KAISER PERMANENTE
Kaiser Permanente Insurance Company

Georgia

Dual Choice Preferred Provider Organization for Large Group (*Non-grandfathered Coverage)*

Certificate of Insurance

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 that group by Kaiser Permanente Insurance Company.

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverage funded through a Group Insurance Policy (Group Policy) issued to Your group by Kaiser Permanente Insurance Company (KPIC). It becomes Your Certificate of Insurance (Certificate) 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. This Certificate along with the Group Application form forms the remainder of the Group Policy. The provisions set forth herein, are incorporated into, and made part of, 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 and the Certificate are governed by the laws of the state in which the Group Policy was delivered. The Group Policy may be amended at any time without Your consent or prior notice to You. Any such amendment will not affect a claim starting before the amendment takes effect. The Group Policy is available for inspection at the Policyholder's office.

This Certificate automatically 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 will be referred to as "You" or "Your".

This Certificate is important to You and Your family. Please read it carefully and keep it in a safe place.

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

Your coverage under the Group Policy includes coverage for Covered Services received from In-Network and Out-of-Network Providers. The provider You select can affect the dollar amount You must pay. To verify the current participation status of a provider, please call the toll-free number listed in the In-Network Provider directory.

If You have an emergency, call 911, or go to the nearest emergency facility. If You receive Emergency Services from an Out-of-Network Provider, and You cannot reasonably reach an In-Network Provider, such emergency care rendered in the course of the emergency will be reimbursed at the In-Network Provider level.

IMPORTANT: If Precertification with KPIC is not obtained when required, or the terms of Preauthorization are not complied with, we will deny the claim for payment and You will be responsible for the cost of the service. Please refer to the PRECERTIFICATION section for a detailed discussion of the Precertification process.

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

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

**Please consult with Your group administrator if the Schedule of Coverage was not included when this Certificate was issued to You.*

INTRODUCTION

This Certificate includes a Schedule of Coverage that will give You a quick overview of Your coverage. It is very important, however, that You read Your entire Certificate of Insurance for a more complete description of Your coverage.

This Certificate uses many terms that have very specific definitions for the purpose of the Group Policy. These terms are defined in the General Definitions section and are capitalized so that You can easily recognize them. Other 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.

Introduction to Your Plan

This Certificate describes the KPIC Preferred Provider Organization (PPO) plan. It is important that You reference the Schedule of Coverage to determine the plan type under which You are covered.

Please read the information in the ACCESS TO CARE section carefully. It will help You understand how the provider You select can affect the dollar amount You must pay.

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:

For coverage, eligibility, name or address changes call 1-855-364-3185, 711 (TTY)

Or You may write to the Administrator:

Kaiser Foundation Health Plan of Georgia, Inc.
P.O. Box 190849
Atlanta, GA 31119-0849

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

If You have any questions regarding services, facilities, or care You receive from an In-Network Provider, please call the toll-free number 1-855-364-3185, 711 (TTY) or visit www.kp.org/dualchoice-georgia

For Precertification of Covered Medical Services or Utilization Review please call the number listed on Your ID card or: 1-800-221-2412, 711 (TTY).

For Precertification of Covered Pharmacy Services or Utilization Review please call the number listed on Your ID card or: 1-800-788-2949, 711 (TTY).

GENERAL DEFINITIONS

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

Accumulation Period means the time period set forth in the Schedule of Coverage.

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

Administrator means Kaiser Foundation Health Plan National Claims Administration P.O. Box 370010 Denver, CO 80237-3150 for claims administration, KFHP GA for premium billing and MedImpact Healthcare Systems, Inc P.O. Box 509098 San Diego, CA 92159-9098 for Outpatient pharmacy claim administration and refers to the administrator of the Group Policy only. 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 Your 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.

Ancillary Services means for purposes of determining when no surprise billing federal notice and consent requirements apply to the following Covered Services rendered by an Out-of-Network Provider in an In-Network facility:

1. items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner.
2. items and services provided by assistant surgeons, hospitalists, and intensivists.
3. diagnostic services, including radiology and laboratory services; and
4. items and services provided by an Out-of-Network Provider if there is no In-Network Provider who can furnish such item or service at such In-Network facility.

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

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

Applied Behavior Analysis (ABA) means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. ABA must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professional certified by a national board of behavior analysts and is typically provided in the home.

GENERAL DEFINITIONS

Autism Spectrum Disorder means autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

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. Applicable Benefit Maximums are contained within the text of this Certificate and/or are shown in the Schedule of Coverage. When a Benefit Maximum is reached, additional Expenses Incurred for the specific benefit, or class of benefits, do not qualify as Covered Charges and 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 the Policy.

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/Maternity Care Services means antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to: 1) uncomplicated pregnancy and labor and delivery; and 2) spontaneous vaginal delivery. Benefits payable for the treatment of Complications of Pregnancy will be covered on the same basis as a Sickness.

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

Brand Non-Preferred Drug means a prescription drug that has been patented and is only produced by one manufacturer and is listed by Us as a drug not preferred or favored to be dispensed.

Brand Preferred Drug means a prescription drug that has been patented and is only produced by one manufacturer and is listed by Us as a drug preferred or favored to be dispensed.

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.

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; or 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.

GENERAL DEFINITIONS

Chemical Dependency/Substance Abuse means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the person's social, psychological, or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

Clinical Nurse Specialist means any licensed RN who holds: (1) a master's degree from a Board of Nursing-approved program which prepares the nurse to provide advanced clinical nursing services; or (2) specialty certification from the American Nurses Association acceptable to the Board of Nursing.

Clinical Trial Programs for Treatment of Children's Cancer means a Phase II and III prescription drug clinical trial program in the state of Georgia, as approved by the federal Food and Drug Administration or the National Cancer Institute for the treatment of cancer that generally first manifests itself in children under the age of 19 and that:

1. Tests new therapies, regimens, or combinations thereof against standard therapies or regimens for the treatment of cancer in children;
2. Introduces a new therapy or regimen to treat recurrent cancer in children; or
3. Seeks to discover new therapies or regimens for the treatment of cancer in children which are more cost effective than standard therapies or regimens; and
4. Has been certified by and utilizes the standards for acceptable protocols established by the:
   a. Pediatric Oncology Group;
   b. Children's Cancer Group; or
   c. Commissioner

Coinsurance means a percentage of charges that You must pay when You receive a Covered Service as described under the **GENERAL BENEFITS** section and the Schedule of Coverage, usually after the Deductible that You are required to pay. Coinsurance amount is applied against the Covered Charge. The percentage of Covered Charges to be paid by the Covered Person is the difference between the Percentage Payable by KPIC and the Maximum Allowable Charge.

