section, Pre-certification is not required when Your Primary Plan has made payment on the Covered Services requiring Pre-certification.

BENEFITS/COVERAGE (What is Covered)

This section describes the **BENEFITS/COVERAGE (What is Covered)** provisions. See your **SCHEDULE OF BENEFITS (Who Pays What)** section to determine if the benefit is a covered service. General limitations and exclusions are listed in the **LIMITATIONS/EXCLUSIONS (What is Not Covered)** section.

Insuring Clause

Upon timely submission of a claim form and proof of loss including but not limited to all documents and information that We need, KPIC will pay the Percentage Payable as defined in the **DEFINITIONS** section of the Maximum Allowable Charge for Covered Services received, provided:

1. The Covered Person is insured under the Group Policy on the date when the Covered Service is received;
2. The claim is for a Covered Service and such Covered Service is Medically Necessary;
3. The claim is for a Covered Service provided or rendered by the Provider in accordance with all the terms and conditions of this Certificate;
4. Prior to payment on the claim, any Deductible, Coinsurance, Copayment and other payment payable applicable to the Covered Service have been satisfied; and
5. The Covered Person has not exceeded the limits related to the Covered Service including but not limited to the Maximum Benefit while Insured or any other maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Payments under this Group Policy, to the extent allowed by law:

1. May be subject to the limitations shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section;
2. May be subject to the General Limitations and Exclusions; and
3. May be subject to Pre-certification.

Unless specifically stated otherwise elsewhere in this Certificate of Insurance or in the **SCHEDULE OF BENEFITS (Who Pays What)** section, coverage includes Necessary Services and Supplies and is as follows:

Outpatient Care

1. Physicians' services including evaluation and management services during office visit or outpatient clinic visit.
2. Nursing care by a Registered Nurse (RN) or, if none is available, as certified by the attending Physician, nursing care by a Licensed Vocational Nurse.
3. Services by a Certified Nurse Practitioner; Physician Assistant; Certified Psychiatric-Mental Health Clinical Nurse Specialist; Licensed Midwife, or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
4. Respiratory therapy rendered by a certified respiratory therapist.
5. Allergy testing materials and allergy treatment material.
6. Dressings, casts, splints.
7. Anesthesia and its administration by a licensed anesthesiologist or licensed nurse anesthetist.
8. Outpatient surgery or diagnostic procedures in a Free-Standing Surgical Facility or other licensed medical facility.
9. Hospital charges for use of a surgical room on an outpatient basis.
10. Outpatient Observation stay.
11. 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
12. Outpatient Birth Services in a Hospital, Birth Center or any other duly licensed facility. Pregnancy and Complications of Pregnancy will be covered on the same basis as any other physical Injury or Sickness.
13. Treatment of Intractable Pain, after reasonable efforts to cure or relieve the cause of the pain. Treatment for Covered Persons must be provided through one of the following:
    a. A primary care provider with documented experience in pain management and whose practice

includes up-to-date treatment;
   b. A pain management specialist who is located in the State of Colorado;
   c. A reasonably requested referral to a pain management specialist, if applicable.
14. Outpatient self-management training and education related to the care of diabetes, including equipment and supplies and medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items in accordance with applicable Colorado law. When prescribed, diabetes outpatient self-management and education must be provided by a certified, registered, or licensed health care professional with expertise in the care of diabetes.
15. Chemotherapy Services
16. Non-Dental Services to treat Temporomandibular Joint (TMJ) disorder.
17. Chiropractic Care Spinal Manipulation services and supplies regardless of the license the provider performing the Service holds.
18. Medically Necessary Bariatric Surgery Services.
19. Nonpharmacological treatment for a patient with chronic pain diagnosis where an opioid might be prescribed.
    Please refer to the Health Plan Evidence of Coverage issued to you separately for this benefit under the HMO In-Network Tier.
20. Abortion Care

Inpatient Hospital Care

1. Room and Board in a Hospital, such as semi-private room or private room when a Physician determines it is medically necessary.
2. Room and Board in a Hospital Intensive Care Unit.
3. Respiratory therapy rendered by a certified respiratory therapist.
4. Physicians' services.
5. Nursing care by a Registered Nurse (RN) or, if none is available, as certified by the attending Physician, nursing care by a Licensed Vocational Nurse.
6. Services by a Certified Nurse Practitioner; Certified Psychiatric-Mental Health Clinical Nurse Specialist; Licensed Midwife, or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
7. Private duty nursing services in an inpatient hospital when medically necessary
8. Dressings, casts, splints.
9. Anesthesia and its administration by a licensed anesthesiologist or licensed nurse anesthetist.
10. Inpatient Birth Services in a Hospital, Birth Center or any other duly licensed facility. Pregnancy and Complications of Pregnancy will be covered on the same basis as any other physical Injury or Sickness.
11. Hospital Confinements in connection with childbirth for the mother or newborn child will not be limited to less than forty-eight (48) hours following a normal vaginal delivery and ninety-six (96) following a Cesarean section, unless, after consultation with the mother, the attending provider discharges the mother or newborn earlier. A stay longer than the above may be allowed provided the attending provider obtains Pre-certification for an extended confinement through KPIC's Medical Review Program If the covered hospital stay for child birth ends after 8 p.m. coverage will be continued until 8 a.m. the following morning. In no case will KPIC require that a provider reduce the mother's or child's hospital confinement below the allowable minimum cited above.
12. Medically Necessary Bariatric Surgery Services.

Ambulance Services

Transportation by an ambulance service for non-Emergency Care when the use of other means of transportation would adversely affect Your condition. Emergency ambulance services received for an Emergency Medical Condition are covered under the HMO In-Network benefit described in under the HMO In-Network Evidence of Coverage issued to you separately.

BENEFITS/COVERAGE (What is Covered)

Autism Spectrum Disorders
Coverage for Autism Spectrum Disorders (ASD) is provided. The following services are in addition to, and not in lieu of, Early Childhood Intervention Services, as provided for under this Policy. Also, Covered Services provided for ASD are in addition to any service, which may be covered and rendered to a Dependent pursuant to an Individualized Family Service Plan, and Individualized Education Program or an Individualized Plan.

Coverage for ASD includes the following:
1. Evaluation for treatment and assessment services;
2. Behavior Training and behavior management and Applied Behavior Analysis, including, but not limited to: consultations, direct care, supervision or treatment, or any combination thereof:
3. Habilitative or Rehabilitative services;
4. Pharmacy Care which as covered under the Outpatient Prescription Drug benefit;
5. Psychiatric Care;
6. Psychological Care, including family counseling; and
7. Therapeutic Care.

The ASD Covered Services listed above, must be rendered in accordance with a Treatment Plan by an Autism Service Provider, as defined under this Policy. When rendered in accordance with a Treatment Plan, such Covered Services are considered to be appropriate, effective, and efficient for the purpose of treating ASD, and not to be regarded as either experimental or investigational.

Visit limits for physical therapy, occupational therapy, and speech therapy do not apply to therapies that are Medically Necessary to treat Autism Spectrum Disorder.

Behavioral Health/Mental Health Services
Diagnosis, treatment, services, or supplies are covered under this Group Policy for Behavioral Health and Mental Health disorders, except Autism Spectrum Disorder or ASD, when received as an inpatient or on an outpatient basis in an office, Hospital, Residential Treatment facility or other licensed medical facility including a community mental health facility, and when diagnosed and treated by a provider duly licensed to diagnosis and treat such conditions. Coverage for Autism Spectrum Disorder or ASD is described under a separate header in this section.

Benefits will be limited to treatment, services or supplies otherwise covered under this Group Policy and will be provided on the same terms and conditions and no less extensive than, those provided for the treatment and diagnosis of other physical diseases or disorders. Behavioral Health/Mental Health Services are covered whether they are voluntary or are court-ordered, when they are Medically Necessary and otherwise covered under this Group Policy.

The use of Body Mass Index (BMI) or Ideal Body Weight (IBW) or any other standard requiring an achieved weight will not be utilized to determine Medical Necessity or level of care appropriateness of the treatment of eating disorders, including but not limited to bulimia nervosa, atypical anorexia nervosa, binge-eating disorder, avoidant restrictive food intake disorder, and other specified feeding and eating disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. BMI or IBW will not be a determining factor when assessing medical necessity or level of care appropriateness for treatment of anorexia nervosa, restricting subtype, or binge-eating/purging subtype as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Services include:
1. Inpatient Hospital services such as testing, treatment, therapy including electroconvulsive therapy, and counseling.
2. Outpatient services:
   (a) Office-based services such as testing, treatment, therapy and counseling.
   (b) Hospital alternative services consisting of: (i) partial hospitalization. Intensive and structured

outpatient treatment offered for several hours during the day or evening. Services can be as intensive as inpatient care but do not require an overnight confinement in an inpatient hospital setting; and (ii) intensive outpatient program.
3. Behavioral/Mental Health and Medical/Surgical Services required for self-inflicted injuries including attempted suicide.

Clinical Trials

We cover Routine Patient Care Costs associated with a clinical trial if all of the following conditions are met:
1. The Covered Person's treating physician, who is providing covered health care services to the person under the health benefit plan contract, recommends participation in the clinical trial after determining that participation in the clinical trial has the potential to provide a therapeutic health benefit to the Covered Person; and
2. The Clinical Trial or study is approved under the September 19, 2000, Medicare National Coverage Decision regarding Clinical Trials, as amended; and
3. The patient care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner; and
4. Prior to participating in a clinical trial or study, the Covered Person has signed a statement of consent indicating that the Covered Person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participating in the Clinical Trial or study, the coverage provided will be consistent with the benefits provided under this Group Policy, including the out-of-network coverage; and
5. The Covered Person suffers from a condition that is disabling, progressive or life-threatening.

Coverage does not include the following:
1. Any portion of the Clinical Trial or study that is paid for by government or a biochemical, pharmaceutical, or medical industry
2. Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
3. Extraneous expenses related to participating in the Clinical trial or study, including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participant may incur;
4. An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant,
5. Costs for the management of research relating to the Clinical Trial or study; or
6. Health care services, although related to the conduct of the Clinical Trial, are otherwise specifically excluded from coverage under this Group Policy.

Dental Services

1. Hospitalization and Anesthesia for Dental Procedures. Covered Services includes hospitalization and general anesthesia administered to a covered Dependent child for dental procedures. The general anesthesia must be provided in a Hospital, outpatient surgical facility, or other licensed facility. Treatment must be provided by an anesthesia provider who is either:
   a) An educationally qualified specialist in pediatric dentistry; or
   b) Any other dentist who is educationally qualified in a recognized dental specialty for which Hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate Hospital training to be granted Hospital privileges.

   In order for the child's hospitalization and general anesthesia to be covered, the child's treating dentist must provide a written opinion to KPIC indicating that:
   a) The Dependent child has a physical, mental, or medically compromising condition; or
   b) The Dependent child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
   c) The Dependent child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental

care cannot be deferred; or
d) The Dependent child has sustained extensive orofacial and dental trauma.

This provision does not apply to treatment rendered for temporomandibular joint disorders.
This provision does not provide coverage for any dental procedure or the services of the dentist.

2. Medically necessary orthodontia limited to dental services within the mouth for treatment of a condition related to or resulting from cleft lip and/or cleft palate.

Dialysis Care
Dialysis services related to acute renal failure and end-stage renal disease including dialysis equipment; training; and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Drugs, Supplies and Supplements
1. Drugs and materials that require supervision or administration by medical personnel during a covered hospital confinement or other covered treatment.
2. Medical Foods, as defined, when related to the treatment of inherited enzymatic disorders caused by single-gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions, include, but are not limited to the following diagnosed conditions: phenylketonuria (PKU), maternal PKU, maple syrup urine disease, tyrosinemia, homocystinuria, histidinemia, urea cycle disorders, hyperlysinemia, glutaric acidemias, methylmalonic acidemia, propionic acidemia, immunoglobin E and immunoglobin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of gastrointestinal tract. Medical Foods may also be for home use, for which a Participating Physician has order a prescription, whether written, oral or electronic transmission. Except for PKU, there is no age limit on benefits for inherited enzymatic disorders, as specified above. The maximum age to receive benefits for PKU is twenty-one (21) years of age except that the maximum age to receive benefits for PKU for women who are of child-bearing age, is thirty-five (35) years of age.
3. Outpatient Prescription Drugs
   Covered Charges include charges for prescribed drugs or medicines or supplies purchased from a licensed pharmacy on an outpatient basis 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; and
   d) Do not exceed the maximum daily supply shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section, except that in no case may the supply be larger than that normally prescribed by a Physician or prescribing provider or dentist

   Such charges are subject to all of the terms and conditions of the Group Policy including Deductibles, Copayment, Coinsurance, exclusions and limitations, unless otherwise set forth in the **SCHEDULE OF BENEFITS (Who Pays What** section.

Drugs Covered:
Covered Charges for outpatient prescription drugs are limited to charges from a licensed pharmacy for:
1) Any medication whose label is required to bear the legend “Caution: federal law prohibits dispensing without a prescription.” Experimental drugs are not covered unless one or more of the following conditions are 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

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 results of which have been published in either the United States or Great Britain.

2) A prescription legend drug for which a written prescription is required;
3) Non-injectable legend drugs (to include legend maintenance drugs). See exclusions list below for exceptions;
4) Compounded medication of which at least one ingredient is a legend drug;
5) Any other drug which under the applicable state law may only be dispensed upon the written prescription of a Physician or other lawful prescriber;
6) Legend prenatal vitamins.
7) Specialty Drugs such as self-administered injectable medications, as indicated in the Preferred Drug List, are covered, subject to the following conditions:
   a) The medication does not require administration by medical personnel;
   b) The administration of the medication does not require observation;
   c) The patient's tolerance and response to the drug does not need to be tested, or has been satisfactorily tested; and
   d) The medication has been prescribed for self-administration at home.

   Self-administered injectable medications must be written on a prescription filled by a pharmacy, and self-administered by the patient or caregiver at home (not administered by providers in medical offices.
8) Prescribed oral anti-cancer medication, which has been approved by the Federal Food and Drug Administration, at a cost not to exceed the Coinsurance or the Copayment level as any intravenously administered or an injected anti-cancer medication prescribed for the same purpose.
9) Insulin and the following diabetic supplies, unless related to the Covered Service for outpatient self-management of diabetes as described in the **BENEFITS/COVERAGE (What is Covered)** section:
   a) Home glucose monitoring supplies;
   b) Syringes and needles;
   c) Acetone and glucose test tablets; and
   d) Glucose test strips;
10) Prescribed contraception drugs or devices.
    Under the Participating Provider Tier: (i) For a three-month supply the first time the prescription contraceptive is dispensed; and (ii) For a twelve-month supply or through the end of Your coverage whichever is shorter for any subsequent dispensing of the same prescription contraceptive regardless of whether You were enrolled in the plan at the time the prescription coverage was dispensed; or (iii) For a three-month period for a prescribed vaginal contraceptive ring intended to last for 3 months; and Under the Non-Participating Provider Tier: A thirty-day supply.
11) Off-label use of drugs used for the treatment of cancer if the drug is recognized for the treatment of cancer in the authoritative reference compendia as identified by the Secretary of the United States Department of Health and Human Service.
12) Renewal of prescription eye drops when: (a) the request for renewal is made: (i) at least 21 days for a 30-day supply or (ii) at least 42 days for a 60-day supply or (iii) at least 63 days for a 90-day supply, from the later of the date the original prescription was dispensed or last renewed and (b) the original prescription states that additional quantities are needed and the renewal request does not exceed the number of additional quantities needed. One additional bottle (limited to one bottle every 3 months) of prescription eye drops is covered when: (a) the additional bottle is requested at the time the original prescription is filled; and (b) the original prescription states that it is needed for use in a day care center, school or adult day program.
13) A five-day supply of at least one of the FDA-approved drugs for the treatment of opioid dependence limited to a first (1st) request within a 12-month period.

Coverage under Other Policy Provisions: Charges for services and supplies that qualify as Covered Charges under this benefit provision will not qualify as Covered Charges under any other benefit provision of the Group Policy.

BENEFITS/COVERAGE (What is Covered)

This Outpatient Prescription Drug Benefit uses an open Formulary. An open Formulary is a list of all FDA-approved drugs unrestricted drugs or devices unless specifically excluded under the plan. The Formulary consists of preferred generic and brand drugs and non-preferred generic and brand drugs and including specialty drugs. Please visit http://info.kaiserpermanente.org/html/kpic-colorado for the Drug Formulary.

Your Outpatient Prescription Drug Benefit is subject to the following utilization management requirements.

Quantity Limits
Quantity limits apply to outpatient prescription drugs for safety and cost reasons and follow the manufacturer's FDA-approved guidelines from their package inserts. Prescribers must obtain authorization for quantities higher than those allowed under the utilization management program.

Age Limits
Age requirements/limits apply to some outpatient prescription drugs and are part of the utilization management program to help ensure You are receiving the right medication at the right time. Such limits restrict coverage for a drug to a certain age for reasons of safety and/or efficacy and as may be recommended to be necessary to promote appropriate use. In addition to age limitations determined by FDA-approved guideline, outpatient prescription drugs will be subject to requirements based on the recommendations of the U.S. Preventative Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC).

Step Therapy process
Selected prescription drugs require step therapy. Step therapy is the protocol that requires a particular sequence of prescription drugs, other than the drug that Your provider recommends for your treatment before We provide coverage for the recommended prescription drugs. The step therapy process encourages safe and cost-effective medication use. Under this process, a "step" approach is required to receive coverage for certain high-cost medications. This means that to receive coverage You may first need to try a proven, cost-effective medication before using a more costly medication. Treatment decisions are always between You and Your Prescribing Provider. Refer to the Formulary for a complete list of medications requiring step therapy. The following outpatient prescription drugs shall not be subject to any Step Therapy requirement: (1) FDA-approved medication on our formulary for the treatment of substance use disorder defined as alcohol use disorder, opioid use disorder, opioid reversal agents, and nicotine dependence; (2) FDA-approved medication on our formulary for the treatment of Stage four (4) advanced metastatic cancer; and (3) FDA-approved medication on our formulary for the prevention of HIV infection and Non-Formulary FDA-approved HIV PrEP medications when prescribed or dispensed by a pharmacist; and (4) FDA-approved HIV treatment medications on our formulary. For purpose of this provision, medications for the prevention of HIV infection include pre-exposure, post-exposure or other drugs approved by the FDA for the prevention of HIV infection.

Your Prescribing Provider should prescribe a first-line medication appropriate for Your condition. If Your 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.

For the treatment of Serious Mental Illness, when step therapy is mandated, You are required to try only one alternative prescription drug before receiving coverage for the medication prescribed by Your Provider. Serious Mental Illness, as defined by the American Psychiatric Association in the latest Diagnostic and Statistical Manual of Mental Disorders, includes the following:
(1) Bipolar disorders (hypomanic, manic, depressive, and mixed);
(2) Depression in childhood and adolescence;
(3) Major depressive disorders (single episode or recurrent);
(4) Obsessive-compulsive disorders;
(5) Paranoid and other psychotic disorders;
(6) Schizoaffective disorders (bipolar or depressive); and
(7) Schizophrenia

Prior Authorization
Prior Authorization is a review and approval procedure that applies to some outpatient prescription drugs and is used to encourage safe and cost-effective medication use. Prior authorization is generally applied to outpatient prescription drugs that have multiple uses, are higher in cost, or have a significant safety concern. The following outpatient prescription drugs shall not be subject to Prior Authorization: (1) FDA-approved medication on our formulary for the treatment of substance use disorder defined as alcohol use disorder, opioid use disorder, opioid reversal agents, and nicotine dependence; and (2) FDA-approved medication on our formulary for the prevention of HIV infection and Non-formulary FDA-approved HIV PrEP medications when prescribed or dispensed by a pharmacist; and (3) FDA-approved HIV treatment medications on our formulary. For purpose of this provision, medications for the prevention of HIV infection include pre-exposure, post-exposure or other drugs approved by the FDA for the prevention of HIV infection.

The purpose of Prior Authorization is to ensure that You receive the right medication for Your medical condition. This means that when Your Prescribing Provider prescribes a drug that has been identified as subject to Prior Authorization, the medication must be reviewed by the utilization management program to determine Medical Necessity before the prescription is filled. Prior authorization reviews address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.
If a drug requires prior authorization, Your Prescribing Provider must work with Us to authorize the drug for Your use. Drugs requiring Prior Authorization have specific clinical criteria that You must meet for the prescription to be eligible for coverage. Refer to the formulary for a complete list of medications requiring Prior Authorization. The most current formulary can be obtained by visiting http://info.kaiserpermanenente.org/html/kpic-colorado. If You have questions about the Prior Authorization or about outpatient prescription drugs covered under Your plan, you can call 1-800-788-2949 (Pharmacy Help Desk) or 711 (TTY) 24 hours a day, 7 days a week (closed holidays).

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

"Prior Authorization" means certain covered outpatient prescription drugs will require an approval where the prescribed medication will be reviewed by Us to determine Medical Necessity before the prescription is filled. This approval process is called the prior authorization process.

"Urgent Prior Authorization Request" means;
A request for prior authorization when based on the reasonable opinion of the Prescribing Provider with knowledge of the Covered Person's medical condition, the time frames allowed for non-urgent prior authorization:
a) Could seriously jeopardize the life or health of the covered person or the ability to regain maximum function; or
b) The Covered Person is subject to severe pain that cannot be adequately managed without the drug benefit that is the subject of request for prior authorization.

"KPIC's Uniform Pharmacy Prior Authorization Request Form" means the standardized prescription drug prior authorization form prescribed by the Colorado Division of Insurance (DOI) that will be used under applicable Colorado state law and regulation.

"Prescribing Provider" means a provider licensed and authorized to write a prescription pursuant to applicable state law to treat a medical condition of a Covered Person.

When an outpatient prescription drug requiring Prior Authorization has been prescribed, You or Your Prescribing Provider must notify the utilization management program as follows:

BENEFITS/COVERAGE (What is Covered)

1. Complete and submit KPIC's Uniform Pharmacy Prior Authorization Request Form available on-line at http://info.kaiserpermanente.org/html/kpic-colorado to the utilization management program as described in item 2 below. You or Your Prescribing Provider can also obtain a copy of KPIC's Uniform Prior Authorization Request Form by calling 1-800-788-2949. Prior authorization requests contained on a form other than KPIC's Uniform Pharmacy Prior Authorization Request Form will be rejected.

2. We will accept KPIC's Uniform Pharmacy Prior Authorization Request Form through any reasonable means of transmission, including, but not limited to, paper, electronic, or any other mutually accessible method of transmission, by sending it via fax at 1-858-790-7100.

3. Within one (1) business day upon Our receipt of a completed Urgent Prior Authorization Request, We will process the Urgent Prior Authorization Request and we will notify You or Your Prescribing Provider and dispensing pharmacy (if applicable) that:
   a) The request is approved; or
   b) The request is denied for any of the following reasons:
      i) Not Medically Necessary;
      ii) The patient is no longer eligible for coverage;
      iii) The request is not submitted on the prescribed KPIC's Uniform Pharmacy Prior Authorization Request Form and must be resubmitted using the prescribed request form.
   c) There is missing material information necessary to determine Medical Necessity. We will notify and request Your Prescribing Provider to submit additional information needed to process the Urgent Prior Authorization Request.
      i) Upon receipt of Our request for additional information, Your Prescribing Provider has a period of two (2) business days within which to submit the requested information; and
      ii) Upon Our receipt of the requested additional information from Your Prescribing Provider, we shall make a determination within one (1) business day of receipt.
      iii) However, upon failure by Your Prescribing Provider to submit the requested additional information within two (2) business days, the Urgent Prior Authorization Request shall be deemed denied; and
      iv) We will provide You, Your Prescribing Provider or dispensing pharmacy (if applicable) with the confirmation of the denial within one (1) business day from the date the Urgent Prior Authorization Request was deemed denied.

4. Within two (2) business days upon receipt of a completed Non-Urgent Prior Authorization Request submitted electronically and within three (3) business days upon receipt of a completed Non-Urgent Prior Authorization Request submitted via fax or electronic mail or verbally with associated written confirmation, We will process and notify You, Your Prescribing Provider and dispensing pharmacy (if applicable) that:
   a) The request is approved;
   b) The request is denied for any of the following reasons:
      i) Not Medically Necessary;
      ii) The patient is no longer eligible for coverage;
      iii) The request is not submitted on the prescribed KPIC Uniform Pharmacy Prior Authorization Request Form and must be resubmitted using the prescribed request form.
   c) There is missing material information necessary to determine Medical Necessity. We will notify and request Your Prescribing Provider to submit additional information needed to process the Non-Urgent Prior Authorization Request.
      i) Upon receipt of Our request for additional information, Your Prescribing Provider has a period of two (2) business days within which to submit the requested information; and
      ii) Upon Our receipt of the additional information from your Prescribing Provider, We shall make a determination within two (2) business days for Non-Urgent Prior Authorization Request submitted electronically and within three (3) business days for Non-Urgent Prior Authorization Request submitted via fax or electronic mail or verbally with associated written confirmation.

iii) However, upon failure by Your Prescribing Provider to submit the requested additional information within two (2) business days, the Non-Urgent Prior Authorization Request shall be deemed denied.
iv) We will provide You, Your Prescribing Provider and dispensing pharmacy (if applicable) with the confirmation of the denial within two (2) business days from the date the Non-Urgent Prior Authorization Request was deemed denied.

5. The Request shall be deemed to have been approved for failure on Our part to:
   a) Request additional information from Your Prescribing Provider; or
   b) To provide the notification of approval to You and Your Prescribing Provider; or
   c) To provide the notification of denial to You and Your Prescribing Provider within the required time frames set forth above from Our receipt of an Urgent Prior Authorization Request or a Non-Urgent Prior Authorization Request from Your Prescribing Provider.

6. We shall provide You, Your Prescribing Provider and the dispensing pharmacy (if applicable) with a confirmation of the deemed approval, as follows:
   a) For Urgent Prior Authorization Request - within one (1) business day of the date the request was deemed approved;
   b) For Non-Urgent Prior Authorization Request submitted electronically – within two (2) business days of the date the request was deemed approved; and
   c) For Non-Urgent Prior Authorization Request submitted via fax or electronic mail or verbally with associated written confirmation – within three (3) business days of the date the request was deemed approved.

7. A Prior Authorization approval is valid for a period of one hundred eighty (180) days after the date of approval.

8. In the event Your Prescribing Provider's Prior Authorization Request is disapproved:
   a) The notice of disapproval will 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 will contain an accurate and clear explanation that specifically identifies the missing material information.

9. Notices required to be sent to You or Your authorized representative or Your Prescribing Provider or dispensing pharmacy (if applicable) shall be delivered by Us in the same manner as the Prior Authorization Request Form was submitted to Us, or any other mutually agreeable accessible method of notification.

10. Prescription drug prior authorization procedures conducted electronically through a web portal, or any other manner of transmission mutually agreeable, shall not require You or Your Prescribing Provider to provide more information than is required by the KPIC's Uniform Pharmacy Prior Authorization Request Form.

<u>Exception Requests for Prior Authorization, Step Therapy, Quantity and Age Limits</u>
You or Your authorized representative or the Prescribing Provider may request an exception or a waiver to the Outpatient Prescription Drug Prior Authorization Request, Step Therapy process, Quantity and Age Limits 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.

To request for an exception or waiver to the Outpatient Prescription Drug Prior Authorization or Step Therapy process or Quantity and Age Limits, please call:1-800-788-2949 (Pharmacy Help Desk).

Additional information on Exception Requests for Step Therapy

Your request for an exception or waiver of Step Therapy of the drug that is on Our Formulary shall be granted if the Prescribing Provider submits justification and supporting clinical documentation if needed that states: (a) the provider attests that required prescription drug is contraindicated or will likely cause an adverse reaction or harm to You; (b) the required prescription drug is ineffective based on Your known clinical characteristics and the known characteristics of the prescription drug regimen; (c) You have tried, while under Your current or previous plan, the step therapy-required prescription drug or another prescription drug in the same pharmacologic class or with the same mechanism of action and such prescription drug was discontinued due to lack of effectiveness, diminished effect or an adverse event; and (d) You, while on Your current or previous plan, is stable on a previous drug selected by the prescribing provider for the medical condition under consideration after undergoing step therapy or after having requested and received a step therapy exception.

We shall grant or deny a step therapy exception request or an appeal of a denial or request with complete information within:

1, Three (3) business days after the receipt of the request; or
2. Twenty-four (24) hours after receipt of the request in cases where exigent circumstances exist.

“Exigent circumstance" means a circumstance in which a covered person is suffering from a health condition that may seriously jeopardize the covered person's life, health, or ability to regain maximum functions.

If We did not receive complete information or if We need additional clinically relevant information, We shall notify the prescribing provider within:

1. Seventy-two (72) hours after submission of the request,
2. Twenty-four (24) hours after the submission of the request if exigent circumstances exist,

We will specify the additional information that is required in order to consider the step therapy exception request or the appeal of the denial of the request pursuant to the criteria described. Once the requested information is submitted to the Us, the applicable period specified above to grant or deny a step therapy exception request or an appeal of a denial of a request applies.

The step therapy exception request or the appeal of the denial of the request is deemed granted for failure on Our part to make a determination on the step therapy exception request or the appeal of the denial of the request or make a request for additional or clinically relevant information within the required time.

When the step therapy exception request is granted, We shall authorize coverage for the prescription drug prescribed by Your prescribing provider.

In the event of the denial of Your initial step therapy exception request, We will inform you in writing on Your right to an internal or external review or appeal of the adverse determination pursuant to **APPEALS AND COMPLAINTS** section.

You may request to waive Step Therapy if the drug is on Our Formulary, You have tried the step therapy-required prescription drug while under Your current or previous health insurance and such prescription drugs were discontinued due to lack of effectiveness, diminished effect or an adverse event. We may require you to submit relevant documentation to support Your request.

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.

If Your request for Outpatient Prescription Drug Prior Authorization or waiver of the Step Therapy process, Quantity and Age limits, is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **APPEALS AND COMPLAINTS** section for a detailed discussion of the grievance and appeals process and Your right to an External Review.

Exclusions for Outpatient Prescription Drug Benefits.

BENEFITS/COVERAGE (What is Covered)

The following are not covered under the Outpatient Prescription Drug Benefit:

1) Internally implanted time-release medications, except contraceptives required by law;
2) Compounded dermatological preparation, which must be prepared by a pharmacist in accord with a Physician's prescription, with ingredients of which are available over the counter;
3) Antacids;
4) For Covered Persons with enterostomies and urinary diversions, the following ostomy supplies and equipment:
    a) Appliances;
    b) Adhesives;
    c) Skin barriers and skin care items;
    d) Belts and clamps;
    e) Internal and appliance deodorants;
5) Drugs when used for cosmetic purposes, including Ioniten (Minoxidil) for the treatment of alopecia, Tretinoin (Retin A) for individuals 26 years of age or older and anti-wrinkle agents (e.g., Renova);
6) Non-legend drugs and non-legend vitamins;
7) Therapeutic devices or appliances, support garments and other non-medical substances, regardless of intended use, unless specifically listed above;
8) Charges for the administration or injection of any drug;
9) Drugs labeled "Caution - limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual, unless for the treatment of cancer as specified in item 1 under Drugs Covered;
10) Hematinics;
11) DESI Drugs - drugs determined by the FDA as lacking substantial evidence of effectiveness;
12) Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institutions which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
13) Minerals;
14) Infertility medications;
15) Anorectic drugs (any drug used for the purpose of weight loss);
16) Fluoride supplements except as required by law.
17) Drugs and medicines, including nicotine patches and chewing gum, in connection with smoking cessation therapy or a behavior modification program

Dispensing Limitations: KPIC will not pay for more than the per prescription or refill supply set forth in the **SCHEDULE OF BENEFITS (Who Pays What)** section. In no case, however, may the supply be larger than that normally prescribed by a Physician or other lawful prescriber.

Direct Reimbursement
If you paid the full price for your prescription, you may request a direct reimbursement from us subject to the applicable Cost Share.

To submit a claim for direct reimbursement you may access the direct member reimbursement form via https://mp.medimpact.com/mp/public/Frameset.jsp?forwardUrl=/mp/public/HelpDesk.jsp to find the direct member reimbursement form or for assistance you may call the MedImpact Customer Contact Center 24 hours a day 7 days a week at 1- 800-788-2949 or email via customerservice@medimpact.com.

<u>Durable Medical Equipment/External Prosthetics and Orthotics</u>

1) Rental of Durable Medical Equipment. Purchase of such equipment may be made if in the judgment of KPIC:
    a) purchase of equipment would be less expensive than rental; or
    b) such equipment is not available for rental.
2) Prosthetic devices (External) are covered including:
    a) external prosthetics related to breast reconstruction resulting from a covered mastectomy;

b) when necessary, to replace, in whole or in part, an arm or a leg; or
c) required to treat cleft lip or cleft palate such as obturators, speech and feeding appliances.

3) Prosthetic devices (internally implanted) are covered as part of the surgical procedure to implant them.
4) Orthotics including diabetic shoes are covered. Repair or replacement of orthotic devices are covered when necessary due to growth. Arch supports and other devices for the foot, except for diabetic shoes, are not covered. Repair or replacement of orthotic devices due to loss or misuse is not covered.

Early Childhood Intervention Services

Eligible Insured Dependents, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Childhood Intervention Services (ECIS) visits as determined by the state law.

NOTE: You may be billed for any ECIS received after the number of visits required by state law is satisfied.

The number of visits required by state law does not apply to:

1. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
2. Services provided to a child who is not an eligible child and whose services are not pursuant to an Individualized Family Service Plan (IFSP); and
3. Assistive technology covered by the Durable Medical Equipment provisions of this Certificate.

Coverage of Early Childhood Intervention Services does not include any of the following:

1) Respite care;
2) Non-emergency medical transportation;
3) Service coordination, as defined by applicable Colorado law; and
4) Assistive technology that is not included as Durable Medical Equipment, which is otherwise covered under the Group Policy.

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.

Emergency Services received for an Emergency Medical Condition are covered under the HMO In-Network benefit described under the HMO In-Network Evidence of Coverage issued to you separately. Covered Services received in an Emergency Department that do not meet the definition of an Emergency Medical Condition will be covered as indicated in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Outpatient observation stays that result from an Emergency Room visit are included in the cost share for the Emergency Room visit.