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

Complications of Pregnancy means 1) conditions requiring hospital confinement 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; 2) ectopic pregnancy which is terminated. Benefits payable for the treatment of Complications of Pregnancy will be covered on the same basis as Sickness.

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.

Comprehensive Rehabilitation Facility means an inpatient or outpatient facility primarily engaged in providing diagnostic, therapeutic and restorative services through licensed health care professionals to injured, ill, or disabled individuals. This facility must be accredited for the provision

of these services by the Commission on Accreditation for Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association

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

Copayment means the predetermined amount, as shown in the Schedule of Coverage, which is to be paid by the Insured for a Covered Service directly to a provider usually at the time the health care is rendered. Copayments are applied on a per visit or per service basis. All Copayments 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 change the Covered Person's appearance; and b) will not result in significant improvement in physical function.

Cost Share means a Covered Person's share of Covered Charges. Cost Share includes and is limited only to the following: 1) Coinsurance; 2) Copayment; 3) Deductible; and any benefit-specific deductible incurred by a Covered Person.

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

Covered Person means a person covered under the terms of the Group Policy and who is, duly enrolled as an Insured Employee or Insured Dependent under the Plan. 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, supplies or treatment which a Covered Person is entitled to receive pursuant to the Group Policy and are defined and listed under the section of this Certificate entitled **GENERAL BENEFITS**.

Creditable Coverage means coverage under one of the types of plans with no more than 90- day gap in coverage:

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

9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191.
10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504)).

Deductible means the amount of Covered Charges a Covered Person must incur, while insured under the Group Policy, before any benefits will be payable during that Accumulation Period.

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

Dependent means a person designated by the Insured Employee as entitled to health care services, subject to acceptance by Us. Dependents include only: a) Your lawful spouse or Domestic Partner, if covered under Your plan and b) Your or Your spouse's child who is of an age within the Age Limits for Dependent Children shown in the Schedule of Coverage, or is named in a Qualified Medical Child Support Order. The word **"child"** includes: a) Your adopted child; b) step-child; c) foster child; d) and any other child who lives with You and for whom You are the legal guardian. A child shall be deemed to be a dependent of not more than one person. Other types of dependents eligible for coverage, if any, are shown in the Schedule of Coverage. Please refer to you Schedule of Coverage to determine whether Domestic Partners are covered under you p[illegible]

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 months in a committed relationship. A Domestic Partner may be regarded as 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 person 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 six (6) 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;
6. Both persons must be capable of consenting to the domestic partnership;
7. Neither person is legally married 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;
2. Can mainly and customarily be used for medical purposes;
3. Is not generally of use to a person in the absence of a Sickness or Injury;
4. Is approved for coverage under Medicare;
5. Is not primarily and customarily for the convenience of the Covered Person;
6. Provides direct aid or relief of the Covered Person's medical condition;
7. Appropriate for use in the home; and
8. Serves a specific therapeutic purpose in the treatment of an illness or injury.

Supplies necessary for the effective use of Durable Medical Equipment are also considered Durable Medical Equipment, such as oxygen or drugs dispensed by Durable Medical

Equipment vendors for use in Durable Medical Equipment items. However, drugs obtained at pharmacies are considered under the Outpatient Prescription Drug benefit even when obtained for use in a Durable Medical Equipment item.

Eligible Employee means a person who, at the time of original enrollment: a) is working for a Policyholder as a full-time employee as shown below or is entitled to coverage under an employment contract; b) by virtue of such employment or contract enrolls for 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 the following:
1. A person who is eligible for Medicare Part A or Medicare Part B, except that this does not apply to those entitled to Medicare benefits who under federal law elect, or are required, to have the Policyholder's health coverage as their primary health care coverage; or
2. Employees who work on a temporary, seasonal or substitute basis.

Emergency Care or Emergency Service means:
1. An appropriate 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 the Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;

2. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment, as are required under the Emergency Medical Treatment and Active Labor Actor or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished);

3. Other Covered Services, not as provided in item 4 below, that are furnished by an Out-of-Network Provider after You are stabilized and as part of an outpatient observation or an inpatient or outpatient stay with respect to the same Visit in which the Emergency Services described in item 1. and 2. above are furnished.

"Visit" as used only in this Section regarding Emergency Services means with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

4. The Covered Services described in item 3. above are not Emergency Services if <u>all of the following</u> conditions are met:

a. The attending emergency physician or treating provider determines that the You are able to travel using nonmedical transportation or nonemergency medical transportation to an available In-Network provider or facility located within a reasonable travel distance, taking into account Your medical condition;

b. The provider or facility furnishing such additional items and services satisfies the applicable notice and consent requirements with respect to such items and services, provided that the written notice also satisfies the following requirements as applicable;

i. In the case of an In-Network emergency facility and an Out-of-Network Provider, the written notice must also include a list of any In-Network Providers at the facility who are able to furnish such items and services involved and You may be referred, at Your option, to such In-Network Provider.

ii. In the case of an Out-of-Network emergency facility, the written notice must include the good faith estimated amount that You may be charged for items or services furnished by the Out-of-Network emergency facility or by Out-of-Network Providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the Out-of-Network emergency facility or Out-of-Network Providers in conjunction with such items or services);

c. You (or your authorized representative) are in a condition to receive the information described in item 4 b. above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and Your or Your authorized representative provide informed consent in accordance with applicable State law.

- For purposes only of this definition "authorized representative" means an individual authorized under State law to provide consent on behalf of a patient, provided that such individual is not a provider affiliated with the facility or employee of the facility, unless such provider or employee is a member of Your family.

Emergency Medical Condition means a medical condition, including a psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

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 function
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 Affordable Care Act of 2010 (ACA) as then constituted or later amended. Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured or any dollar Benefit Maximum. Unless otherwise prohibited by applicable law, day or visit limits may be imposed on Essential Health Benefits. Applied Behavioral Analysis Services for the treatment of Autism Spectrum disorder, Voluntary Termination of Pregnancy, Pediatric Hearing Aids and related Covered Services and Adult routine eye exams, are not an Essential Health Benefit. The following services found in Your Optional Benefits, Limitation and Exclusion section, if covered under Your plan, are not Essential Health Benefits: Adult Hearing Aids, Infertility Treatment, and Adult Vision Services-Optical Hardware.

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.

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

1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or

2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered

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.

Formulary means a list of covered drugs or devices.

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

Generic Preventive Prescription Drug is a generic prescription drug that is on Our preventive drug list. This category does not include those preventive drugs required under the Affordable Care Act (ACA).

Generic Preferred Drug is a prescription drug that does not bear the trademark of a specific manufacturer and is listed by Us as a drug preferred or favored to be dispensed.