Family Planning Services

1. Contraceptives which require medical administration in Your doctor's office, including drugs and implanted devices and the professional services to implant them
2. Vasectomy

Gender Affirming Care Services

Benefits for Gender Affirming Care Covered Services are covered in the same manner as any other medical or surgical coverage, as set forth under this Certificate regardless of the Covered Person's sexual orientation or gender identity. These benefits include hormone therapy and associated laboratory services, pre-surgical and post-surgical care, and the treatment of complications. Non-surgical physical and behavioral health services are also covered including but not limited to office visits, counseling,

preventive health services and prescription drugs.

Medically Gender Affirming Care Surgery Services
Medically necessary surgery to treat gender dysphoria is covered in the HMO In-Network Tier as described in the Health Plan Evidence of Coverage issued to you separately.

1) Radical Mastectomy
2) Prostatectomy
3) Pectoral implants.
4) Voice modification surgery

Benefits for other Gender Affirming Covered Services are covered in the same manner as any other medical or surgical coverage, as set forth under this Certificate including hormone therapy and the treatment of complications.

Hearing Services
Limited only to minor Dependents under the age of 18:
1) Hearing exams and tests by audiologist needed to determine the need for hearing correction.
2) For minor Dependents under the age of 18 with a verified hearing loss, coverage shall also include:
   a) Initial hearing aids and replacement hearing aids not more frequently than every five years;
   b) A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c) Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

Home Health Care
Home Health Services. The following services provided by a Home Health Agency under a plan of care to Covered Persons in their place of residence are covered:
a) Skilled nursing services;
b) Certified or licensed nurse aid services under the supervision of a Registered Nurse or a qualified therapist;
c) Physical therapy;
d) Occupational therapy;
e) Speech therapy and audiology;
f) Respiratory and inhalation therapy;
g) Nutrition counseling by a nutritionist or dietitian;
h) Medical social services, medical supplies; prosthesis and appliances suitable for home use; rental or purchase of durable medical equipment; and
i) Drugs, medicines, or insulin

Home health services do not include:
a) Food services or meals, other than dietary counseling;
b) Services or supplies for personal comfort or convenience, including Homemaker Services; and
c) Services related to well-baby care.

Covered Home Health Services are limited to intermittent care services. Intermittent care services means services are limited to 28 hours per week and less than 8 hours a day.

Such services must be provided in the Covered Person's home and according to a prescribed treatment plan established by a Physician in collaboration with the home health provider. Home health care must be required in lieu of hospitalization or in place of hospitalization. Services of up to four hours by a home health aide shall be considered as one visit.

Hospice Care
This provision only applies to a Terminally Ill Covered Person with a life expectancy of less than six (6) months receiving Medically Necessary care under a Hospice Care program. Benefits may exceed six (6)

months should the Terminally Ill Covered Person continue to live beyond the prognosis for life expectancy. Covered Services include Hospice Care Benefits when a Covered Person's Physician provides KPIC a written certification of the Covered Person's Sickness along with a prognosis of life expectancy; and a statement that Hospice Care is Medically Necessary.

A copy of the Hospice program's treatment plan may be required before benefits will be payable.

Hospice Care benefits are limited to:
1. Physician services
2. Nursing care, including care provided by a Licensed Vocational Nurse or Certified Nurse's Aide, when under the supervision of a Registered Nurse or specialized rehabilitative therapist;
3. Physical, speech or occupational therapy and audiology;
4. Respiratory and inhalation therapy including oxygen and respiratory supplies;
5. Medical social services;
6. Nutrition counseling by a nutritionist or dietitian;
7. Rental or purchase of durable medical equipment;
8. Prosthetic and orthopedic appliances;
9. Medical supplies including drugs and biologicals;
10. Diagnostic testing necessary to manage the terminal illness;
11. Medically necessary transportation needed for hospice services;
12. Family counseling related to the Covered Person's terminal Sickness including bereavement support; and
13. Respite care.

Covered Persons who elect to receive Hospice Care are not entitled to any other benefits under the Group Policy for the terminal Sickness. Services and charges incurred by the Covered Person in connection with an unrelated illness will be processed in accordance with coverage provisions applicable to all other illnesses and/or injuries.

No payments will be made for expenses that are part of a Hospice Care program that started after coverage under the Group Policy ceased.

Infertility Services
Infertility Services are covered in the HMO In-Network Tier as described in the Health Plan's Evidence of Coverage under Reproductive Support Services, issued to you separately.

X-ray, laboratory procedures, and other associated services for diagnosis, and treatment of underlying medical condition causing involuntary infertility, will be covered under the appropriate benefit in the SCHEDULE OF BENEFITS (Who Pays What) section of Your Certificate of Insurance

Laboratory Services

Pathology services and laboratory tests, services and materials.

Preventive Care Services
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. Benefits for preventive care are not subject to any Deductible amount. Services remain subject to all Coinsurance, Copayment, and other plan provisions and limitations. Preventive care benefits are limited to the following:

a) Routine nursery care and Physician charges for a newborn while the mother is confined. The care is covered as part of the mother's admission.

b) Age appropriate examinations as follows:

BENEFITS/COVERAGE (What is Covered)

(i) Ages 0-12 months:	1 Newborn home visit during the first week of life if the newborn was released from the hospital less than 48 hours after delivery. 5 Well-child Visits and 1 PKU (phenylketonuria) test
(ii) Ages 13-35 months:	2 Well-child Visits;
(iii) Ages 3-6	3 Well-child Visits;
(iv) Ages 7-12	3 Well-child Visits;
(v) Ages 13-18	1 Age appropriate Health Maintenance Visit every year 1 Diphtheria-tetanus vaccine; 1 Hepatitis B vaccination if not given previously;
(vi) No age limitation	1 Diphtheria-tetanus vaccine every ten years; 1 Age Appropriate Health Maintenance Visit every three years; 1 fasting lipid panel;
(vii) No age limitation	1 Diphtheria-tetanus vaccine every ten years; 1 Fasting lipid panel every five years; Either annual hemoccult or 2 sigmoidoscopic visualizations between ages 50 – 70; 1 Age Appropriate Health Maintenance visit every 24 months;
(viii) No age limitation	1 Influenza immunization every year; 1 Pneumococcal vaccine at or after age 65; 1 Diphtheria-tetanus vaccine every ten years;
(ix) All persons	1 Age Appropriate Health Maintenance Visit every year; 1 Smoking cessation education program benefit under Physician supervision or as authorized by plan.
(x) All persons	Annual Mental Wellness check up
(xi) All persons	Annual Mental Health Examination performed by a Qualified Mental Health Provider up to 60 minutes
(xii) Ages 18 and over	Unhealthy Alcohol Use Screening
(xiii) Ages 12 and over	Preventive Screening for Depression
(xiv) No age limitation	Perinatal maternal counseling for persons at risk

c) Routine mammograms as follows:
   i) For women age thirty-five (35) through age thirty-nine (39), one baseline mammogram;
   ii) For women age forty (40) through age forty-nine (49), one mammogram every two years, or more frequently upon recommendation of a Physician; and
   iii) For women age fifty (50) and older, 1 mammogram every twelve (12) months.

   Benefits are limited to a maximum payment of the lesser of the actual charge or amount provided for under the most recent annual national Consumer Price Index - Urban (CPI-U) published by the U.S. Bureau of Labor and Statistics. Benefits are exempt from Deductibles.

d) Prostate Screening as follows when performed by a qualified medical professional, including but not limited to a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or Physician assistant:
   i) For men age forty (40) through age forty-nine (49), one screening per Accumulation Period if the Covered Person's Physician determines he is at high risk of developing prostate cancer; and
   ii) For men age fifty (50) and older, one screening per Accumulation Period.

   A prostate screening test consists of a prostate-specific antigen ("PSA") blood test and a digital rectal examination. Benefits are limited to a maximum payment of the lesser of the actual charge or $85 per screening and are exempt from any Deductibles.

e) Colorectal screening services are covered for:
   i) Asymptomatic average-risk adults, who are 50 years of age or older and
   ii) Covered Persons who are at high risk for colorectal cancer. Such high-risk Covered Persons include those individuals who have:
      1. a family medical history of colorectal cancer;
      2. a prior occurrence of cancer or precursor neo-plastic polyps;
      3. a prior occurrence of a chronic digestive disease condition, such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis, or other predisposing factors, as determined by a duly authorized provider.

   Benefits are provided for tests, as determined by a duly authorized provider, that detect adenomatous polyps or colorectal cancer consistent with modalities that are included in "A" Recommendation or a "B. Recommendation of the Task Force.

f) Fecal DNA Screening

g) Expanded coverage of breast cancer screening services which includes:
   (1) The use of non-invasive imaging modality as recommended by the provider and within the appropriate use guidelines as determined by determined by the American College of Radiology and the National Comprehensive Cancer Network, for all individuals possessing at least one (1) risk factor for breast cancer including:
      (i) A family history of breast cancer;
      (ii) Being 40 years of age or older; or
      (iii) An increased lifetime risk of breast cancer determined by a risk factor model such as tyrer-cuzick, BRCAPRO, or GAIL by or other clinically appropriate risk assessment models.
   (2) Diagnostic imaging for further evaluation or supplemental imaging within the same policy year based on factors including a high lifetime risk for breast cancer or high breast density when deemed appropriate by the provider and the appropriate use guidelines as determined by determined by the American College of Radiology and the National Comprehensive Cancer Network.

i) All Center for Disease Control's (CDC) Advisory Committee on Immunization Practices (ACIP) recommended immunizations for respiratory syncytial virus (RSV) including all associated costs of administration for:
   (i) People 60 years and older under shared decision-making with their health care provider,
   (ii) Pregnant people that would provide protection to infants up to 6 months of age, and
   (iii) A monoclonal antibody product that will help protect all infants under 8 months and some older babies at increased risk of severe illness caused by RSV

Reconstructive Services

1. Reconstructive surgery including reconstruction of both the diseased and non-diseased breast after mastectomy to produce symmetrical appearance; and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
2. Treatment of Covered Persons, without regard to age, born with cleft lip and/or cleft palate, including the following procedures when found to be Medically Necessary: oral and facial surgery; surgical management and follow-up care by plastic surgeons and oral surgeons;
3. Treatment necessary for congenital hemangiomas and port wine stains.

BENEFITS/COVERAGE (What is Covered)

Rehabilitation and Habilitation Services

1. Physical therapy to restore, keep, learn or improve skills or functioning. Therapy must be provided as prescribed by the attending Physician.
2. Speech therapy to restore, keep, learn or improve skills or functioning. This includes speech and language therapy and audiologic assessments and treatments for cleft lip and cleft palate.
3. Occupational therapy to restore, keep, learn or improve skills or functioning. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. Therapy must be attended as prescribed by the attending Physician and the attending
4. Multidisciplinary rehabilitation services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program to restore, keep, learn or improve skills or functioning.
5. Pulmonary therapy to restore respiratory function after an illness or injury.
6. Cardiac Rehabilitation.

Treatment of Sexually Transmitted Infection

Treatment of a sexually transmitted infection (STI) is covered. Sexually transmitted infection refers to chlamydia, syphilis, gonorrhea, HIV, and relevant types of hepatitis as well as any other sexually transmitted infection, regardless of mode of transmission.

Treatment" means medically necessary care including FDA approved medication for the management of the existing STI Please refer to Your SCHEDULE OF BENEFITS (What Pays What) section.

Skilled Nursing Facility Care

Room and Board and other services rendered in a Skilled Nursing Facility. Care must follow a Hospital Confinement, and the Skilled Nursing Facility confinement must be the result of an Injury or Sickness that was the cause of the Hospital Confinement. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved, and no further significant measurable improvement can be anticipated.

Substance Use Disorder Services

Diagnosis, treatment, services or supplies are covered under this Group Policy for a Substance Use Disorder when received as an inpatient or on an outpatient basis in an office, Hospital, Residential Treatment facility or other licensed medical facility when diagnosed and treated by a provider duly licensed to diagnosis and treat such conditions. Medication-Assisted Treatment (MAT), a combination of behavioral therapies and medications approved by the FDA to treat substance use disorders (SUD), is covered. This coverage includes services provided by Opioid Treatment Programs (OTPs) for methadone administration and maintenance for the treatment of opioid use disorder (OUD).

Benefits will be limited to treatment, services or supplies otherwise covered under this Group Policy and will be provided on the same terms and conditions and no less extensive than, those provided for the treatment and diagnosis of other physical diseases or disorders. Substance Use Disorder Services are covered whether they are voluntary or are court-ordered, when they are Medically Necessary and otherwise covered under this Group Policy.

Services include:

1) Inpatient services including services in a Residential Treatment facility and medical management of withdrawal symptoms in connection with Substance Use Disorder. Medical Services for alcohol and drug Detoxification are covered in the same way as for other medical conditions.
2) Outpatient services:
   (a) Office-based services such as testing, treatment, therapy and counseling
   Hospital alternative services consisting of: (i) partial hospitalization or intensive and structured outpatient treatment offered for several hours during the day or evening. Services can be as intensive

as inpatient care but do not require an overnight confinement in an inpatient hospital; and (ii) intensive outpatient treatment program.

Transplant Services
Transplant services in connection with an organ or tissue transplant procedure are covered for a Covered Person who is a recipient in the HMO In-Network Tier as described in the Health Plan Evidence of Coverage issued to you separately.

Donor Services which include Health Care Services related to living organ donation are covered. Health Care Services as defined in this section are procedures to harvest an organ of a living organ donor and all Services required before and after the procedure. Covered Charges incurred by a Covered Person who is a living organ donor or prospective living organ donor are covered under the donor's coverage.

Urgent Care Services
Treatment in an Urgent Care Center. Urgent Care services are covered under the HMO In-Network benefit level described in the Health Plan Evidence of Coverage issued to you separately.

Vision Services
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.

Routine eye exams and refractive eye tests to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses.

All vision services not listed above are not covered, 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. Lenses, frames or contacts or their replacements.
5. Contact lens modification, polishing and cleaning.
6. Optical Hardware
7. Low vision aids

X-ray and Special Procedures
1. Diagnostic X-ray, services and materials, including isotopes.
2. Diagnostic mammograms.
3. Electrocardiograms, electroencephalograms and mammograms.
4. Therapeutic X-ray Services and materials including radiation therapy. Radiation treatment is limited to:
   a) X-ray therapy when used in lieu of generally accepted surgical procedures or for the treatment of malignancy; or
   b) the use of isotopes, radium or radon for diagnosis or treatment.
5. MRI, CT, PET and nuclear medicine.

LIMITATIONS/EXCLUSIONS (What is Not Covered)

No payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following, unless specifically stated otherwise in the Group Policy or elsewhere in this Certificate, including, the **SCHEDULE OF BENEFITS (Who Pays What)** section, or any Rider or Endorsement that may be attached to the Group Policy. Refer to the **DEFINITIONS** section for the meaning of capitalized terms.

1. Charges in excess of the Maximum Allowable Charge.
2. Charges for non-Emergency Services in an Emergency Department or independent Freestanding Emergency Department.
3. Covered Services other than Emergency Services outside the United States.
4. Except for Emergency Services, weekend admission charges for non-Emergency Care Hospital services except when surgery is performed on the day of admission or the next day. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
5. Covered Services including but not limited to confinement, treatment, services or supplies which are not Medically Necessary. This exclusion does not apply to preventive or other Covered Services specifically covered under the Group Policy.
6. Covered Services including but not limited to confinement, treatment, services or supplies not prescribed, authorized or directed by a Physician or that are received while not under the care of a Physician.
7. Covered Services including but not limited to treatment, services, or supplies provided by: (a) the Covered Person; (b) the Covered Person's spouse, partner in a civil union or Domestic Partner (if covered); (c) a child, sibling, or parent of the Covered Person or of the Covered Person's spouse, partner in a civil union or Domestic Partner (if covered); or (d) a person who resides in the Covered Person's home.
8. Covered Services including but not limited to 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.
9. Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third-party coverage.
10. Injury or Sickness arising out of, or in the course of, past or current work for pay, profit or gain, unless workers' compensation or benefits under similar law are not required or available.
11. Injury or Sickness contracted while on duty with any military, naval, or air force of any country or international organization.
12. Dental care and dental X-rays; dental appliances; orthodontia; and dental services resulting from medical treatment, including surgery on the jawbone and radiation treatment, except as provided for covered dependent children under the Hospitalization and Anesthesia for Dental Procedures provision and Medically Necessary orthodontia for the treatment of cleft lip and palate.
13. Cosmetic Surgery, plastic surgery, or other services or procedures that primarily serve to improve the Covered Person's appearance and will not result in significant improvement in physical function. This exclusion does not apply to services that: (a) will correct significant disfigurement resulting from a non-congenital Injury or Medically Necessary surgery; (b) are incidental to a covered mastectomy; or (c) are necessary for treatment of congenital hemangioma and port wine stains; or (d) are Gender Affirming Care services determined to be Medically Necessary to treat gender dysphoria.
14. Any drug, procedure or treatment for sexual dysfunction regardless of cause, including but not limited to Inhibited Sexual Desire, Female Sexual Arousal Disorder, Female Orgasmic Disorder, Vaginismus, Male Arousal Disorder, Erectile Dysfunction and Premature Ejaculation.
15. Non-prescription drugs or medicines; vitamins, nutrients, and food supplements even if prescribed or administered by a Provider unless otherwise covered under this Plan or required by state or federal law.
16. Any Covered Service including but not limited to any treatment, procedure, drug, or equipment or device which KPIC determines to be experimental or investigational. This means that one of the following is applicable:
    a. The service is not recognized in accordance 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 used in testing or in other studies on human patients; or

b. 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.