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

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

Hearing Aid (as used in the Hearing Services section under Pediatric Hearing Aids and Services**)** means any nonexperimental and wearable instrument or device offered to aid or compensate for impaired hearing that is worn in or on the body. The term 'hearing aid' includes any parts, ear molds, repair parts, and replacement parts of such instrument or device, including, but not limited to, nonimplanted bone anchored hearing aids, nonimplanted bone conduction hearing aids, and frequency modulation systems. Personal sound amplification products shall not qualify as hearing aids.

Home Health Care means treatment and part-time or intermittent skilled nursing care in the Covered Person's home when:

1. The member is homebound because of illness or injury; and
2. The nursing services provided are not primarily for the comfort or convenience of the member or custodial in nature; and

3. The services are ordered by a physician and are directly related to an active treatment plan of care established by the physician and provided by a Home Health Care Agency; and
4. The services are provided in lieu of a continued hospitalization, confinement in a skilled nursing facility (SNF), or receiving outpatient services outside of the home; and
5. The skilled nursing care is appropriate for the active treatment of a condition, illness, disease, or injury to avoid placing the member at risk for serious medical complications; and
6. The treatment provided is appropriate for the member's condition including the amount of time spent providing the service as well as the frequency and duration of the services.

Home Health Care Agency means a public or private agency that specializes in giving nursing and other therapeutic services in the home. The agency must be licensed as such (or if no license is required, approved as such) by a state department or agency having authority over home health agencies.

Hospice Care means home-based palliative and supportive care by a licensed hospice for terminally ill patients. The care must be provided directly or on a consulting basis with the patient's Physician or a community agency, such as a visiting nurses' association. For purposes hereof, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 6 months.

Hospital means an institution that is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC, which:
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: a) is licensed by the Georgia State Department of Health Services; and b) operates under a waiver of licensure granted by the Georgia State Department of Mental Health.

Independent Freestanding Emergency Department means a health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law; and provides any emergency services.

Infusion Therapy means a slow injection of a substance into a vein or tissue

Injury means an accidental bodily injury sustained by a Covered Person.

In-Network Pharmacy means a Kaiser Permanente or Network Pharmacy.

In-Network Provider means a Kaiser Permanente or Network Provider.

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

Insured Employee means a Covered Person who is an employee of the Policyholder.

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 RN or other specially trained Hospital personnel.

Kaiser Permanente Pharmacy means a pharmacy owned and operated by Kaiser Foundation Health Plan, Inc. (KFHP) as reflected in the provider directory.

Kaiser Permanente Provider means the Permanente Medical Group and facilities owned and operated by Kaiser Foundation Health Plan, Inc. (KFHP) and any other provider We designate as a Kaiser Permanente Provider as reflected in the provider directory.

Maximum Allowable Charge means:

1. For Covered Services from an In-Network Provider, the Negotiated Rate as defined under part 3 b) below;

2. For Covered Services listed in (a) through (c) below, furnished by an Out-of-Network Provider the Out-of-Network Rate less any Cost Share owed by You:

a) Emergency Services; or

b) Non-Emergency Services rendered by an Out-of-Network Provider at In-Network facilities, including Ancillary Services and Covered Services for unforeseen urgent medical needs; or

c) Air Ambulance Service

Your Cost Share will be calculated based on the Recognized Amount and will be treated as In-Network Cost Sharing for the purpose of accumulation to Your Deductible, if any, and In-Network Out-of-Pocket Maximum.

3. For all other Covered Services from an Out-of-Network Provider, the lesser of:

a) The Usual, Customary and Reasonable Charge (UCR).
The UCR is the charge generally made by a Physician or other provider of Covered Services. The charge cannot exceed the general level of charge made by other providers within an area in which the charge is incurred for Injury or Sickness comparable in severity and nature to the Injury or Sickness being treated. The general level of charges is determined in accord with schedules on file with the authorized 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 a particular level of charges.

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

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

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

c) The Actual Billed Charges for the Covered Services:
The charges billed by the provider for Covered Services.

For dental services, outpatient prescription drugs dispensed and rendered by Out-of-Network Providers, the amount payable by KPIC is the lesser of the Actual Billed Charges or the same amount paid to an In-Network Provider for the same service or item.

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

We will determine the Maximum Allowable Charge and whether such item or service is a Covered Service under the Group Policy.

Maximum Benefit While Insured means the dollar limitation of Covered Charges as shown in the Schedule of Coverage 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.

Medically Necessary means services that a prudent physician or other healthcare provider would provide, in the judgment of the Medical Review Program, are:

1. Essential for the diagnosis or treatment of a Covered Person's Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;

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

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

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven (7) days per week.

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 Illness means a disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

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 a covered confinement or other covered treatment. Only drugs and materials that require administration by medical personnel are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to surgically implanted **Prosthetic Devices (Internally Implanted)**, oxygen, blood, blood products, biological sera, internally implanted medications, contraceptive devices and implantable contraceptives. 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 has negotiated with In-Network Provider (or Preferred Provider Network) to accept as payment in full for Covered Services rendered to Covered Persons.

Network Pharmacy means MedImpact pharmacies under a written contract with a KPIC. MedImpact Pharmacies include but are not limited to Riteaid, Kroger, and Walgreens.

Network Provider means a health care provider duly licensed in the state in which they are practicing, including a Primary Care Physician, Specialty Care Physician, Hospital, laboratory, or other similar entity under a written contract with KPIC or KPIC's contracted provider network as reflected in the provider directory.

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

Non-Essential Health Benefits means benefits other than Essential Health Benefits.

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

Order means a valid court or administrative order that:
1. Determines custody of a minor child; and
2. Requires a non-custodial parent to provide the child's medical insurance coverage or to pay any portion of the medical expenses resulting from medical treatment of the child.

Out-of-Network Pharmacy means a pharmacy that does not have an In-Network Pharmacy agreement with KPIC or its Administrator in effect at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You fill prescriptions at an Out-of-Network Pharmacy. Please consult with Your group administrator for a list of In-Network Pharmacies.

Out-of-Network Provider means a Hospital, Physician or other duly licensed health care provider or facility that does not have a participation agreement with KPIC or its Administrator 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 an Out-of-Network Provider. Please consult Your group administrator for a list of In-Network providers or You may contact Member Services at the number shown on Your ID card.

Out-of-Network Rate means one of the following:
1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to this plan and KPIC, Out-of-Network Provider, and the item or service, the amount for the item or service determined in accordance with the All-Payer Model Agreement.

2. If there is no such All-Payer Model Agreement applicable to the item or service, but a specified State law is in effect and applicable to this plan, KPIC, Out-of-Network Providers and the item and service, the amount for the item or service determined in accordance with such specified State law.

3. If there is no such All-Payer Model Agreement or specified State law applicable to this plan, KPIC, the Out-of-Network Provider and the item or service, the initial payment made by us or the amount subsequently agreed upon by KPIC and the Out-Of-Network Provider.

4. If none of the three payment methodologies described in (1)-(3) above apply, an amount determined by a certified independent dispute resolution (IDR) entity pursuant to the federal IDR.

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.

Percentage Payable means that percentage of Covered Charges payable by KPIC. This is a fixed percentage that, when added to the Coinsurance percentage shown in your Schedule of Coverage

(SOC), totals 100%. To illustrate, If the Coinsurance amount shown in your SOC is 10%, the Percentage Payable that KPIC pays is 90%. Likewise, a Coinsurance of 20%, 30% or 40% would have a Percentage Payable of 80%, 70% or 60% respectively. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services to calculate the benefit payable under the Group Policy.

Permanente Medical Group means The Southeast Permanente Medical Group and other Permanente Medical Groups as reflected in the provider directory.

Physician means a health practitioner who is duly licensed in the state in which the treatment is rendered. He or she must be practicing within the scope of that license. The term does not include a practitioner who is defined elsewhere in this **GENERAL DEFINITIONS** section.

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

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.

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

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

Precertification/Precertified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program.

Preferred Provider Organization (PPO) means an organization that contracts with medical providers, such as hospitals and doctors, to create a network of in-network providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Preventive Care means measures taken to prevent a disease rather than curing it or treating its symptoms. Preventive care:

1. Protects against disease such as in the use of immunizations,
2. Promotes health, such as counseling on tobacco use; and
3. Detects disease in its earliest stages before noticeable symptoms develop such as screening for breast cancer.

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

Primary Care Physician/Provider means a Physician or provider specializing in internal medicine, family practice, obstetrics/gynecology, or pediatrics.

Prosthetics Devices (External) and Orthotics means devices that are rigid or semirigid- external devices which are:

1. Required to support or correct a defective form or function of an inoperative or malfunctioning body part; or
2. To restrict motion in a diseased or injured part of the body; or
3. Required to replace all or any part of a body organ or extremity; or
4. Therapeutic footwear for severe diabetic foot disease in accord with Medicare guidelines.

   Orthotics do not include casts.

   Examples of external prosthetics include artificial limbs, parental and enteral nutrition, urinary collection and retention systems, colostomy bags and other items and supplies directly related to ostomy care and eyeware after cataract surgery. Supplies necessary for the effective use of prosthetic device are also considered prosthetics.

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

Qualifying Payment Amount means the amount calculated using the methodology described in in applicable federal regulation for the same or similar item or service provided by a facility or provider of the same or similar facility type or in the same or similar specialty, as applicable, in the geographic region in which the item or service is furnished with respect to the same insurance market.

Recognized Amount means:
1.In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan, KPIC, Out-of-Network Provider, and the item or service, the amount for the item or service in accordance with the All-Payer Model Agreement.

2. If there is no such All-Payer Model Agreement applicable to the item or service, then, in a State which has in effect a specified State law that applies to the plan, KPIC, Out-of-Network Provider and the item or service, the amount for the item or service is determined in accordance with such specified State law.

3. If neither an All-Payer Model Agreement or a specified State law applies to the item or service, then the lesser of: the amount billed by the Out-of-Network Provider or the Qualifying Payment Amount.

Reconstructive Surgery means a surgery performed to significantly improve a physical function; or to correct significant disfigurement resulting from an Injury or covered surgery, such as a covered mastectomy.

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.

Rehabilitative Services means services provided to restore previously existing physical function 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 chemical dependency or mental health treatment. Services must be above the level of custodial care and include:

1) Room and Board;
2) individual and group chemical dependency 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.

Service Area means the following counties Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Lamar, Meriwether, Newton, Paulding, Pickens, Pike, Rockdale, Spalding, Walton, Clarke, Madison, Oconee, and Oglethorpe. Chattahoochee, Harris, Marion and Muscogee. Bibb, Bleckley, Crawford,

Houston, Jones, Laurens, Monroe, Peach, Pulaski, Twiggs, Bryan, Bulloch, Chatham, Effingham, Evans, and Liberty.

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

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

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

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

Specialty Care Visits means consultations and second opinions with Physicians other than Primary Care Physicians in departments other that those listed under the definition of Primary Care Physicians.

Specialty Drugs means prescribed medications including self-injectable drugs as listed in Our Drug Preferred List. The level of coverage of Specialty Drugs is set forth in Your Schedule of Coverage.

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).

Telehealth means the use of information and communications technologies, including, but not limited to, telephones, remote patient monitoring devices or other electronic means which support clinical health care, provider consultation, patient and professional health related education, public health, and health administration.

Telemedicine means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, as prescribed by applicable federal and state laws, rules, and regulations, and legally allowed to practice in this state, while such patient is at an originating site and the health care provider is at a distant site. Audio-only telephone communication is covered when:

a) no other means of real-time two-way audio, visual, or other telecommunications or electronic communications are available to the member due to lack of availability; or
b) when provided for mental or behavioral health services.

GENERAL DEFINITIONS

Total Disability means: a) inability of the Insured Employee, due solely to Sickness or Injury, to perform with reasonable continuity the substantial and material duties of regular and customary work; and b) an Insured Dependent's complete inability, due solely to Sickness or Injury, to engage in the normal activities of a person of the same sex and age. The Covered Person must not, in fact, be working for pay or profit.

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

Urgent Care Facility means a legally operated facility distinct from a hospital emergency room, an office or clinic legally operated to provide health care services to diagnose and treat illness or injury for unscheduled ambulatory patients seeking immediate medical attention.

You/Your refers to the Insured Employee who is enrolled for benefits under the Group Policy.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

Eligibility for Insurance

You must be an Eligible Employee and live or work within the Service Area on the first day of enrollment or Dependent of an Eligible Employee to become insured under the Group Policy.

Full-Time (Permanent Employee)

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

Contributions

You must pay part of the cost of the insurance, unless the Policyholder's Application for coverage specifies that the Policyholder will pay the full cost of the Covered Person's' coverage. In no event will the Policyholder contribute less than one-half of the cost of the employee's insurance.

Eligibility Date

Your Eligibility Date is the effective date of the Group Policy if You are an Eligible Employee on that date, or the Policyholder's application for the Group Policy indicates that the eligibility waiting period does not apply to those employees who are employed by the Policyholder on the effective date of the Group Policy. Otherwise, Your Eligibility Date is the date agreed upon by KPIC and the Policyholder.

Any delay in an Eligible Employee's effective date will not be due to a health status-related factor, as defined under the Health Insurance Portability and Accountability Act of 1996, or as later amended.