This exclusion will not apply to Clinical Trials covered in the **BENEFITS/COVERAGE (What is Covered)** section or to Routine Patient Care Costs related to clinical trials if the Covered Person's treating Physician recommends participation in the clinical trial after determining that participation in such clinical trial has the potential to provide a therapeutic health benefit to the Covered Person.

17. Special education and related counseling or therapy, or care for learning deficiencies or behavioral problems. This applies whether or not the services are associated with manifest Mental Health disorder or other disturbances.
18. Services or supplies rendered for the treatment of obesity; however, Covered Charges made to diagnose the causes of obesity or charges made for treatment of diseases causing obesity or resulting from obesity are covered.
19. Covered Services including but not limited to confinement, treatment, services or supplies that are required:
    a. Only for insurance, travel, employment, school, sports participation, camp, government licensing, or similar purposes; or
    b. Only by a court of law except when medically necessary and otherwise covered under this Group policy.
20. Personal comfort items such as telephones, radios, televisions, or grooming services.
21. 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 treatment or certification or the presence of a supervising licensed nurse.
22. Intermediate care. 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.
23. Routine foot care such as trimming of corns and calluses.
24. Confinement or treatment that is not completed in accordance with the attending Physician's orders.
25. Hearing Therapy except where Medically Necessary to treat cleft lip and cleft palate.
26. Hearing aids for adults age 18 and over.
27. Services of a private-duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility.
28. Outpatient private duty nursing services.
29. Acupuncture; biofeedback; massage therapy; or hypnotherapy.
30. Health education, including but not limited to: (a) stress reduction; (b) weight reduction; or (c) the services of a dietitian.
31. Medical social services except those services related to discharge planning in connection with: (a) a covered Hospital Confinement; (b) covered Home Health Agency Services; or (c) covered Hospice Care.
32. Living expenses or transportation, except as provided for under Covered Services in the **BENEFITS/COVERAGE (What is Covered)** section.
33. Second surgical opinions, unless required under the Medical Review Program.
34. Eye refractions, orthoptics, contact lenses, or the fitting of glasses or contact lenses; radial keratotomy or any other surgical procedures to treat a refractive error of the eye, except as specified in the **BENEFITS/COVERAGE (What is Covered)** section for Vision services.
35. Reversal of sterilization.
36. Services provided in the home other than Covered Services provided through a Home Health Agency or related to Hospice Care services, as set forth under the **BENEFITS/COVERAGE (What is Covered)** section.
37. Repair or replacement of Prosthetics resulting from misuse or loss.

LIMITATIONS/EXCLUSIONS (What is Not Covered)

38. Infertility services are not covered which include treatment of involuntary infertility, and all services and supplies related to conception by artificial means including but not limited to prescription drugs related to such services, artificial insemination, in vitro fertilization, ovum transplants, gamete intra fallopian transfer and zygote intra fallopian transfer, donor semen, donor eggs and Services related to their procurement and storage. These exclusions apply to fertile as well as infertile individuals or couples.
39. Maintenance therapy for rehabilitation.
40. Travel immunizations.
41. Non-human and artificial organs and their implantation.
42. Gene therapy unless you meet the Medical Review Program criteria.
43. Surrogate pregnancy and services in connection with a Surrogacy Arrangement if the surrogate mother is not a Covered Person. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and 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. For Covered Persons in a Surrogacy Arrangement, please refer to "Surrogacy arrangements" under the **GENERAL POLICY PROVISIONS** section for information about your obligations to Us in connection with a Surrogacy Arrangement, including Your obligations to reimburse Us for any Covered Services We cover and to provide information about anyone who may be financially responsible for Covered Services the baby (or babies) receive.

NOTE: This plan does not impose any Pre-existing condition exclusion.

MEMBER PAYMENT RESPONSIBILITY

Deductible
Before any benefits will be payable during the Accumulation Period, a Covered Person must first satisfy the Deductible shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. Unless otherwise specified in the **SCHEDULE OF BENEFITS (Who Pays What) and MEMBER PAYMENT RESPONSIBILITY** section, the Deductible applies to all Covered Services. The Deductible will apply to each Covered Person separately and must be met within each Accumulation Period. When Covered Charges equal to the Deductible are incurred and submitted to Us, the Deductible will have been met for that Covered Person.

Payments under the Group Policy 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 the applicable Cost Share and any amounts in excess of the Maximum Allowable Charge for a Covered Service received from a Non-Participating Provider. (Refer to the definition of Maximum Allowable Charge shown in the **DEFINITIONS** section.)

Self-Only Deductible
For a self-only enrollment (family of one Covered Person), there is only one Deductible known as Self-Only Deductible. When the Covered Person reaches their Self-Only Deductible, they will begin paying Copayment or Coinsurance.

Individual Deductible
For family enrollment (family of two or more Covered Persons), there is a Deductible for each individual family member known as Individual Deductible. Unless otherwise indicated in the **SCHEDULE OF BENEFITS (Who Pays What)** section or elsewhere in the Policy, the Accumulation Period Deductible as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section applies to all Covered Charges incurred by a Covered Person during an Accumulation Period. The Deductible applies separately to each Covered Person during each Accumulation Period. When 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. Benefits will not be payable for Covered Charges applied to the Deductible.

Family Deductible Maximum
The Deductible for a family has been satisfied for an Accumulation Period when a total of Covered Charges, shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section, has been applied toward the family members' Individual Deductibles.

If the Family Deductible Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section is satisfied in any one Accumulation Period by Covered Persons in a family enrollment unit, then the Individual Deductible for any Covered Person in the family enrollment unit 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.

Benefit-specific deductibles
Some Covered Services are subject to additional or separate deductibles amounts as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. These additional or separate deductibles do not contribute towards satisfaction of the Self-only or Individual or Family Deductible.

NOTE: Please refer to the **SCHEDULE OF BENEFITS (Who Pays What)** section for the actual amount of Your Individual and Family Deductible.

Copayment/Coinsurance
You must pay any Copayment, Coinsurance as well as Deductibles for Covered Services. These Cost

MEMBER PAYMENT RESPONSIBILITY

Shares are paid directly to the Provider. Copayment, Coinsurance and Deductible amounts are listed in **SCHEDULE OF BENEFITS (Who Pays What)** section. If You receive Covered Services from a Non-Participating Provider not chosen by You at a Participating Provider facility, You are liable only for the Participating Provider Cost Share for the Covered Services You receive. In this circumstance You are not liable for the difference between the Participating Provider Cost Share and the Non-Participating Provider's billed charges. If you receive a bill from a Non-Participating Provider in the circumstances described above, please call **Customer Service** at 1-855-364-3184 for assistance.

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.

Covered Charges applied to satisfy any Deductibles under this Group Policy do not count toward satisfaction of the Out-of-Pocket Maximum. Coinsurance paid for Covered Services apply to the Out-of Pocket unless otherwise specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

Amounts in excess of the Maximum Allowable Charge or Benefit Maximum 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.

Unless otherwise specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section Copayment amounts and outpatient pharmacy cost shares are not subject to nor do they contribute towards the satisfaction of the Out-of-Pocket Maximum.

Self-Only Out-of-Pocket Maximum
For a self-only enrollment (family of one Covered Person), there is only one Out-of-Pocket Maximum known as Self-Only Out-of-Pocket Maximum. When the Covered Person reaches their Self-Only Out-of-Pocket Maximum, they no longer pays Copayments or Coinsurance for those Covered Services that apply towards the Out-of-Pocket Maximum for the rest of the Accumulation Period.

Individual Out-of-Pocket Maximums:
When the Covered Person's Cost Share amounts equals or exceeds the Individual Out-of-Pocket Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section during an Accumulation Period, the Percentage Payable will be 100% of Covered Charges for the same Covered Person for the remainder of that Accumulation Period.

Family Out-of-Pocket Maximums:
When the family's Cost Share amounts for all Covered Persons in a family enrollment unit equal or exceed the Family Out-of-Pocket Maximum shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section during an Accumulation Period, then the Percentage Payable will be 100% of further Covered Charges incurred by all Covered Persons in a family enrollment unit for the remainder of that Accumulation Period.

NOTE: Please refer to the **SCHEDULE OF BENEFITS (Who Pays What)** section for the actual amount of Your Self-Only, Individual and Family Out-of-Pocket Maximum.

Deductible and Out-of-Pocket Maximum Takeover Credit
Any Expenses Incurred by a Covered Person while covered under the Prior Coverage will be credited toward satisfaction of Deductibles and Out-of-Pocket Maximums, as applicable, under the Group Policy if:
1. The expenses were incurred during the 90 days before the Effective Date of the Group Policy;
2. The expenses were applied toward satisfaction of the deductibles or Out-of-Pocket Maximum under the Prior Coverage during the 90 days before the Effective Date of the Group Policy; and
3. The expenses would be considered Covered Charges under the Group Policy.

MEMBER PAYMENT RESPONSIBILITY

For Group Policies with effective dates of coverage during the months of April through December, Expenses Incurred from January 1 of the current year through the effective date of coverage with KPIC may be eligible for credit.

For Group Policies with effective dates of coverage during the months of January through March, Expenses Incurred up to ninety (90) days prior to the effective date with KPIC may be eligible for credit.

You must submit all claims for the Deductible Takeover Credit within 90 days from the effective date of coverage with KPIC.

Prior Coverage means the Policyholder's group medical plan that the Group Policy replaced. KPIC will insure any eligible person under the Group Policy on its Effective Date, subject to the above provisions which apply only to Covered Persons who on the day before the Group Policy's Effective Date were covered under the Prior Coverage.

Maximum Allowable Charge
Payments for Expenses incurred 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. In addition to applicable Cost Sharing, Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service from a Non-Participating Provider. Such difference will not apply towards the satisfaction of the Out-of-Pocket Maximum nor any Deductible under the Group Policy. (Refer to the definition of Maximum Allowable Charge shown in the **DEFINITIONS** section of the Certificate.)

Other Maximums
To the extent allowed by law, certain Covered Services and supplies are subject to internal limits or maximums. These additional limits or maximums are shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

NOTE: Please refer also to the **SCHEDULE OF BENEFITS (Who Pays What)** section at the beginning of this Certificate of Insurance.

CLAIMS PROCEDURE (How to File a Claim)

All claims under the Group Policy will be administered by:

National Claims Administration- Colorado
PO Box 37315
Denver, CO 80237-9998
1-855-364-3184 (Toll-Free)
711 (TTY)

Questions about Claims
For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when You call the number shown above, or You may write to the address shown above. Claim forms are available from Your employer.

Claim Filing Requirements
Set forth below is a description of Our claim filing requirements. You may also request a separate copy of Our claim filing requirements by writing to Us. We will respond to such requests within fifteen (15) calendar days. If We change any of the requirements, We will provide You with a copy of the revised requirements within fifteen (15) calendar days of the revision.

Claim Forms
We will provide the claimant with the notice of claim form. You must give Us written notice of claim within twenty (20) days, but in no event more than 12 months after the occurrence or commencement of any loss covered by the Policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. You may give notice or may have someone do it for You. The notice should give Your name and Your policy number. The notice should be mailed to Us at Our mailing address or to Our Claims Administrator at the address provided above.

When We receive Your notice of claim, We will send You forms for filing Proof of Loss. The forms may be obtained from and must be filed with KPIC's Administrator's office at the address set forth above. If We do not send You these forms within fifteen (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. Clean Claims, as defined, will be paid, denied or settled within thirty (30) calendar days after receipt if submitted electronically, or within forty-five (45) calendar days, if the claim is submitted by any other means. If a claim is denied in whole or in part, the written notice of denial will contain: (1) reasons for the denial; (2) reference to the pertinent provisions of the Group Policy on which the denial is based; and (3) information concerning the Covered Person's right of appeal.

If additional information is required to complete the processing of Your Claim, We will request such information within thirty (30) calendar days after receiving Your Claim. We will provide a full explanation in writing as to what additional information is needed to resolve the claim from Your group or health care provider, or You. The person or entity receiving the request for additional information must submit all additional information to Us within thirty (30) calendar days after receiving the request. Under applicable Colorado law, We may deny a claim if You and/or the provider fail to submit the requested additional information in a timely manner. Absent fraud, all claims, except those considered to be Clean Claims, shall be paid, denied, or settled within ninety (90) calendar days after receipt by KPIC.

If the Covered Person is dissatisfied with the results of a review, the Covered Person may request a reconsideration. The request must be in writing and filed with KPIC's Administrator at the address set forth above. The written request for reconsideration must be filed within thirty (30) days after the notice of denial is received. A written decision on reconsideration will be issued within thirty

(30) days after receipt of the request for reconsideration.

Proof of Loss
Written Proof of Loss must be sent to Us or to Our Administrator at the address shown on the preceding page within 90 days after the day services were received. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, but in no event, later than one year from the time proof is otherwise required, except in the absence of legal capacity. If You receive services from a Participating Provider, that provider will normally file the claim on Your behalf. At Your option, You may direct, in writing to KPIC, that benefits be paid directly to the provider.

Payment of Benefits
Benefits will be payable to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Covered Person immediately upon receipt of due written proof of loss. The Covered Person, at his or her option, may assign, in writing to KPIC, all or part of such benefits directly to a person or institution on whose charges a claim is based.

A Covered Person may also authorize KPIC to pay benefits directly to a person or institution on whose charges a claim is based. Any such payments will discharge KPIC to the extent of payment made. Unless allowed by law, KPIC's payments may not be attached, nor be subject to, a Covered Person's debts.

At the Covered Person's option, any benefits for health expenses for covered medical transportation services may be assigned, in writing to KPIC, 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.

KPIC shall not retroactively adjust a claim based on eligibility if:
(1) The provider received verification of eligibility within two (2) business days prior to delivery of services unless the Policyholder notified KPIC:
    (a) That Employee is no longer eligible.
    (b) That Policyholder no longer intends to maintain coverage for the Group;
    (c) Within ten (10) business days after the date that Employee is no longer eligible or covered because the employee left employment without notice to the Policyholder/Employer or employment was terminated because of gross misconduct.
(2) The provision of benefit is a required policy provision pursuant to state law unless the Policyholder notified KPIC of Employee's ineligibility within the timeframe provided in (1) (c).

Reimbursement of Providers
Reimbursement for services covered under this health insurance plan which are lawfully performed by a person licensed by the State of Colorado for the practice of osteopathy, medicine, dentistry, optometry, psychology, chiropractic, or podiatry shall not be denied when such services are rendered by a person so licensed. Licensed persons shall include registered professional nurses and licensed Clinical Social Workers within the scope of professional nursing or licensed social worker practice.

Legal Actions
No action at law or in equity may be brought to recover under the Group Policy prior to the expiration of 60 days after the claim has been filed as required by the Group Policy. Also, no action may be brought after three years from the expiration of the time within which proof of loss is required by the Group Policy.

Time Limitations
If any time limitation provided in the Group Policy 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 Group Policy is extended to agree with the minimum permitted by the applicable law.

CLAIMS PROCEDURE (How to File a Claim)

Assignment of Benefits to Colorado Department of Social Services
If a Covered Person receives medical assistance from the State of Colorado, under Colorado law, the State is deemed to have an assignment on all benefit payments made for medical expenses on behalf of the Covered Person or any other covered family member. The assignment remains in effect as long as the individual is eligible for and receives medical assistance benefits from the State. This means that KPIC may pay benefits directly to the State when KPIC is aware that the Covered Person is a medical assistance recipient. Any payments made by KPIC in good faith pursuant to the State's assignment will fully discharge KPIC's obligation to the extent of the payment.

NOTE: For general information on claims, and how to submit Pre-Service Claims, Concurrent Care Claims, and Post-Service Claims, see the **APPEALS AND COMPLAINTS** section. For covered Services by Non-Participating Providers, you may need to submit a claim on your own. Contact **Customer Service** for more information on how to submit such claims.

GENERAL POLICY PROVISIONS

Time Effective
The effective time for any dates used is 12:01 a.m. at the address of the Policyholder.

Incontestability
Any statement made by the Policyholder or a Covered Person in applying for insurance under this Policy will be considered a representation and not a warranty. Its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement as determined by a court of competent jurisdiction. Only statements that are in writing and signed by the Policyholder and/or Covered Person may be used in a contest.

This Policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue and that no statement made for the purpose of effecting insurance coverage under the policy with respect to a person shall be used to avoid the insurance with respect to which such statement was made or to reduce benefits under such policy after such insurance has been in force for a period of two years during the lifetime of the Covered Person unless such statement is contained in a written instrument signed by the person making such statement and a copy of that instrument is or has been furnished to the person making the statement or to the beneficiary of any such person.

Misstatement of Age
If the age of any person insured under this health insurance plan has been misstated: 1) premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

Medical 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.

Money Payable
All sums payable pursuant to this Policy must be paid in the lawful currency of the United States.

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:
1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions, and limitations of the Policy;
2. Accept claim forms and requests for claim payment from the custodial parent; and
3. 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:
1. The Order is no longer valid;
2. The Dependent child has become covered under other health insurance or health coverage;
3. In the case of employer-provided coverage, the employer has stopped providing family coverage for all employees; or
4. The Dependent child is no longer a Covered Person under the Policy.