Enrollment Rules

For an Eligible Employee to become a Covered Person, the Eligible Employee must:

1. Complete a KPIC or KPIC-approved enrollment form;
2. Provide any information needed to determine the Eligible Employee's eligibility, if requested by Us;
3. Agree to pay any portion of the required premium, if applicable, and
4. Must live or work within the Service Area.

Effective Date of Your Insurance

Your effective date of insurance is determined by the time period in which You complete Your enrollment as described below:

1. **Initial Enrollment**: Initial enrollment is effective following completion of any waiting period, not to exceed ninety (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. Your Group will inform You of the effective date of coverage for You and Your eligible Dependents.
2. **Late Enrollment**: If You enroll for coverage more than thirty-one (31) days after Your initial eligibility date, You will be considered a Late Enrollee. Late Enrollees are eligible for enrollment only during the Annual Open Enrollment period set by the Policyholder. If You enroll during this period, Your effective date is the date agreed upon between the Policyholder and KPIC.

Late Enrollee means an Eligible Employee or Dependent who enrolls under the Group Policy after the initial enrollment period during which the Eligible Employee or Dependent was eligible for coverage but declined to enroll. However, an Eligible Employee or Dependent will not be considered a Late Enrollee if:

a) The Eligible Employee or Dependent qualifies under the Special Enrollment Rules as described in the **ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE** section;
b) The Eligible Employee or Dependent applies during the Annual Open Enrollment Period;

3. **Annual Open Enrollment Period**. 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. 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. Enrollment rules vary from group to group. 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. If You enroll during the Annual Open Enrollment Period, Your effective date is the date agreed upon between the Policyholder and KPIC.

4. **Special Enrollment.** You may apply for enrollment as a Subscriber and existing Subscriber may apply to enroll eligible Dependents, prior to the Annual Open Enrollment if You/and or Your Dependent have experienced any of the qualifying events set forth in the **Special Enrollment** below as described in the **ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE** section.

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

For an eligible Dependent to become a Covered Person, You must:
1) Complete a KPIC or KPIC-approved enrollment form;
2) Provide any information needed to determine Your Dependent's eligibility, if requested by Us; and
3) Agree to pay any portion of the required premium, if applicable.

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.

Full-Time Student means a Dependent child who attends an accredited high school, college, university, technical school, trade school, or vocation school on a full-time basis for five calendar months or more during the Accumulation Period or was prevented from being so enrolled due to a Sickness or Injury. 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. Proof of Sickness or Injury that prevented the student from being enrolled, as certified by the attending Physician, must be given to KPIC.

Exceptions

The age limits for Dependent Children shown above do not apply to a Dependent child who is and continues to be both: 1) incapable of self-sustaining employment due to a physical disability or

developmental disability that occurred prior to the age limit and 2) chiefly dependent on 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 physical disability or developmental disability; or b) the date the child no longer chiefly depends on You for support and maintenance.

Proof of such incapacity and dependency must be furnished to KPIC within thirty-one (31) days 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 immediately following the child's attainment of the limiting age.

Eligibility Date

A Dependent's eligibility date is the later of: (a) Your eligibility date; or (b) the date the person qualifies as Your Dependent. A child named in an Order qualifies as Your Dependent on the date specified in the Order. An adopted child qualifies as Your Dependent on the earlier of, the date of adoption, or the date of Placement for Adoption. A foster child qualifies as Your Dependent on the date of placement in foster care.

Effective Date of Dependent Coverage

A Dependent's effective date of insurance is the date determined from the Enrollment Rules that follow.

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 in an applicable Service Area.

Likewise, availability of Medicaid coverage will not be considered in the determination of eligibility for coverage.

Enrollment Rules

1. **Initial Enrollment**. If You enroll a Dependent within the 31-day period that follows his or her eligibility date, his or her effective date is the later of: (a) Your effective date of insurance; or (b) the first day of the calendar month coinciding with or next following the Dependent's eligibility date.
2. **Late Enrollment**: If You enroll a Dependent for coverage more than thirty-one (31) days after the Dependent's initial eligibility date, the Dependent will be considered a Late Enrollee. Late Enrollees are eligible for enrollment only during the Annual Open Enrollment Period set by the Policyholder. If You enroll a Dependent during this period, his or her effective date is the date agreed upon between the Policyholder and KPIC.
3. **Annual Open Enrollment**. If You enroll a Dependent during the Open Enrollment Period, the Dependent's effective date is the date agreed upon by KPIC and the Policyholder.
4. **Special Enrollment**. If You enroll a Dependent during this period, his or her effective date is the date agreed upon between the Policyholder and KPIC.

Special Enrollment

An Eligible Employee or Dependent is not considered a Late Enrollee when one of the following qualifying events applies:

(1) The person meets the following requirements:

(a) At the time of initial enrollment, the person was covered under another employer's medical plan and certified, at the time of initial enrollment, that coverage under the other employer medical plan was the reason for declining coverage; and

(b) The person has lost or will lose coverage under the other employer plan because of:

i) termination or change in status of employment of the Eligible Employee or of the person through whom the individual was covered as a Dependent; or;
ii) termination of the other employer's medical plan; or
iii) cessation of an employer's contributions toward an employee's or Dependents' medical coverage; or
iv) a reduction in the number of hours of the Eligible Employee's employment or through whom the individual was covered as a Dependent; or
v) You are a Dependent of someone who becomes entitled to Medicare (Title XVII of the Federal "Social Security Act"), as amended; or.
vi) death of the Eligible Employee or person through whom the individual was covered as a Dependent; or
vii) legal separation or divorce.

(2) If You gain or become a Dependent as a result of marriage, birth, adoption, Placement for Adoption or Placement in Foster Care, You may be able to enroll yourself and Your new Dependents, provided that You request enrollment within 30 days after the marriage, birth, adoption, Placement for Adoption or Placement in Foster Care.

(3) The Eligible Employee or Dependent is employed by an employer who offers multiple health benefit plans and the individual elects coverage under a different plan during an Annual Open Enrollment Period.

(4) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan and the request for enrollment is made within 30 days after issuance of the court order.

(5) No written statement can be provided proving that prior to declining the medical coverage, the Eligible Employee was provided with, and signed acknowledgment of, written notice specifying that failure to elect coverage during the 30-day period following the person's eligibility date could result in the person being subject to Late Enrollment rules.

(6) The person meets the criteria described in paragraph "1" of this provision and was under a COBRA continuation provision and the coverage under that provision has been exhausted.

(7) The Exchange determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:

- A qualified individual was not enrolled in a qualified health plan.
- A qualified individual was not enrolled in the qualified health plan that the individual selected.
- A qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost sharing reductions.

(8) The Eligible Employee's or Dependent's coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly-sponsored or subsidized health plan, has been involuntarily terminated within 63 days of applying for coverage under the Group Policy.

(9) If You waive medical coverage under the Plan for Yourself and/or Your Dependents because You are enrolled in Medicaid or Your state's Children's Health Insurance Program (CHIP formerly known as SCHIP), You will be permitted to enroll in the Plan when:

a. You or Your Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility, provided You request enrollment within 60 days of the loss of coverage.

b. You or Your Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, provided You request enrollment within 60 days from the time eligibility is determined.

Special Enrollment Rules

I. Court or Administrative Ordered Coverage for a Dependent Child

If a Covered Person is required by an Order to provide health coverage for an eligible child and the Covered Person is eligible for coverage under the Group Policy, the Covered Person may enroll the eligible child under the Group Policy by sending KPIC a written application, a copy of the Order, and any additional amounts due as a result of the change in coverage.

If the Covered Person fails to apply for coverage for the Dependent child pursuant to the Order, the custodial parent, the state medical assistance agency, or the state child support enforcement agency or a delegate child support enforcement unit may submit the application for insurance for the eligible child.

The coverage for any child enrolled under this provision will continue pursuant to the terms of this 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 Policy;
3. The employee is no longer an Insured Employee under the Group Policy;
4. All family coverage is eliminated for members of the employer group; or
5. Non-payment of premium.

II. Future Dependents

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. The Dependent must be enrolled within 31 days of their eligibility date or they will be considered a Late Enrollee.

III. Newborns

A newborn Dependent child is insured from birth. If the cost of Your Dependent coverage would increase because of the addition of a newborn Dependent, You must enroll the newborn Dependent for insurance and agree to pay the additional cost within 31 days of that Dependent's birth in order for insurance to extend beyond the 31-day period. If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next Open Enrollment Period to enroll the child for coverage.

If the cost of Your coverage would not increase as a result of the child being enrolled under the coverage, You should still notify Us, in writing, of the child's birth within 31 days. This will allow Us to add the child to Our records and help avoid delays on any claim You might file on behalf the child.

IV. Adopted Children

An adopted child is insured from the earlier of the date of adoption or the date of Placement for Adoption. If the cost of Your Dependent coverage would increase because of the addition of an adopted child, You must enroll the adopted child for insurance and agree to pay the additional cost within 31 days of his or her eligibility date in order for insurance to extend beyond the 31-day period. If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next Open Enrollment Period to enroll the child for coverage.

If the cost of Your coverage would not increase as a result of the child being enrolled under the coverage, You should still notify Us, in writing, of the child's adoption or placement within 31 days of the event. This will allow Us to add the child to Our records and help avoid delays on any claim You might file on behalf the child.

V. Late Enrollees

An Eligible Employee or Dependent is not considered a Late Enrollee when one of the qualifying events set forth in the **Special Enrollment** applies.

If You declined enrollment for yourself or Your Dependents (including Your spouse) because of other health insurance coverage, You may, in the future be able to enroll yourself or Your Dependents under the Group Policy, provided that You request enrollment within 30 days after Your other coverage ends. In addition, if You have a new Dependent as a result of marriage, birth, adoption or Placement for Adoption, You may be able to enroll yourself and Your Dependents, provided that You request enrollment within 30 days after the marriage, birth, adoption, or Placement for Adoption.

Termination of an Insured Employee's Insurance

Your insurance will automatically terminate on the earlier of:

1. The latter of, the date of Your written notice of voluntarily terminating Your or Your Dependent's coverage under the Group Policy to Your employer, or the date KPIC receives the termination notice from Your employer;
2. The date You cease to be covered by KPIC;
3. The date the Group Policy is terminated;
4. The date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
5. The end of the grace period after the employer fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion; or
6. 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.

Termination of Insured Dependent's 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 calendar month in which the person ceases to qualify as a Dependent;
3. The date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. The date Your insurance ends, unless continuation of coverage is available to the Dependent under the provisions of the Group Policy;

5. The end of the grace period after the employer fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion;
6. The date the Group Policy is terminated;
7. The date the Dependent, or the Dependent's representative, commits an act of fraud or makes an intentional misrepresentation of a material fact.

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 (3) months if full-time work ends because of disability or two (2) months if work ends because of layoff or leave of absence other than family care leave of absence. These provisions apply as long as You continue to meet Your Groups written eligibility requirements and This Plan has not terminated. You may be required to pay the full cost of the continued insurance during any such leave.

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

Rescission for Fraud or Intentional Misrepresentation

Subject to any applicable state or federal law, if 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 material fact was committed after the Effective Date of Your coverage.

If Your or Your dependent's policy is rescinded or cancelled, You have the right to appeal the rescission or cancellation. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **INDEPENDENT EXTERNAL REVIEW PROCESS** section for Your right to an Independent Medical Review.

ACCESS TO CARE

Benefit Levels for In-Network Providers or Out-of-Network Providers
Your coverage provided under the Group Policy includes coverage for Covered Services received from In-Network Providers, consisting of Kaiser Permanente Providers and Network Providers, as well as Out-of-Network Providers.

In-Network Providers
In-Network Providers include Kaiser Permanente Providers and Network Providers as defined in the **GENERAL DEFINITIONS** section.

Kaiser Permanente Providers:

- Your out-of-pocket expenses for certain services received from Kaiser Permanente Providers may be lower than similar services provided by Network Providers. See the Schedule of Coverage for more information.
- Kaiser Permanente Providers will obtain any necessary Precertification on your behalf.
- Kaiser Permanente Providers will submit claim forms on your behalf.

Network Providers inside KP States:

For purposes of this Access to Care section KP States means: Georgia, California, Colorado, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia.

- Your out-of-pocket expenses for certain services received from Network Providers may be lower than similar services provided by Out-of-Network Providers.
- You are responsible for assuring your Network Provider has obtained necessary Precertification.
- Network Providers will submit claim forms on your behalf.

Services outside KP States by a Network Provider

When You receive services outside KP States Your Network Providers consists of the Cigna PPO Network and other contracted providers. A current listing of Network Providers outside KP states is available by calling the Customer Service number listed on Your ID card or You may also visit www.kp.org/dualchoice-georgia

For services provided by a Network Provider the following apply:

- Your out-of-pocket expenses for certain services received from Network Providers may be lower than similar services provided by Out-of-Network Providers.
- Network providers will obtain any necessary Precertification on Your behalf.
- Network Providers will submit claim forms on your behalf.