Termination by KPIC
KPIC may terminate the Group Policy or any insurance under the Group Policy on any premium due date by giving no less than 31 days written notice when the Policyholder:
1. Fails to pay premiums or contributions in accordance with the plan provisions, or KPIC does not receive premium payments in a timely manner; or
2. Commits an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact under the terms of the Group Policy; or
3. Fails to comply with a material health benefit plan contract provision, including contribution or group participation rules; or
4. No longer has any Covered Persons living, residing or working in the service area of the Preferred Provider Organization with respect to a Group Policy providing coverage, in whole or in part, in connection with a Preferred Provider plan.

If KPIC decides to discontinue offering this particular health benefit plan in the group market, KPIC may discontinue all coverage under the Group Policy. KPIC will give written notice of this type of nonrenewal to each Policyholder 90 days before the date coverage terminates. KPIC will offer each Policyholder whose coverage is discontinued the option to purchase another group health benefits plan currently offered by KPIC in the applicable state without regard to any health status-related factor of any Covered Person, including any individuals who may become eligible for the replacement coverage. Health benefit plan under this section means a particular product and not a plan design.

If KPIC stops offering all health insurance coverage in the group market, in the applicable state, KPIC has the right not to renew all policies issued on this form. KPIC will give written notice of this type of nonrenewal to the Policyholders and all Covered Persons 180 days before the date coverage terminates. Notice to an Insured Employee will be deemed notice to the Insured Dependents of that Insured Employee.

The Policyholder will be liable for all unpaid premiums for the period during which the Group Policy was in force with respect to any Covered Person whose coverage terminates.

Completion of Covered Services by a Terminated Provider
If You are inpatient in a Hospital, Skilled Nursing Facility, or a hospice for Hospice Care at the time of a Participating Provider's termination, You will continue to receive coverage for Covered Services until Your date of discharge from such inpatient facility consistent with applicable Colorado law.

As to services other than inpatient services, We will advise You in writing as to the specific extension of time, under Colorado law, pertaining to the rendition of Covered Services by a terminated Participating Provider

Coordination of Benefits Provisions Application
This Coordination of Benefits ("COB") provision applies when the Covered Person has health care coverage under more than one Plan. Plan is defined below.

The order-of-benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the primary plan is the secondary plan. The Secondary plan may reduce the benefits it

pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions Related to Coordination of Benefits

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

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The **order-of-benefit payment rules** determine whether this plan is a "Primary plan" or "Secondary plan" when compared to another plan covering the person

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

D. **Allowable Expense** is a health care service or expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service or portion of an expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The following are examples of expenses that are not Allowable Expenses:
   (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private hospital room expenses.
   (2) If a Covered Person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
   (3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable

Expense.

(4) If a Covered Person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

G. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order-of-Benefit Payment Rules

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

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

B. (1) Except as provided in paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always Primary unless the provisions of both plans state that the complying Plan is Primary.

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

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is Secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary plan and the Plan that covers the Covered Person as a dependent is the Secondary plan. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is Secondary to the Plan covering the person as a dependent; and Primary to the Plan covering the person as

other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
   (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      (i) The Plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      (ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
   (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is Primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
      (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      (iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         - The Plan covering the custodial parent;
         - The Plan covering the spouse of the custodial parent;
         - The Plan covering the non-custodial parent; and then
         - The Plan covering the spouse of the non-custodial parent.
   (c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a Covered Person is a dependent of an active employee and that same Covered Person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

(5) Longer or Shorter Length of Coverage. The Plan that covered the Covered Person as an

employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the Covered Person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary plan.

Effect on the Benefits of this Plan

A. When this Plan is Secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. The claims administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. The claims administrator need not tell, or get the consent of, any person to do this. Each Covered Person claiming benefits under this Plan must give the claims administrator any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by the claims administrator is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Surrogacy arrangements

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") except that we will recover no more than half of the monetary compensation you receive. 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 the 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 Covered Services that the baby receives).

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:

Equian
Kaiser Permanente
Surrogacy Mailbox
P.O. Box 36380
Louisville KY 40233

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" section 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 **Customer Service** at 1-855-364-3184.

Value-Added Services
Voluntary health promotion programs may be available to You. These value-added services may be 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 or 711 (TTY) 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.

TERMINATION/NON-RENEWAL/CONTINUATION

Termination of an Insured Employee's Insurance
Except as provided in the Continuation of Medical Benefits provision, Your insurance will automatically terminate on the earlier of:

1. The date the employee or employee's Dependents cease to be covered by Health Plan as a Point of Service member;
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; or
5. The last day of the month You cease to qualify as an Eligible Employee.

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. The Health Plan Evidence of Coverage more fully explains the eligibility, effective date, and termination provisions.

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;
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.

Medically Necessary Leave of Absence for Student Dependent
If You, as a Dependent, are enrolled in a post-secondary educational institution, Your coverage will not terminate due to a Medically Necessary Leave of Absence before the date that is the earlier of: (a) one year after the first day of the Medically Necessary Leave of Absence or (b) the date coverage would otherwise terminate under the terms of the Group Policy.

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 Group's written eligibility requirements and This health insurance plan has not terminated. You may be required to pay the full cost of the continued insurance during any such leave.

Rescission for Fraud or Intentional Misrepresentation
Subject to any applicable state or federal law, if KPIC makes a determination that You performed an act, practice or omission that constitutes 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 of a material fact occurred, if the fraud or intentional misrepresentation of a material fact was committed after the Effective Date of Your coverage.

TERMINATION/NON-RENEWAL/CONTINUATION

If Your or Your Dependent's Policy is rescinded, you have the right to appeal the rescission. Please refer to the **APPEALS AND COMPLAINTS** section of this Certificate for a detailed discussion of the grievance and Appeals process and Your right to an Independent External Review.

CONTINUATION OF MEDICAL BENEFITS (FEDERAL)

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

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 COBRA law. Please contact Your Group if You want to know how to elect COBRA coverage or how much You will have to pay Your Group for it.

Eligibility for Continued Health Coverage
A Covered Person whose group health coverage under the policy would end due to a qualifying event may have a right to elect continued Health Coverage for a limited period.

The phrase "health coverage" means the benefits of the policy that are based on Expenses Incurred for medical care.

A "Qualifying Event" is any one of the following events that would cause the Covered Person to lose health coverage under the policy:
"A" The death of the covered employee;
"B" The termination (other than by reason of the covered employee's gross misconduct), or reduction in hours, of such employee's employment;
"C" The divorce or legal separation of the covered employee and his or her spouse, partner in a civil union or Domestic Partner;
"D" The covered employee's becoming entitled to Medicare benefits;
"E" A child's ceasing to be an eligible Dependent under the terms of this health insurance plan.

Written Notices and Election Required
Covered Persons must notify their employers of a qualifying event set forth in "C" or "E". That notice must be given within sixty (60) days after the event occurs. If such timely notice is not given, the event will not entitle the Covered Person to continued health coverage.

The employer will notify Covered Persons who become entitled to elect continued health coverage. That notice will be furnished within 14 days of: (a) the date timely notice of a qualifying event set forth in "C" or "E" is received; or (b) the date any other qualifying event occurs. If that notice from the employer is not given or is late, the qualifying event will not entitle the Covered Person to continued health coverage. Should a court or government agency require KPIC to pay any benefits as though coverage had been continued, the employer will reimburse KPIC in the full amount that KPIC is required to pay.

A Covered Person will have sixty (60) days in which to elect continued health coverage. That sixty (60) days starts with the later of: (a) the date the qualifying event would cause the Covered Person to lose health coverage under this health insurance plan; or (b) the date the employer provides timely notice to the Covered Person of his or her right to elect continued health coverage. A Covered Person who does not make a timely written election will not receive continued health coverage unless included as a spouse, partner in a civil union or Domestic Partner or child in another family member's timely election.

Effect of Other Continuations
If this health insurance plan otherwise provides any health coverage after a qualifying event: (a) such coverage that is not an option will not defer or extend the maximum period of continued health coverage in this provision; and (b) such coverage that is an elected option will be deemed a waiver of continued health coverage under this provision. However, if a covered employee elects such alternate health

coverage for a spouse, partner in a civil union or Domestic Partner or child; and while that coverage is in effect another qualifying event occurs; then the alternate health coverage for the spouse, partner in a civil union or Domestic Partner or child will not end sooner than it would have under this provision.

Payment for Continued Health Coverage
The employer may require a Covered Person to pay for this continued health coverage. That payment will not exceed 102 percent of the total employer and employee cost of providing the same benefits to a Covered Person who has not had a qualifying event. The Covered Person will not be required to make such payments less frequently than monthly.

Benefits under Continued Health Coverage
This continued health coverage will at all times provide the same health care benefits as would have been afforded to the Covered Person had a qualifying event not occurred. This includes any changes in the health coverage under this health insurance plan as may become effective while continued health coverage is in effect.

Termination of Continued Health Coverage
A Covered Person's continued health coverage under this provision will end at the earliest of the following dates:
1. The date which ends the "Maximum Period" as defined below;
2. The date that This Plan no longer covers the employer that sponsored the coverage before the Qualifying Event;
3. The date ending the last period for which the Covered Person has made any required payment for continued Health Coverage on a timely basis; or
4. The date after electing continued Health Coverage on which the Covered Person first becomes: a) covered under any other group health plan (as an employee or otherwise) which does not exclude or limit any pre-existing condition of the Covered Person; or b) entitled to Medicare benefits.

The "Maximum Period" referred to above will start with the date of the Qualifying Event and will end: (a) with the date eighteen (18) months after a qualifying event set forth in "B"; or (b) with the date thirty-six (36) months after any other Qualifying Event. In applying this maximum period, if continued health coverage is already in effect when a qualifying event other than as set forth in "B" occurs, the maximum period will not end less than thirty-six (36) months from the date of the original qualifying event; and if a Qualifying Event set forth in "D" occurs, the Maximum Period as to the Covered Employee's spouse, partner in a civil union or Domestic Partner or child for that or any subsequent Qualifying Event will not end less than thirty-six (36) months from the date the Covered Employee became entitled to Medicare benefits.

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 to twenty-nine (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 eighteen (18) months, KPIC may increase the premium it charges by as much as 50 percent. 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 thirty (30) days after Social Security determines that the Covered Person is no longer disabled. The Covered Person must notify the employer within thirty (30) days of the date of such a Social Security determination.

TERMINATION/NON-RENEWAL/CONTINUATION

Continued Health Coverage from a Prior Plan
Continued Health Coverage will also be provided if: (a) this health insurance plan replaced a prior benefit plan of the 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 this health insurance plan had been in effect when the Qualifying Event occurred. But no benefits will be paid under this health insurance plan for health care Expenses Incurred before its effective date.

Continued Health Coverage under 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.

CONTINUATION OF MEDICAL BENEFITS (STATE)

Continuation of Health Coverage
A Covered Person must be given the option to elect continuation of this health insurance plan for himself or herself and any Dependents if:
1. The Covered Person's eligibility to receive coverage has ended for any reason other than discontinuance of the Group Policy in its entirety or with respect to an insured class;
2. Any premium or contribution required from or on behalf of the Covered Person has been paid to the termination date; and
3. The Covered Person has been continuously insured under the Group Policy, or under any Group Policy providing similar benefits which it replaces, for at least six (6) months immediately prior to termination.

A Covered Person has the right to continue coverage for: (a) a period of eighteen (18) months after termination of employment; or (b) until the Covered Person becomes re-employed, whichever occurs first. Should new coverage exclude a condition covered under the continued plan, coverage under the prior employer's plan may be continued for the excluded condition only for the eighteen (18) months or until the new plan covers the condition, whichever occurs first.

The Covered Person must elect to continue coverage and pay the applicable amount to apply toward the premium within twenty (20) days after termination of employment. If proper notification is not given to the Covered Person, the Covered Person may elect to continue coverage and pay the applicable amount to apply toward the insurance within thirty (30) days after termination of employment.

Reduced Work Hours
The Policyholder may elect to contract with KPIC to continue coverage under the same conditions and for the same premium for Covered Person, even if the Policyholder reduces the working hours of such Covered Person to less than thirty (30) hours per week, provided the following conditions are met:
1. The Covered Person has been continuously employed as a full-time employee of the Policyholder and has been insured under the Group Policy or any Group Policy providing similar benefits which said policy replaces, for at least 6 months immediately prior to such reduction in working hours;
2. The Policyholder has imposed such reduction in working hours due to economic conditions; and
3. The Policyholder intends to restore the Covered Person to a full 40-hour work schedule as soon as economic conditions improve.

APPEALS AND COMPLAINTS

Claims and Appeals
KPIC will review claims and appeals, and We may use medical experts to help Us review them. The following terms have the following meanings when used in this "**APPEALS and COMPLAINTS**" section:

1. A **Claim** is a request for us to:
   a. Pay for a Service that You have not received (Pre-Service claim),
   b. Continue to pay for a Service that You are currently receiving (Concurrent Care Claim), or
   c. Pay for a Service that you have already received (Post-Service claim).

2. An Adverse Benefit Determination is Our decision to do any of the following:
   a. Deny Your Claim, in whole or in part, including:
      i) A denial, in whole or in part, of a Pre-Service Claim (preauthorization for a Service), a Concurrent Care Claim (continue to provide or pay for a Service that You are currently receiving) or a Post-Service Claim (a request to pay for a Service) in whole or in part; or
      ii) A denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or
      iii) A denial of a request for Services on the ground that the Service is experimental or investigational.
   b. Terminate Your coverage retroactively except as the result of non-payment of premiums (also known as Rescission or Retroactive Cancellation); or
   c. Uphold Our previous Adverse Benefit Determination when You appeal.

   In addition, when We deny a request for medical care because it is excluded under this policy and you present evidence from medical professional licensed pursuant to the Colorado Medical Practice Act acting within the scope of his or her license that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then Our denial shall be considered an adverse benefit determination.

3. An Appeal is a request for Us to review Our initial Adverse Benefit Determination.

If You miss a deadline for making a Claim or Appeal, We may decline to review it.

Except when simultaneous External Review can occur, You must exhaust the Internal Claims and Appeals Procedure as described below in this **"APPEALS and COMPLAINTS"** section unless We fail to follow the claims and appeals process described in this Section.

Language and Translation Assistance
You may request language assistance with Your Claim and/or Appeal by calling **Member Services** at 1-800-632-9700 or 711(TTY).

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-632-9700.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-632-9700.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-632-9700.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-632-9700.

Appointing a Representative
If You would like someone including your provider (medical facility or health care professional) to act on Your behalf regarding Your Claim, You may appoint an authorized or designated representative. You must make this appointment in writing. Please contact **Customer Service** at 1-855-364-3184 or 711 (TTY) for

information about how to appoint a representative. You must pay the cost of anyone You hire to represent or help You.

Help with Your Claim and/or Appeal

You may contact the Colorado Division of Insurance at:

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

Reviewing Information Regarding Your Claim

If You want to review the information that We have collected regarding Your Claim, You may request, and We will provide without charge, copies of all relevant documents, records, and other information. You may request our Authorization for Release of Appeal Information form by calling **Member Relations** at 1-855-364-3184 or 711 (TTY).

You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of Your Claim. To make a request, You should contact **Customer Service** at 1-855-364-3184 or 711 (TTY).

Providing Additional Information Regarding Your Claim and/or Appeal

When You appeal, You may send Us additional information including comments, documents, and additional medical records that You believe support Your Claim. If We asked for additional information and You did not provide it before We made Our initial decision about Your Claim, then You may still send Us the additional information so that We may include it as part of Our review of Your Appeal, if You ask for one. Please send all additional information to the Department that issued the Adverse Benefit Determination.

When You appeal, You may give testimony in writing or by telephone. Please send Your written testimony to **Member Relations** . To arrange to give testimony by telephone, you should contact **Member Relations a**t 1-855-364-3184 or 711 (TTY).

We will add the information that You provide through testimony or other means to Your Claim file and We will review it without regard to whether this information was submitted and/or considered in Our initial decision regarding Your Claim.

Sharing Additional Information That We Collect

If We believe that Your Appeal of Our initial Adverse Benefit Determination will be denied, then before We issue Our next Adverse Benefit Determination We will also share with You any new or additional reasons for that decision. We will send You a letter explaining the new or additional information and/or reasons and inform You how You can respond to the information in the letter if You choose to do so. If You do not respond before We must make Our next decision, that decision will be based on the information already in Your Claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending Your Claim and Appeal to Us as described in this **APPEALS and COMPLAINTS** section:

1. Pre-Service Claims (Urgent and Non-Urgent)
2. Concurrent Care Claims (Urgent and Non-Urgent)
3. Post-Service Claims

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

APPEALS AND COMPLAINTS

Your internal review process includes (a) one mandatory level of review which is the First Level Appeal and (b) a voluntary second level of review which is the Voluntary Second Level Appeal. The Voluntary Second Level Appeal may only occur at your option. If you disagree with our decision on your First Level Appeal, your adverse First Level Appeal decision notice will tell you how to submit a Voluntary Second Level Appeal.

When you file an appeal, We will review Your Claim without regard to our previous Adverse Benefit Determination. The individual who reviews Your Appeal will not have participated in Our original decision regarding Your Claim nor will he/she be the subordinate of someone who did participate in Our original decision.