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 benefits to be payable at the In-Network Provider level, a Covered Person must receive care from an In-Network Provider. To verify the current participation status of a provider, please call the toll-free number for Customer Service at 1-855-364-3185. A current listing of KPIC's In-Network Providers is available by calling the Customer Service number listed on Your ID card or You may also visit www.kp.org/dualchoice-georgia

ACCESS TO CARE

Out-of-Network Providers

If a Covered Person receives care from an Out-of-Network Provider as defined in the **GENERAL DEFINITIONS** section, benefits under the Group Policy are payable at the Out-of-Network Provider level.

- Your out-of-pocket expenses for services received from Out-of-Network Providers may be higher than similar services provided by In-Network Providers.
- You are responsible for assuring Your Out-of-Network Provider has obtained necessary Precertification.
- You may be required to pay the full amount for the care You receive and submit a claim form for reimbursement.
- You are also responsible for paying amounts that are greater than the Maximum Allowable Charge, except when specified in the No Surprise Billing Protections provision below.

KPIC is not responsible for Your decision to receive treatment, services or supplies from In-Network or Out-of-Network Providers. Additionally, KPIC is neither responsible for the qualifications of providers nor the treatments, services or supplies under this coverage. You are responsible for assuring Your Network Provider and Out-of-Network Provider has obtained necessary Precertification.

Please see the **PRECERTIFICATION** section for a detailed discussion of the Precertification process.

No Surprise Billing Protections

The following services are subject to protections under state and or federal no surprise billing laws.

1. Out-of-Network Emergency Services,
2. Covered Services Provided by an Out-of-Network Provider at an In-Network Facility
3. Out-of-Network Air Ambulance Services

Notwithstanding any provisions of this Certificate of Insurance to the contrary, when you receive the services listed in items 1-3 above you are protected from balancing billing, sometimes called surprise billing. Surprise billing or balance billing means billing by an Out-of-Network Provider for the difference between what KPIC agreed to pay and the full amount billed by the Out-of-Network Provider. You are only responsible for the In-Network Cost Share for these services and the Cost Shares will be treated as In-Network Cost Shares for the purpose of accumulation to Your Deductible, if any, and In-Network Out-of-Pocket Maximum.

Out-of-Network Providers rendering the Covered Services listed in the services described above, may not bill or collect more than Your In-Network Cost Share and may not bill You the difference between the Actual Billed Charges and the Maximum Allowable Charge.

An Out- of-Network Provider may balance bill You when the Out-of-Network Provider rendering services in an In-Network facility has satisfied the applicable notice and consent requirements, if permitted to provide notice and obtain consent, including but not limited to providing notice to You of the estimated charges for the items and services, that the provider is an Out-of-Network Provider and has obtained written consent from You to be treated and balanced billed by the Out-of-Network Provider.

The applicable state or federal notice and consent requirements do not apply to Out-of-Network Providers with respect to:

1. Emergency Services until you are stabilized; and

2. The following Covered Services rendered by an Out-Of-Network Provider in an In-Network facility:
   a. Ancillary Services; and
   b. Items or services that are Covered Services and are furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Network Provider satisfied the notice and consent criteria.

Such items and services furnished by Out-of-Network Providers will always be subject to the reimbursement described in the Maximum Allowable Charge definition and are prohibited from balance billing You.

In any other circumstance, including and not limited to when You or Your authorized representative give consent, an Out-of-Network Provider may balance bill You.

PRECERTIFICATION

NOTE: If Your employee benefit plan is covered by Title 1 of the Employee Retirement and Income Security Act of 1974 (ERISA), You may have other appeal rights guaranteed to You under Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA). These rights are explained under the section of this Certificate entitled CLAIMS AND APPEALS PROCEDURES.

Precertification through the Medical Review Program

This section describes:

1. The Medical Review Program and Precertification procedures for Medical Benefits other than outpatient prescription drugs;
2. How failure to obtain Precertification affects coverage;
3. Precertification administrative procedures;
4. Which clinical procedures require Precertification; and
5. How to appeal an adverse determination by the Medical Review Program.

See the Outpatient Prescription Drug benefit in the **GENERAL BENEFITS** section for information regarding Precertification for outpatient prescription drugs.

Precertification must be obtained for all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment. If Your services are provided by a Kaiser Permanente Provider, the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. If Precertification is required, it must be obtained to avoid a reduction in benefits. It is important to work with your provider to be certain services are Precertified when required or you will pay for the cost of the service.

Precertification will not result in payment of benefits that would not otherwise be covered under the Group Policy if You are no longer covered under the plan at the time the services are received, benefits under the plan have been exhausted, or in cases of fraud by You or the provider.

Medical Review Program means the organization or program that: (1) evaluates proposed treatments and/or services to determine Medical Necessity; and (2) assures that the care received is appropriate and Medically Necessary to the Covered Person's health care needs; and (3) manages Your plan of care. If the Medical Review Program determines that the care is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours a day, seven (7) days a week at 1-800-221-2412, 711 (TTY) or fax 1-404-364-4743.

The following treatments or services must be Precertified by the Medical Review Program:

1. Ambulatory Surgery including but not limited to:
   a. Blepharoplasty
   b. Cryosurgery of the prostate
   c. Oral surgery
   d. Sclerotherapy
   e. Septoplasty
   f. Sinus surgery
   g. Uterine artery embolization
   h. Uvulopalatoplasty
2. Applied Behavior Analysis

3. Bariatric surgery and subsequent procedures
4. Biofeedback
5. Clinical trials
6. Cognitive Rehabilitation (outpatient and home)
7. Dental procedures and dental anesthesia
8. Durable Medical Equipment
9. Endoscopy procedures (includes pill/video method)
10. Enteral solutions
11. Experimental/investigational procedures and drugs
12. Genetic testing
13. Habilitative Therapy
14. High Tech Radiology Services including but not limited to Magnetic Resonance Imaging (MRI), MRA, CTA, CT Scan, Myelogram, Nuclear Medicine Scans and PET scan
15. Home health care and Home Infusion services
16. Hospice (home and inpatient)
17. Hospitalization for dental procedures
18. Hyperbaric Oxygen Treatment
19. Implantable devices such as cochlear implants and left ventricular assist devices.
20. Infertility Services
21. Injectable Drugs
22. Inpatient hospital confinements (including acute admissions from the Emergency Room post stabilization);
    a. Inpatient acute admissions
    b. Inpatient care at a Comprehensive Rehabilitation Facility
    c. Inpatient care at a Skilled Nursing Facility or other licensed medical facility;
    d. Inpatient mental health services
    e. Inpatient chemical dependency substance abuse services
23. Intacs – lens used for eye disorders
24. Multidisciplinary rehabilitation Services programs
25. Non-Emergency Ambulance Services
26. Observation stays in a hospital
27. Orthotripsy
28. Pain Management
29. Pediatric Hearing Aid(s) and services
30. Prosthetics and orthotics
31. Radiation Therapy, including but not limited to SBRT, SRS, SGRT, IMRT, and Proton
32. Reconstructive surgery including but not limited to:
    a. Breast augmentation and reductions
    b. Craniofacial reconstruction
    c. Ocular surface reconstruction
    d. Orthognathic surgery
    e. Any procedure performed by a plastic surgeon.
33. Rehabilitation:
    a. Physical therapy (outpatient and home)
    b. Occupational Therapy (outpatient and home)
    c. Speech Therapy (outpatient and home)
    d. Respiratory Therapy (home)
34. Sexual Dysfunction treatment
35. Sleep studies, including home sleep studies.
36. Spinal surgery
37. Stimulator therapy, including but not limited to: bladder disorders, brain disorders, pain management, and stomach disorders