1. Pre-Service Claims and Appeals
   Pre-service Claims are requests that We pay for a Service that You have not yet received. Failure to receive authorization before receiving a Service that must be authorized or pre-certified in order to be a covered benefit may be the basis for Our denial of Your Pre-service Claim. If You receive any of the Services You are requesting before We make Our decision, Your Pre-service Claim or Appeal will become a Post-service Claim or Appeal with respect to those Services. If You have any general questions about Pre-service Claims or Appeals, please call **Permanente Advantage** at 1-888-525-1553 or 711 (TTY).

   Here are the procedures for filing a Pre-service claim, a Non-Urgent Pre-service Appeal, and an Urgent Pre-service Appeal.

   a. Pre-Service Claim
      Tell KPIC in writing that You want Us to pay for a Service You have not yet received. Your request and any related documents You give us constitute Your Claim. You or Your Provider must either mail or fax Your Claim to:

      Permanente Advantage
      8955 Miramar San Diego Drive, 2nd Floor Room 20R22
      San Diego, CA 92108
      1-888-525-1553 (phone)
      1-866-368-0266 (fax)

      If You want Us to consider Your Pre-service Claim on an Urgent basis, the request should tell us that. We will decide whether Your Claim is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Claim is Urgent. If We determine that Your Claim is not Urgent, We will treat Your Claim as Non-Urgent. Generally, a Claim is Urgent only if using the procedure for Non-Urgent Claims: (a) Could seriously jeopardize Your life, health, or ability to regain maximum function; or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the Services You are requesting. We may, but are not required to, waive the requirements related to an urgent claim and appeal thereof, to permit you to pursue an Expedited External Review.

      Non-Urgent Pre-Service Claim
      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 five (5) business days after We receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, so long as We notify You and inform You and Your Provider prior to the expiration of the initial five (5) day period and explain the circumstances for which we need the extension.

If We need more information, We will ask You and Your Provider for additional information within the initial five (5) business day decision period, and We will give You and Your Provider two (2) business days from receipt of Our request to send the additional information. We will make a decision within five (5) business 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 the additional information (including documents) from You or Your Provider within two (2) business days after receipt of Our request, We will make a decision based on the information We have.

We will send written notice of Our decision to You and if applicable to Your Provider.

Urgent Pre-Service Claim

If Your Pre-service Claim was considered on an Urgent basis and We have all the information We need, We will notify You and Your Provider of Our decision (whether adverse or not) orally or in writing within two (2) business days but not later than seventy-two (72) hours after We receive Your Claim. Within twenty-four (24) hours after We receive Your Claim, We may ask You and Your Provider for more information. We will give You and Your Provider within two (2) business days from receipt of Our request to send the additional information. We will notify You and Your Provider of Our decision within two (2) business days but not longer than forty-eight (48) hours of receiving the first piece of requested information. If We do not receive the additional information (including documents) from You or Your Provider within two (2) business days after receipt of Our request, We will make a decision based on the information We have and We will notify You of Our decision either orally or in writing. If We notify You of Our decision orally, We will send You and Your Provider written confirmation within three (3) days after that.

Your Pre-Service Claim shall be deemed to have been approved for failure on Our part to:

a) Request additional information needed to process the claim from You and Your Provider; or
b) Provide the notification of approval to You and Your Provider; or
c) Provide the notification of denial to You and Your Provider

within the required time frame set forth above.

Validity of Approval of a Pre-Service Claim

An approval of a Pre-Service Claim is valid for a period of one hundred eighty (180) days after the date of approval and continues for the duration of the authorized course of treatment. Once approved, We cannot retroactively deny a Pre-certification request for a treatment or service. This 180-day approval does not apply if:

a) The Pre-Service Claim approval was based on Fraud; or
b) The provider never performed the services that were requested; or
c) The service provided did not align with the service that was approved; or
d) The person receiving the service no longer had coverage under the plan on or before the date the service was delivered; or
e) The covered person's benefit maximums were reached on or before the date the service was delivered.

If We deny Your Claim (if We do not agree to pay for all the Services You requested), Our Adverse Benefit Determination notice will tell You why We denied Your Claim and how You can appeal.

b. Non-Urgent Pre-Service First Level Appeal

Within one hundred eighty (180) days after You receive our Adverse Benefit Determination notice, You must tell us by either calling us or writing to us that You want to Appeal Our denial of Your Pre-service Claim. We will count the one hundred eighty (180) calendar days starting five (5) business

days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period.

Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) the specific Service that You are requesting, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) All supporting documents. Your request and the supporting documents constitute Your Appeal.

For medical benefits other than Outpatient Prescription Drugs, You must either mail or fax Your Appeal to:

Permanente Advantage
8954 Rio San Diego Drive, 2nd Floor Room 20R22
San Diego, CA 92108
1-888-525-1553 (phone)
1-866-338-0266 (fax)

For Outpatient Prescription Drugs, You can appeal orally by calling 1-800-788-2949 (Pharmacy Help Desk) or in writing by mailing to:

KPIC Pharmacy Administrator
Grievance and Appeals Coordinator
10181 Scripps Gateway Court
San Diego, CA 92131

We will schedule an appeal meeting in a time frame that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal (who was not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that five-(5) day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than thirty (30) days after we receive Your Appeal.

If we deny Your Appeal, our Adverse Benefit Determination notice will tell you why we denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

c. Urgent Pre-Service First Level 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

For medical benefits other than Outpatient Prescription Drugs, You can appeal orally by calling **Permanente Advantage** at 1-888-525-1553 or in writing by mailing or sending by fax to:

Permanente Advantage
8954 Rio San Diego Drive, 2nd Floor room 20R22
San Diego, CA 92108
1-888-525-1553 (phone)
1-866-338-0266 (fax)

For Outpatient Prescription Drugs, You can appeal orally by calling 1-800-788-2949 (Pharmacy Help Desk) or in writing by mailing to:

KPIC Pharmacy Administrator
Grievance and Appeals Coordinator
10181 Scripps Gateway Court
San Diego, CA 92131

When You send Your Appeal, You may also request simultaneous External Review of Our initial Adverse Benefit Determination. If You want simultaneous External Review, Your Appeal must tell Us this. You will be eligible for the simultaneous External Review only if Your Pre-service Appeal qualifies as Urgent. If You do not request simultaneous External Review in Your Appeal, then You may be able to request External Review after We make Our decision regarding Your Appeal (see "External Review" in this "**APPEALS and COMPLAINTS**" section) if Our internal Appeal decision is not in your favor.

We will decide whether Your Appeal is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Appeal is Urgent. If We determine that Your Appeal is not Urgent, We will treat Your Appeal as Non-Urgent. Generally, an Appeal is Urgent only if using the procedure for Non-Urgent Appeals (a) Could seriously jeopardize Your life, health, or ability to regain maximum function; or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) Would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the Services You are requesting. We may, but not required to waive the requirements related to an Urgent Appeal to permit you to pursue an Expedited External Review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

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 seventy-two (72) hours after We received Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within three (3) days after that.

If We deny Your Appeal, our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

2. Concurrent Care Claims and Appeals.
Concurrent Care Claims are requests that KPIC continues to pay for an ongoing course of covered treatment or services for a period of time or number of treatments, when the course of treatment already being received will end. If You have any general questions about Concurrent Care Claims or Appeals, please call **Permanente Advantage** at 1-888-525-1553 or 711 (TTY).

APPEALS AND COMPLAINTS

Unless You are appealing an Urgent Concurrent Care Claim, if We either (a) Deny Your request to extend Your current authorized ongoing care (Your Concurrent Care Claim) or (b) Inform You that the authorized care that You are currently receiving is going to end early and You then appeal our decision (an Adverse Benefit Determination), then during the time that We are considering Your Appeal, You may continue to receive the authorized Services. If you continue to receive these Services while We consider Your Appeal and Your Appeal does not result in our approval of Your Concurrent Care Claim, then KPIC will only pay for the continuation of services until we notify you of our appeal decision

Here are the procedures for filing a Concurrent Care Claim, a Non-Urgent concurrent care appeal, and an Urgent concurrent care appeal:

a. Concurrent Care Claim

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

Permanente Advantage
8954 Rio San Diego Drive, 2nd Floor, Room 20R22
San Diego, CA 92108
1-888-525-1553 (phone)
1-866-338-0200 (fax)

If You want us to consider Your Claim on an Urgent basis and You contact us at least twenty-four (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) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (b) Would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without extending Your course of covered treatment.. We may, but are not required to waive the requirements related to an urgent claim and appeal thereof to permit you to pursue an Expedited External Review.

We will review Your Claim, and if We have all the information We need We will make a decision within a reasonable period of time. If You submitted Your Claim twenty-four (24) hours or more before Your care is ending, We will make our decision before Your authorized care actually ends (that is, within 24 hours of receipt of Your claim). If Your authorized care ended before You submitted Your Claim, We will make our decision within a reasonable period of time but no later than fifteen (15) days after we receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, if We send You notice before the initial fifteen-(15) day period ends and explain the circumstances and the reason for the extension and when we expect to make a decision.

If We tell You We need more information, We will ask You for the information before the initial decision period ends and We will give you until Your care is ending or, if Your care has ended, forty-five (45) days to send us the information. We will make our decision as soon as possible, if Your care has not ended, or within fifteen (15) days after We first receive any information (including documents) we requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within the stated timeframe after We send Our request, We will make a decision based on the information We have within the appropriate

timeframe, not to exceed fifteen (15) days following the end of the forty-five (45) days that We gave you for sending the additional information.

We will send written notice of our decision to You and, if applicable to Your Provider, upon request. Please let Us know if You wish to have Our decision sent 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 twenty-four (24) hours after We received Your Appeal. If We notify You of Our decision orally, We will send You written confirmation within three (3) days after receiving Your Claim.

If We deny Your Claim (if we do not agree to pay for extending the ongoing course of treatment or services), our Adverse Benefit Determination notice will tell you why We denied Your Claim and how You can appeal.

b. Non-Urgent Concurrent Care First Level Appeal

Within one hundred eighty (180) days after you receive our Adverse Benefit Determination notice, you must tell us by either calling us or writing to us that you want to appeal our Adverse Benefit Determination. We will count the one hundred eighty (180) calendar days starting five (5) business days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The ongoing course of covered treatment that you want to continue or extend, (4) All of the reasons why you disagree with our Adverse Benefit Determination and (5) All supporting documents. Your request and all supporting documents constitute Your Appeal. You must either mail or fax appeal to:

Permanente Advantage
8954 Rio San Diego Drive, 2nd Floor Room 20R22
San Diego, CA 92111
1-866-525-1553 (phone)
1-866-338-0266 (fax)

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The members of the appeals committee who will review your appeal will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that five-day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send You a written decision as soon as possible if You care has not ended but not later than thirty (30) days after We receive Your Appeal.

If We deny Your Appeal, Our Adverse Benefit Determination decision will tell You why We denied Your Appeal and will include information about any further process, including External Review, that may be available to You.

c. Urgent Concurrent Care First Level Appeal

Tell us that You want to urgently appeal our Adverse Benefit Determination regarding Your urgent concurrent claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The ongoing course of covered treatment that You want to continue or extend, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) All supporting documents. Your request and the supporting documents constitute Your Appeal. You may submit your appeal orally by calling Permanente Advantage at 1-888-525-1553 or in writing by mailing or sending by fax to:

Permanente Advantage
8954 Rio San Diego Drive, 2nd Floor Room 20R22
San Diego, CA 92108
1-888-525-1553 (phone)
1-866-338-0266 (fax)

When You send Your Appeal, You may also request simultaneous External Review of Our Adverse Benefit Determination. If You want simultaneous External Review, Your Appeal must tell Us this. You will be eligible for the simultaneous External Review only if Your Concurrent Care Claim qualifies as Urgent. If You do not request simultaneous External Review in Your Appeal, then You may be able to request External Review after We make Our decision regarding Your Appeal (see "External Review" in this **"APPEALS and COMPLAINTS"** section).

We will decide whether Your Appeal is Urgent or Non-Urgent unless Your attending health care provider tells Us Your Appeal is Urgent. If We determine that Your Appeal is not Urgent, We will treat Your Appeal as Non-Urgent. Generally, an Appeal is Urgent only if using the procedure for Non-Urgent Appeals (a) Could seriously jeopardize Your life, health, or ability to regain maximum function: or (b) If You have a physical or mental disability that creates an imminent and substantial limitation on Your existing ability to live independently; or (c) 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 may, but not required to waive the requirements related to an Urgent appeal to permit you to pursue an Expedited External Review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written complaints, documents, record and other materials for the reviewer or reviewers to consider; and to receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

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 seventy-two (72) hours after we receive Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within three (3) days after that.

If We deny Your Appeal, Our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information about any further process, including External Review, that may be available to You.

3. Post-Service Claims and Appeals

Post-service Claims are requests that We for pay for Services You already received, including Claims for Out-of-Plan Emergency Services. If You have any general questions about Post-Service Claims or Appeals, please call **Customer Service** at 1-855-364-3184 or 711 (TTY).

APPEALS AND COMPLAINTS

Here are the procedures for filing a Post-Service Claim and a Post-service Appeal:

a. Post-Service Claim
Within twenty (20) days, but in no event more than twelve (12) months from the date You received the Services, mail Us a letter explaining the Services for which You are requesting payment or reimbursement. Provide Us with the following: (1) Member/Patient Name, (2) The date You received the Services, (3) Where You received them, (4) Who provided them, (5) Why You think We should pay for the Services, (6) .You must include a copy of the bill, Your medical records for these services, Your receipt if You paid for these services and any supporting documents. Your letter and the related documents constitute Your Claim. Or, You may contact **Customer Service** at 1-855-364-3184 or 711 (TTY) to obtain a Claims form. You must mail Your Claim to **Claims Department** at:

National Claims Administration- Colorado
PO Box 373150
Denver, CO 80237-9998

Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

We will review Your Claim, and if We have all the information We need We will send You a written decision within thirty (30) days after We receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, if We notify You within fifteen (15) days after We receive Your Claim and explain the circumstances and the reason for the extension and when we expect to make the decision. If We tell You We need more information, We will ask You for the information and We will give you forty-five (45) days from the date of Your receipt of Our notice to send Us the information. We will make a decision within fifteen (15) days after We receive the first piece of information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within forty-five (45) days after We send Our request, We will make a decision based on the information We have within fifteen (15) days following the end of the forty-five (45) day period

If We deny Your Claim (if We do not pay for all the Services You requested), Our Adverse Benefit Determination notice will tell You why We denied Your Claim and how You can appeal.

b. Post-Service First Level Appeal
Within one hundred eighty (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. We will count the one hundred eighty (180) calendar days starting five (5) business days from the date of the initial decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) The specific Services that You want Us to pay for, (4) All of the reasons why You disagree with Our Adverse Benefit Determination, and (5) Include all supporting documents such as medical records. Your request and the supporting documents constitute Your Appeal. You must either mail or fax Your Appeal to:

Kaiser Foundation Health Plan of Colorado
Member Relations, Appeals
PO Box 37806
Denver, CO 80237
1-855-364-3184 (phone)
1-866-466-4042 (fax)

We will schedule an appeal meeting in a timeframe that permits us to decide your appeal in a timely manner. You may be present for the appeal meeting in person or by telephone conference, and you may bring counsel, advocates and health care professionals to the appeal meeting. Unless you request to be present for the appeal meeting in person or by telephone conference, we will conduct your appeal as a file review. You may present additional materials at the appeal meeting. The appeals committee members who will review your appeal (who were not involved in our original decision regarding your claim) will consider this additional material. Upon request, we will provide copies of all information that we intend to present at the appeal meeting at least five (5) days prior to the meeting, unless any new material is developed after that 5-day deadline. You will have the option to elect to have a recording made of the appeal meeting, if applicable, and if you elect to have the meeting recorded, we will make a copy available to you.

We will review Your Appeal and send You a written decision within 30 days after We receive Your Appeal.

If We deny Your Appeal, Our Adverse Benefit Determination will tell You why We denied Your Appeal and will include information regarding any further process, including External Review, that may be available to You.

Appeals of Retroactive Coverage Termination (Rescission or Retroactive Cancellation)

We may terminate your coverage retroactively (see Rescission for Fraud or Intentional Misrepresentation under **TERMINATION/NON-RENEWAL/CONTINUATION** section). We will send you written notice at least thirty (30) days prior to the termination. If you have general questions about retroactive coverage terminations or appeals, please call the **Customer Service** at 1-855-364-3184.

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

Within one hundred eighty (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 membership termination, and (3) All supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland CA 94612

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

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including External Review, that may be available to you. Contact Member Relations at 1-800-788-0710 or 711 with any question about your First Level Appeal Rights.

Voluntary Second Level Appeal

A Voluntary Second Level Appeal is another review by Us that occurs after the mandatory internal Appeal decision is communicated to You if You remain dissatisfied with Our decision. This in-person review permits You to present evidence to the Second Level Appeal Panel and to ask questions**. Choosing a Voluntary Second Level Appeal will not affect Your right, if you have one, to request an independent External Review.**

APPEALS AND COMPLAINTS

Here is the procedure for a Voluntary Second Level of Appeal for medical benefits and Outpatient Prescription Drugs:

Within sixty (60) days from the date of Your receipt of Our notice regarding Your First Level of Appeal decision, we must receive your Voluntary Second Level Appeal requesting the review of the adverse decision. We will count the sixty (60) days starting five (5) business days from the date of the First Level of Appeal decision notice to allow for delivery time unless you can prove that you received the notice after that 5-business day period. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) The specific Service that You are requesting, (4) All of the reasons why You disagree with Our Adverse Benefit Determination (mandatory internal Appeal decision), and (5) All supporting documents. Your request and the supporting documents constitute Your request for a Voluntary Second Level of Appeal.

For medical benefits, You must either mail or fax Your Appeal to:

Kaiser Foundation Health Plan of Colorado
Member Relations, Appeals
PO Box 378066
Denver, CO 80237
1-855-364-3184 (phone)
1-866-466-4042 (fax)

For Outpatient Prescription Drugs, You must either mail or fax Your appeal to:

KPIC Pharmacy Administrator
Grievance and Appeals Coordinator
10181 Scripps Gateway Court
San Diego, CA 92131
1-800-788-2949 (phone)
1-858-790-6060 (fax)

Within sixty (60) calendar days following receipt of Your request, KPIC will hold a Voluntary Second Level Appeal meeting. KPIC shall notify You of the date on which the Voluntary Second Level Appeal Panel will meet at least twenty (20) days prior to the date of this in-person meeting. You have the right to request a postponement by calling **Member Appeals Program** at 1-888-370-9858 and your request cannot be unreasonably denied. You have the right to appear in person or by telephone conference at the review meeting. We will make our decision within seven (7) days of the completion of this meeting.

You may present Your Appeal in person before the Voluntary Second Level Appeal Panel, or request a file review. If You would like to present Your Appeal in person, but an in-person meeting is not practical, You may present Your Appeal by telephone by calling e **Member Appeals Program** at 1-888-370-9858. Please indicate in Your Appeal request how you want to present Your Appeal. Unless you request to be present for the special meeting in person or by telephone conference, we will conduct your appeal as a file review

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

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

Second Level Appeal meeting, then You must let Us know that at least seven (7) days prior to that meeting. You must appoint this attorney as Your representative in accordance with our procedures.

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

If You would like further information about the Voluntary Second Level Appeal process, to assist You in making an informed decision about pursuing a Voluntary Second Level Appeal, please call **Member Appeals Program** at 1-888-370-9858. Your decision to pursue a Voluntary Second Level Appeal will have no effect on Your rights to any other benefits under this health insurance plan, the process for selecting the decision maker and/or the impartiality of the decision maker.

External Review

Following receipt of an adverse First Level Appeal or Voluntary Second Level Appeal decision letter, You may have a right to request an External Review. There is no minimum dollar amount for a claim to be eligible for an External Review. You will not be responsible for the cost of the External Review.

You have the right to request an independent External Review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that i (1) relies on ,medical judgment including but not limited to medical necessity, appropriateness, health care setting, level of care or effectiveness of a benefit, a denial of a pre-certification for a Service; or (2) concludes that a treatment or service is experimental or investigational; a denial of a request for services on the ground that the Service is not Medically Necessary, appropriate; or 3) concludes that parity exists in the non-quantitative treatment limitation applied to Behavioral Health/Mental Health or Substance Use Disorder benefits; (4) involves consideration of whether We are complying with federal law requirements regarding surprise billing and cost-sharing protections pursuant to the No Surprises Act or (5) involves a decision related to rescission of your coverage.

If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for External Review. However, independent External Review is available when we deny your appeal because you request medical care that is excluded under your plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

To request External Review, You must submit a completed Independent External Review of Carrier's Final Adverse Determination form (you may call **Member Relations** at 1-800-788-0710 to request another copy of this form) which will be included with the mandatory internal appeal decision letter and explanation of Your Appeal rights, to **Member Appeals Program** within four (4) months of the date of receipt of Our mandatory First Level Appeal decision or of Our Voluntary Second Level Appeal decision. We shall consider the date of receipt for Our notice to be three (3) days after the date on which Our notice was postmarked, unless You can prove that You received our notice after the three (3)-day period ends.

You must include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Member Relations** at 1-800-788-0710 to request a copy of this form).

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

Expedited External Review

With respect to an Urgent Pre-Service Claim, You may request an Expedited External Review if (1) You have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize Your life, health, or ability to regain maximum function; or, (2) If You have a physical or mental existing disability that creates an imminent and substantial limitation to Your existing ability to live independently, or (3) In the opinion of a Physician with knowledge of Your medical condition, the timeframe for completion of a standard review would subject You to severe pain that cannot be adequately managed without the medical services that You are seeking.

You may request Expedited External Review simultaneously with your expedited internal appeal as permitted under this Plan. A request for an Expedited External Review must be accompanied by a written statement from Your Physician that Your condition meets the expedited criteria. You must include the Physician's certification that You meet External Review criteria when You submit Your request for External Review along with the other required information (described, above). No Expedited External Review is available when You have already received the medical care that is the subject of Your request for External Review. If You do not qualify for Expedited External Review, We will treat Your request as a request for Standard External Review.

Additional Requirements for External Review regarding Experimental or Investigational Services
You may request External Review or expedited External Review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for External Review or expedited External Review must include a written statement from your physician that either (a) Standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b)There is no available standard health care service or treatment covered under this plan that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited External Review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for External Review.

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

If We deny Your request for Standard or Expedited External Review, including any assertion that We have not complied with the applicable requirements related to Our Internal Claims and Appeals Procedure, then We may notify You in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that We send this denial notice to You, We will send a copy of it to the Division of Insurance.

You will not be able to present Your Appeal in person to the Independent External Review Organization. You may, however, send any additional information that is significantly different from information provided or considered during the Internal Claims and Appeal Procedure and, if applicable Voluntary Second Level of Appeal process. If You send new information, We may consider it and reverse our decision regarding Your Appeal.

You may submit Your additional information to the Independent External Review Organization for consideration during its review within five (5) working days of Your receipt of Our notice describing the Independent Review Organization that has been selected to conduct the External Review of Your Claim. Although it is not required to do so, the Independent Review Organization may accept and consider additional information submitted after this five (5)-working day period ends.

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

If the Independent External Review Organization overturns Our denial of payment for care You have already received, We will issue payment within five (5) working days. If the Independent Review organization overturns Our decision not to authorize Pre-service or Concurrent Care Claims, KPIC will authorize care within one (1) working day. Such Covered Services shall be provided subject to the terms and conditions applicable to benefits under this health insurance plan.

Except when External Review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal, You must exhaust Our Internal Claims and Appeals Procedure (but not the Voluntary Second Level of Appeal) for Your Claim before You may request External Review, unless We have failed to comply with federal and/or state law requirements regarding Our Claims and Appeals Procedures.

Additional Review

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

INFORMATION ON POLICY AND RATE CHANGES

Entire Contract and Changes
The Policyholder will act on behalf of all the Insured Employees in all matters pertaining to the Group Policy, and the following will be binding upon all Covered Persons: (1) every act done by the Policyholder; (2) every agreement between KPIC and the Policyholder; and (3) every notice given by either party to the other.

The entire contract between the Policyholder and KPIC consists of the Group Policy, certificates, amendments or riders incorporated by reference, the attached application of the Policyholder; and the applications, on file, if any, of the Insured Employees. All statements made by the Policyholder or Insured Employees will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Policyholder or Insured Employees will be used in defense to a claim under the Group Policy, unless it is contained in a written application.

No change in the Group Policy will be valid unless:
1. It is noted on, or attached to, the Group Policy;
2. Signed by an executive officer of KPIC; and
3. Delivered to the Policyholder.

KPIC may change, cancel, or discontinue coverage, to the extent permitted by law, provided under the Group Policy without the consent of the Policyholder or Insured Employees. Payment of premium, after a change has been made and incorporated into the Group Policy, will be deemed acceptance of the changes made by KPIC. The Policyholder must mail or deliver notice of cancellation or discontinuance to all Insured Employees at least thirty-one (31) days prior to the date of cancellation or discontinuance of the Group Policy. Notice to the Insured Employee will be considered notice to any Insured Dependent of the Insured Employee.

No agent has the authority to:
1. Change the Group Policy;
2. Waive any provisions of the Group Policy;
3. Extend the time for payment of premiums; or
4. Waive any of KPIC's rights or requirements.

Premium Rates
KPIC may change any of the premium rates as of any Group Policy Anniversary, or at any other time by written agreement between the Policyholder and KPIC on any premium due date when:
1. The terms of the Group Policy are changed;
2. A division, a subsidiary or an affiliated company is added to the Group Policy; or
3. For reasons other than the above, such as, but not limited to, a change in factors bearing on the risk assumed. The rate may not be changed within the first six months following the Group Policy Effective Date.

KPIC will give the Policyholder thirty-one (31) days advance written notice of any change in premium.

KPIC will give the Policyholder a thirty-one (31) day grace period for the payment of any premium.

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.

"A" Recommendation means a recommendation adopted by the Task Force, which strongly recommends that clinicians provide a preventive health care service because the Task Force found there is a high certainty that the net benefit of the preventive health care service is substantial.

Accumulation Period – The time period set forth in the **SCHEDULE OF BENEFITS (Who Pays What)** section.

ACIP means the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention in the Federal Department of Health and Human Services, or any successor entity.

Administrator means Kaiser Foundation Health Plan of Colorado. 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.

Air Ambulance Service means medical transport by a rotary wing air ambulance, or fixed wing air ambulance, as defined under applicable federal law for patients.

Age Appropriate Health Maintenance Visit means an exam which includes the following components:
1. Age appropriate physical exam (but not a complete physical exam unless this is age appropriate);
2. History
3. Anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.); and
4. Exercise and nutrition counseling (including foliate counseling for women of child bearing age).

Applied Behavior Analysis means the use of behavioral analytic methods and research findings to change socially important behaviors in meaningful ways.

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: (a) A federally funded or approved trial; (b) a clinical trial conducted under an FDA investigational new drug application; or (c) A drug that is exempt from the requirement of an FDA investigational new drug application.

Autism Services Provider means any person, who provides direct services to Covered Persons with Autism Spectrum Disorder, is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and who meets one of the following:
1. Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the Colorado medical board, and has at least one (1) year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
2. Has a doctoral degree in one of the behavioral or health sciences and has completed one (1) year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
3. Has a master's degree or higher in behavioral sciences and is nationally certified as a "Board Certified Behavior Analyst" or certified by a similar nationally recognized organization; or

4. Has a master's degree or higher in one (1) of the behavior or health sciences, is credentialed as a "Related Services Provider," and has completed one (1) year of direct supervised experience in behavioral therapies. Related Services Provider means physical therapist, an occupational therapist or speech therapist that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders; or
5. Has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a Board-Certified Associate Behavior Analyst or certified by a similarly recognized organization; or
6. Is nationally registered as a "registered behavior technician" by the behavior analyst certification board or by a similar nationally recognized organization and provides direct services to a person with an Autism Spectrum Disorder under the supervision of an autism services provider described in sub-subparagraph (1), (2), (3), (4), or (5) above.

Autism Spectrum Disorders (ASD) means a disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis; and includes the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders in effect at the time of the diagnosis: Autistic Disorder, Asperger's Disorder, and atypical Autism, as a diagnosis within pervasive developmental disorder, not otherwise specified.

Autism Treatment Plan means a plan developed for a Covered Person by an Autism Services Provider and prescribed by a Physician and licensed psychologist pursuant to comprehensive evaluation or reevaluation for a Covered Person consisting of the Covered Person's diagnosis, proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which by which the plan will be updated. The Treatment Plan shall be developed in accordance with patient-centered medical home, as defined under applicable Colorado law

"B" Recommendation means a recommendation adopted by the Task Force, which recommends that clinicians provide a preventive health care service because the Task Force found there is high certainty that the net benefit is moderate or there is a moderate certainty that the net benefit is moderate to substantial.

Behavioral Health/Mental Health and Substance Use Disorder:
1. Means a condition or disorder, regardless of etiology, that maybe the result of a combination of genetic and environmental factors and that falls under any of the diagnostic categories listed in the Mental Disorders section of the most recent version of:
   (a) The International Statistical Classification of Diseases and Health Related Problems;
   (b) The Diagnostic and Statistical Manual of Mental Disorders; or
   (c) The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood; and
2. Includes Autism Spectrum Disorder

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 Accumulation Period Deductible and Out-of-Pocket Maximum. Benefit Maximum does not apply to Essential Health Benefits, as defined under this health insurance plan received at either the Participating Provider level or the Non-Participating level.

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 ante partum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: (1) uncomplicated pregnancy and labor; and (2) spontaneous vaginal delivery.

Benefits payable for the treatment of complications of pregnancy will be covered on the same basis as any other Sickness.

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 that same year.

Certificate of Insurance (Certificate) means a certificate issued to the Policyholder that summarizes the coverage to which Covered Persons are entitled. It is a part of the Group Policy with Your Employer and is also subject to the terms of the Group Policy.

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.

Child Health Supervision Services means those preventive services and immunizations required to be provided in a Colorado basic and standard health benefit plan in accordance with Colorado Code Section 10-16-105 (7.2), as then constituted and later amended to covered Dependent children up through age twelve (12). Services must be provided by a Physician or pursuant to a physician's supervision or by a primary health care provider who is a Physician's assistant or Registered Nurse who has additional training in child health assessment and who is working in collaboration with a Physician.

Clean Claim means a claim for payment of health care expenses that is submitted to KPIC on an industry standard claim form with all required fields completed with correct and complete information in accordance with KPIC's published filing requirements. A Clean Claim does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

Clinical Social Worker means a person who is licensed as a clinical social worker, and who has at least five years of experience in psychotherapy (as defined by the state of Colorado) under appropriate supervision, beyond a master's degree.

Clinical Trial means an experiment, in which a drug or device is administered to dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs, as well as the use of drug in combination with alternative therapy or dietary supplement.

DEFINITIONS

Coinsurance means a percentage of charges that You must pay as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section when You receive a Covered Service as described under the **BENEFITS/COVERAGE (What is Covered)** section and the Policy Schedule. Coinsurance amount is applied against the Covered Charge.

Complications of Pregnancy means

1. conditions when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; or
2. Non-elective cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include conditions such as false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Complications of Pregnancy are covered under this Certificate as any other Sickness or Injury.

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 of 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 twenty-four 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 BENEFITS (Who Pays What)** section, which is to be paid by the Insured for a Covered Service, usually at the time the health care is rendered. All Co-payments applicable to the Covered Services are shown in the Schedule of Coverage.

Cosmetic Surgery means surgery that: (a) is performed to alter or reshape normal structures of the body in order to improve the Covered Person's appearance; and (b) will not result in significant improvement in physical function. Cosmetic Surgery is not covered under this Policy.

Cost Share means a Covered Person's share of Covered Charges. Cost Share includes and is limited only to the following: 1) Coinsurance; 2) Co-payment; 3) per benefit deductibles; and 4) Deductible.

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. A Covered Person who is enrolled as an Insured Employee or Insured Dependent under the Plan. Also, sometimes referred to as member. No person may be covered as both an Insured Employee and a Dependent at the same time under a single Group Policy.

Covered Services means those services and items which a Covered Person is entitled to receive pursuant to the Group Policy and are defined and listed under the section entitled **BENEFITS/COVERAGE (What is Covered)** subject to the exclusions and limitations set forth in this Certificate.

DEFINITIONS

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 Covered Charges equal to the Deductible are incurred and submitted to Us, the Deductible will have been met for that Covered Person except if there is an additional or separate deductible that is applicable.

Some Covered Services are subject to additional or separate deductible amounts as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section. These additional or separate deductibles are neither subject to, nor do they contribute towards the satisfaction of the Self-Only Deductible or Individual Deductible or the Family Deductible Maximum.

Dependent means:

1) Your lawful spouse, partner in a civil union or Domestic Partner (if Domestic Partner is covered under this plan); or
2) Your or Your spouse's/Your partner in a civil union or Your Domestic Partner natural or adopted or foster child, if that child is under age the age of 26.
3) Other unmarried dependent person who meet all of the following requirements:
   a) Is under the dependent limiting age specified in the **SCHEDULE OF BENEFITS (Who Pays What)** section; and
   b) You or Your Spouse or Your partner in a civil union or Your Domestic Partner is the court-appointed permanent legal guardian or was before the person reached age 18.
4) Your or Your Spouse or Your partner in a civil union, Your Domestic Partner unmarried child of any age; who is medically certified as disabled and dependent upon You, Your Spouse, Your partner in a civil union or Your Domestic Partner, are eligible to enroll or continue coverage as Your Dependents if the following requirements are met:
   a) They are financially dependent on You or Your Spouse, Your partner in a civil union or Your Domestic Partner; and
   b) You give us proof of the Dependent's disability and dependency annually if We request it.
5) An Individual who:
   a. Meets the criteria listed in paragraphs numbers 1, 2, 3 and 4 of this definition, and
   b. Is eligible for and enrolled in the Group Policy.

Detoxification means the process of removing toxic substances from the body.

Domestic Partner means an unmarried adult who resides with the Insured Employee for at least six (6) months in a committed relationship and is enrolled as Dependent. A Domestic Partner may be regarded as a Dependent, upon meeting Our prescribed requirements, which include the following:

1. Both persons must have a common residence for a period of at least six months prior to eligibility for this coverage;
2. Both persons must agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership;
3. Neither person is married nor a member of another domestic partnership or have been a party to a domestic partnership that was terminated within twelve (12) months before becoming eligible for this coverage;
4. The two persons are not related by blood in a way that would prevent them from being married to each other in conformity with state law;
5. Both persons must be at least 18 years of age and be the same sex;
6. Both persons must be capable of consenting to the domestic partnership;
7. Neither person is legally married to or legally separated from another person; and
8. Both persons must have duly executed a declaration of domestic partnership on a form agreed to by Us.

Durable Medical Equipment means equipment which:

1. Is designed for repeated use; and

2. Can mainly and customarily be used for medical purposes; and
3. Is not generally of use to a person in the absence of a Sickness or Injury; and
4. Is approved for coverage under Medicare, including insulin pumps and insulin pump supplies; and
5. Is not primarily or customarily for the convenience of the Covered Person; and
6. Provides direct aid or relief of the Covered Person's medical condition; and
7. Is Appropriate for use in the home; and
8. Serves a specific therapeutic purpose in the treatment of an illness or injury; or
9. Is an apnea monitor.

Durable Medical Equipment does not include:
1. Oxygen tents;
2. Equipment generally used for comfort or convenience that is not primarily medical in nature (e.g., bed boards, bathtub lifts, adjust-a-beds, telephone arms, air conditioners, and humidifiers);
3. Deluxe equipment such as motor driven wheelchairs and beds, except when such deluxe features are necessary for the effective treatment of a Covered Person's condition and in order for the Covered Person to operate the equipment;
4. Disposable supplies, exercise and hygiene equipment, experimental or research equipment, and devices not medical in nature such as sauna baths, elevators, or modifications to the home or automobile. This exclusion does not apply to disposable diabetic supplies;
5. Devices for testing blood or other body substances, except diabetic testing equipment and supplies;
6. Electronic monitors of bodily functions, except infant apnea monitors;
7. Replacement of lost equipment;
8. Repair, adjustments, or replacements necessitated by misuse;
9. More than one piece of Durable Medical Equipment serving essentially the same function; except for replacements other than those necessitated by misuse or loss; and
10. Spare or alternate use equipment.

Early Childhood Intervention Services (ECIS) means services as defined by the Colorado Department of Human Services in accordance with Part C of the Individuals with Disabilities Education Act of 2004, as then constituted and later amended, that are authorized through an Insured Dependent's Individualized Family Service Plan, but excluding non-emergency medical transportation; respite care; service coordination, as defined under applicable federal regulation; and assistive technology.

Eligible Employee means a person who, at the time of original enrollment: (a) is working for a Policyholder as a full-time employee as described below or is entitled to coverage under an employment contract; (b) by virtue of such employment or contract enrolls under the Group Policy and (c) reached an eligibility date. Eligible Employee includes sole proprietors, partners of a partnership, or independent contractor if they are included as employees under a health benefit plan of the Policyholder, engaged on a full-time basis in the employer's business or are entitled to coverage under an employment contract.

The term Eligible Employee does not include employees who work on a temporary seasonal or substitute basis.

Eligible Insured Dependent means an infant or toddler, from birth up to the child's third birthday, who has significant delays in development or has a diagnosed physical or mental condition that has high probability or resulting in significant delays in development or who is applicable is eligible for Early Childhood Intervention Services pursuant to applicable Colorado law. Please refer to the definition of Insured Dependent.

Emergency Care or Emergency Services All of the following with respect to an Emergency Medical Condition:
1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a

hospital or or an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act (EMTLA) or as would be required under EMTLA if such section applied to an independent freestanding emergency department, requires to Stabilize the patient.
3. Covered Services that are furnished by a Provider (regardless of the department of the hospital in which such items or services are furnished) after the Covered Person is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in paragraphs 1 and 2 of this definition are furnished provided, however, if the Provider obtains consent of the Covered Person pursuant to applicable law, then such Covered Services will not be considered to be Emergency Care or Emergency Services.

Emergency Medical Condition: A medical condition, including psychiatric conditions, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. 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 the Patient Protection and Affordable Care Act of 2010 (PPACA) as then constituted or later amended. Essential Heath Benefits, as defined under the Policy are not subject to any annual and lifetime dollar limits or any Dollar Benefit Maximum. Unless otherwise prohibited by applicable law, day or visit limits may be imposed on Essential Health Benefits. Adult routine eye exams, routine eye refraction tests for adults and hearing aids for adults are not Essential Health Benefits.

Expense(s) Incurred means expenses a Covered Person incurs for Covered Services. An expense is deemed incurred as of the date of the service, treatment, or purchase of the item that is a Covered Service.

Formulary means a list of prescription drugs or devices we cover.

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.

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

Habilitative Services means services and devices that help a person retain, learn or improve skills and

functioning for daily living. 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 outpatient settings.

Health Plan means Kaiser Foundation Health Plan of Colorado.

Health Plan Evidence of Coverage describes the health care coverage provided under the group agreement between the Kaiser Foundation Health Plan of Colorado (Health Plan) and your group.

HMO coverage means services provided, authorized or arranged by Health Plan under a separate agreement.

HMO Physician/Provider is a physician or provider contracted with the Health Plan to provide services under the Health Plan's Evidence of Coverage.

Home Health Agency means an agency which has been certified by the Colorado Department of Public Health and Environment as meeting the provisions of Title XVIII of the Federal "Social Security Act," as amended, for home health agencies and is engaged in arranging and providing nursing services, Home Health Services, and other therapeutic and related services.

Home Health Visit is each visit by a member of the home health team, provided on a part-time and intermittent basis as included in the plan of care. Services of up to four hours by a home health aide shall be considered as one visit

Homemaker Services means services provided to a Covered Person for Hospice Care which include:
1. General household activities including the preparation of meals and routine household care; and
2. Teaching, demonstrating and providing the Covered Person or their family with household management techniques that promote self-care, independent living and good nutrition.

Hospice Care means home-based palliative and supportive care by a licensed hospice for terminally ill patients. 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 Hospice Care, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 6 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 for 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 is currently licensed or certified by the Colorado Department of Public Health and Environment pursuant to the Department's authority under applicable Colorado law.

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

Individualized Education Plan means a written plan for an Insured Dependent with a disability that is developed, reviewed, and revised in accordance with Colorado's applicable statutory and regulatory

standards.

Individualized Family Service Plan is a written plan developed pursuant of to applicable federal statutory and regulatory standards, which authorizes the provision of Early Childhood Intervention Services to an Eligible Insured Dependent and to his or her family.

Individualized Plan means a written plan designed by an interdisciplinary team for the purpose of identifying the following: (a) needs of the Covered Person or family receiving the services; (b) the specific services and supports appropriate to meet such needs; (c) the projected date of initiation of services and supports; and (d) the anticipated results to be achieved by receiving the services and supports.

Insured Dependent means a Covered Person who is a Dependent of an Insured Employee.

Insured Employee means a Covered Person who is an Eligible 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;
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.

Interdisciplinary Team means a group of qualified individuals, which includes, but is not limited to, a Physician, Registered Nurse, clergy/counselors, volunteer director and/or trained volunteers, and appropriate staff who collectively have expertise in meeting the special needs of Hospice patients and their families.

Intractable Pain means a pain state in which the cause of the pain cannot be removed and which in the generally accepted course of medical practice no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending Physician and one or more Physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain.

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 Participating Providers, the Negotiated Rate as defined under Paragraph 3 (b).
2. For Covered Services from Non-Participating Providers rendering the following services:
   (a) Emergency or Non-Emergency Services rendered in Participating facilities by physicians and other professionals that are Non-Participating Providers:
   (b) Emergency Services rendered in a non-Denver Health Hospital Authority operated Non-Participating facility.
   (c) Emergency Services rendered in a Denver Health Hospital Authority operated Non-Participating Provider facility.
   the reimbursement rate according to state and federal law.

Other than applicable cost sharing (Deductible, Coinsurance or Copayments) Non-Participating Providers

rendering services in the state of Colorado may not balance bill a Covered Person for the difference between the Maximum Allowable Charge and the Actual Billed Charges. However, a Non-Participating Provider may balance bill a Covered Person when the Covered Person chooses to use the Non-Participating Provider.

3. For all other Covered Services from a Non-Participating Provider, the lesser of:
   (a) The Usual, Customary and Reasonable Charge (UCR):
   The Usual, Customary & Reasonable (UCR) Charge is the lesser of: or
      (i) The charge generally made by a Physician or other supplier of services, medicines, or supplies;
      (ii) The general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for a Covered Service comparable in severity and nature to the Injury of 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 particular 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 Non-Participating Provider of any amount in excess of the UCR when the UCR is less than the actual billed charges. Such difference will not apply toward 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

Maximum Benefit While Insured means the dollar limitation of Covered Charges as shown in the **SCHEDULE OF BENEFITS (Who Pays What)** section that will be paid for a Covered Person, while covered under the Group Policy. Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured at the Participating Provider level.

Medical Foods means prescription metabolic formulas and their modular counterparts, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or board-certified gastroenterologist and for which medically standard methods of diagnosis, treatment, and monitoring

exist. Such formula are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via a tube or oral route under the direction of Participating Physician. This definition shall not be construed to apply to cystic fibrosis patients or lactose- or soy-intolerant patients.

Medically Necessary means Covered Services that, in the judgment of the Medical Review Program are:

1. Essential and medically appropriate 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, the Covered Person's family, and/or the convenience of the health care provider or facility;
6. Not primarily custodial care;
7. Not experimental or investigational; and
8. 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 Covered 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 the Covered Service Medically Necessary or covered by the Group Policy.

Medically Necessary Leave of Absence or Medical Leave of Absence means a leave of absence from a post-secondary educational institution or a change in enrollment of the dependent at the institution that: (a) begins while the Dependent is suffering from a serious illness; (b) is medically necessary, and (c) causes the Dependent to lose student status for the purpose of Dependent coverage

Medical Review Program means the organization or program that (1) evaluates proposed treatments and/or services to determinate Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours a day, seven days a week.

Medical Social Services means those services provided by an individual who possesses a baccalaureate degree in social work, psychology, or counseling, or the documented equivalent in a combination of education, training, and experience. Such services are provided at the recommendation of a Physician for the purpose of assisting a Covered Person or the family in dealing with a specific medical condition.

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 Please refer to the definition of **Behavioral Health, Mental Health and Substance Use Disorder** above.

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 actually

administered during any covered confinement or administered during other covered treatment. 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, 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.

Negotiated Rate means the fees KPIC or its affiliate has negotiated with a Provider to accept as payment in full for Covered Services rendered to Covered Persons.

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 or KPIC's Provider network 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 health insurance plan without incurring the status of being a Late Enrollee.

Orthotics means rigid or semi rigid external devices which: 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.

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

Out-of-Pocket Maximum means the maximum amount of Cost Share a Covered Person will be responsible for in an Accumulation Period.

Palliative Services means those services and/or interventions which produce the greatest degree of relief from the symptoms of a terminal Sickness.

Partial Hospitalization means continuous treatment for at least three (3) hours, but not more than twelve (12) hours, in any 24-hour period.

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 health care provider duly licensed in the state in which such provider is practicing, including a Primary Care Physician, Specialty Care Physician, Hospital, Participating Pharmacy, laboratory, other similar entity under a written contract with a Preferred Provider Organization (PPO), KPIC or its Administrator. Please consult with Your group administrator for a list of Participating Providers

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

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.

DEFINITIONS

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 **DEFINITIONS** section.

Placement for Adoption means circumstances under which a person assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement terminates at the time such legal obligation terminates.

Plan means the part of the Certificate and 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 or that section.

Policyholder means the employer(s) or trust(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 health insurance plan Effective Date of any year; and (2) terminating, unless otherwise noted on the Group Policy, on the same date shown on the **SCHEDULE OF BENEFITS (Who Pays What)** section. If this health insurance plan Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

Pre-certification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment other than outpatient prescription drugs, made by the Medical Review Program. Consistent with applicable Colorado law, the sole responsibility for obtaining any necessary Pre-certification rest with the Participating Provider, who recommends or orders Covered Services, and not with the Covered Person.

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

Preferred Brand Name Prescription Drug means a prescription drug that has been patented and is only produced by one manufacturer and is listed in Our Preferred Drug List of preferred prescribed medication.

Preferred Drug List is a listing of preferred prescribed medications that are covered under Your group coverage. Such listing is subject to change. Any product, which is not indicated in the listing or in updates thereof, will be considered a non-preferred medication. You may request a copy of the **Preferred Drug List,** Our Formulary, by calling Pharmacy Help Desk, Monday through Friday, toll-free at (800) 788-2949.

Preferred Generic Prescription Drug means a prescription drug which does not bear the trademark of a specific manufacturer. Such drug is also listed in Our drug formulary of preferred prescribed medication.

Preferred Provider Organization (PPO) means a KPIC plan type, in which Covered Persons have access to a network of contracted providers and facilities referred to as preferred or Participating Providers. Generally, a higher level of benefits applies to Covered Services received from preferred or Participating Providers and facilities. The **SCHEDULE OF BENEFITS (Who Pays What)** section shows the plan type under which the Covered Person is insured.

Pregnancy means the physical condition of being pregnant, but does not include Complications of Pregnancy.

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.

DEFINITIONS

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 Provider means a Physician or other licensed provider specializing in internal medicine, family practice, general practice, internal medicine, and pediatrics.

Prosthetic Devices (External) means 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. Supplies necessary for the effective use of prosthetic device are also considered prosthetics.

Prosthetic Devices (Internally implanted) means 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, surgically implanted artificial hips and knees and intraocular lenses.

Psychiatric Care means direct or consultative services provided by a psychiatrist, who is duly licensed by the State Board of Medical Examiner in accordance with applicable Colorado law.

Psychological Care means direct or consultative services provided by a psychologist, who is licensed by the State Board of Psychologist Examiners pursuant to applicable e Colorado law or a social worker, who is licensed by the State Board of Social Work Examiners pursuant to applicable Colorado law.

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.

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 means services and devices provided to restore previously existing physical function which has been lost as a result of illness or injury when a physician determines that therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

Residential Treatment means Medically Necessary services 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.
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 an illness or a disease of a Covered Person. Sickness will include congenital defects or birth abnormalities.

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 Provider means a Physician or other licensed provider whose practice is limited to a certain branch of medicine, which includes non-standard medical-surgical services because of the specialized knowledge required for service delivery and management. Such services may include consultations with Physicians or Providers other than Primary Care Physicians or Providers in departments other than those listed under the definition of Primary Care Provider.

Specialty Care Visits means consultations with Specialty Care Providers.

Specialty Drugs means prescribed medications such as self-injectable medications, as listed in Our Drug Preferred List. The level of coverage of Specialty Drugs is set forth in Your **SCHEDULE OF BENEFITS (Who Pays What)** section.

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 refer to the definition of Behavioral Health/Mental Health and Substance Use Disorder above.

Task Force means the U.S. Preventive Services Task Force, or any successor organization, sponsored by the Agency for Healthcare Research and Quality, the health services research arm of the federal Department of Health and Human Services

Telehealth means a mode of delivery of health care services through HIPAA-compliant telecommunications systems, including information, electronic, and communication technologies, remote monitoring technologies, and store-and-forward transfers, to facilitate the assessment, diagnosis, consultation, treatment, education, care management, or self-management of a Covered Person's health care while the Covered Person is located at an originating site and the provider is located at a distant site.

Terminally Ill means that a Covered Person's life expectancy, as determined by a Physician, is not greater than six months.

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

Urgent Care Center means a facility that meets all of the tests that follow:
1. It mainly provides urgent or emergency medical treatment for acute conditions;
2. It does not provide services or accommodations for overnight stays;
3. It is open to receive patients each day of a calendar year;
4. It has on duty at all times a Physician trained in emergency medicine and nurses and other supporting personnel who are specially trained in emergency care;
5. It has: x-ray and laboratory diagnostic facilities; and emergency equipment, trays, and supplies for use in life threatening events;
6. It has a written agreement with a local acute care hospital for the immediate transfer of patients who require greater care than can be furnished at the facility; written guidelines for stabilizing and transporting such patients; and direct communication channels with the acute care hospital that are immediate and reliable;
7. It complies with all licensing and other legal requirements.

Virtual Care Services means the mode of delivery of health care services via Telehealth, voice only telephone or HIPAA-compliant email/online chat or video visits.

Well-child Care Services means those preventive services and immunization services as set forth in the **BENEFITS/COVERAGE (What is Covered)** section of this Certificate. Services must be provided by a Physician or pursuant to Physician's supervision or by a primary health care provider who is a Physician's assistant or Registered Nurse, who has additional training in child health assessment and who is working in collaboration with a Physician.

Well-child Visit means a visit to a primary care provider that includes the following elements:
1. Age appropriate physical exam, but not a complete exam, unless the exam is age appropriate;
2. History;
3. Anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behavior, etc.);
4. Growth and development assessment, which also includes safety and health education counseling for other children.

DEFINITIONS

You/Your refers to the Insured Employee who is enrolled for benefits under this health insurance plan**.**

Emergency and Non-emergency Services Disclosure

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for

Emergency services

If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most the provider or facility may bill you is your plan's in- network cost- sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post- stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. <u>This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services</u>. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, please contact your insurance company at the number on your ID card, or the Division of Insurance at 303-894-7490, 1-800-930-3745, or DORA_Insurance@state.co.us.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Visit DOI Out-of-Network website (https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/out-of-network-health-care) for more information about your rights under Colorado state law.

Ambulance Information: Balance billing claims related to services provided by air ambulances are governed by federal law. Services provided by ground ambulances are regulated by Colorado state law and do not allow private companies to balance bill. However, you may be balance billed for emergency services you receive if the ambulance service provider is a publicly funded fire agency or if the ambulance services are for a non-emergency, such as ambulance transport between hospitals, that is not a post- stabilization service.