38. Transplant Services (pre-transplant, transplant, and post-transplant)
39. Wound therapy (outpatient or home)

Note: The above list is subject to change. For the most current information, please call the Medical Review Program at 1-800-221-2412, 711 (TTY), twenty-four (24) hours a day, seven (7) days a week.

IMPORTANT: If Precertification is not obtained when required, or the terms of Precertification are not complied with we will deny the claim for payment. If the treatment or service is deemed not to be Medically Necessary before the service is received or upon appeal, the treatment or service will not be covered. Likewise, if a Hospital Confinement or other inpatient care is extended beyond the number of days first preauthorized without further Precertification (concurrent review), benefits for the extra days: (1) will similarly be denied; or (2) will not be covered if deemed not to be Medically Necessary.

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

Emergency Services
Precertification is not required for Emergency Services however, it is very important that you, your provider, or someone else acting on your behalf, call us to notify us that you need Post-Stabilization Care. Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Stabilized. Please call Customer Service at 1-855-364-3185, 711 (TTY).

Pregnancy Precertification: When a Covered Person is admitted to a Hospital for the delivery of a child, the Covered Person is entitled to stay in the Hospital without any Precertification for a minimum of:
1. Forty-eight (48) hours for a normal vaginal delivery; and
2. Ninety-six (96) hours for a Cesarean section delivery.

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

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

Precertification Procedures
The Covered Person or his or her attending Physician must notify the Medical Review Program as follows:

1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a 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 Precertified or within 48 hours following a vaginal delivery or 96 hours following a cesarean section, or as soon as reasonably possible, for Hospital Confinement in connection with childbirth expected to extend beyond the 48 or 96-hour period.

3. Other treatments or procedures requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Precertification but at least three days prior to performance of any other treatment or service requiring Precertification.
4. During the first trimester of pregnancy if the Covered Person intends to have Birth Services covered under this plan.

A Covered Person 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 medical 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 requested treatment or service.

If the Covered Person or the Covered Person's provider does not provide the necessary information or will not release necessary information, Precertification will be denied.

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

NOTE: *Any questions about Your rights under ERISA should be directed to the plan administrator named in Your employer's ERISA plan document or the nearest area office of the U.S. Department of Labor, Labor-Management Services Administration*

DEDUCTIBLES AND MAXIMUMS

Deductible
For certain benefits, before any benefits will be payable during the Accumulation Period, a Covered Person must first satisfy the Deductible shown in the Schedule of Coverage. The Deductible must be met within each Accumulation Period. Benefits will not be payable for Covered Charges applied to the Deductible. When Covered Charges equal to the Deductible are incurred and submitted to Us, the Deductible will have been met for that Covered Person or Family. All Covered Services are subject to the Plan Deductible unless otherwise specified in the Schedule of Coverage. Covered Charges paid with respect to Emergency Services, Air Ambulance Services provided by an Out-of-Network Provider or Covered Services rendered by an Out-of-Network Provider in an In-Network facility will be counted toward any applicable In-Network Deductible.

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 his or her Self-Only Deductible, he or she will begin paying Copayments or Coinsurance.

Individual Deductible
Unless otherwise indicated in the Schedule of Coverages elsewhere in the Policy, the Accumulation Period Individual Deductible as shown in the Schedule of Coverage 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 Coverage, has been applied toward the covered family members' Individual Deductibles.

If the Family Deductible Maximum as shown in the Schedule of Coverage is satisfied in any one Accumulation Period by covered family members, then the individual Deductible will not be further applied to any other Covered Charges incurred during the remainder of that Accumulation Period.

NOTE: The Accumulation Period Deductible does not apply to Preventive Benefits required under the Affordable Care Act (ACA) received at the In-Network Provider tier. Preventive Benefits required under the Affordable Care Act (ACA) that are received at the Out-of-Network Provider tier, however, are subject to the Accumulation Period Deductible.

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

NOTE: Please refer to the **SCHEDULE OF COVERAGE** for the actual amount of Your Individual and Family Deductible.

DEDUCTIBLES AND MAXIMUMS

Percentage Payable
The Percentage Payable is applied to Covered Charges after any applicable Deductible has been met. The Covered Person pays the coinsurance as set forth in the Schedule of Coverage.

Out-of-Pocket Maximums
Any part of a charge that does not qualify as a Covered Charge will not be applied toward satisfaction of the Out-of-Pocket Maximum. Covered Charges applied to satisfy the Deductible under this Group Policy count toward the satisfaction of the Out-of-Pocket Maximum. Cost Share incurred on Essential Health Benefits apply to the out-of-Pocket Maximum. Charges in excess of the maximum Allowable Charge or Benefit Maximum and additional expenses a Covered Person must pay because Precertification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum. Cost Shares paid with respect to Emergency Services, Air Ambulance Service provided by an Out-of-Network Provider or Covered Services rendered by an Out-of-Network Provider in an In-Network facility will be counted toward any applicable In-Network 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 his or her Self-Only Out-of-Pocket Maximum, he or she 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 Maximum
When the Cost Share incurred by a Covered Person enrolled in self-only coverage equals the Self Only Out-of-Pocket Maximum shown in the Schedule of Coverage during an Accumulation Period, the Covered Person will not be required to pay any additional Cost Share for Covered Services for remainder of that Accumulation Period.

When the Cost Share incurred by a Covered Person in a family of two or more Covered Persons equals the Individual Out-of-Pocket Maximum shown in the Schedule of Coverage during an Accumulation Period, the Covered Person will not be required to pay any additional Cost Share for Covered Services for the remainder of that Accumulation Period.

Family Out-of-Pocket Maximum
When the Cost Share incurred by covered family members equals the Out-of-Pocket Maximum shown in the Schedule of Coverage during an Accumulation Period, the covered family members will not be required to pay any additional Cost Share for Covered Services for the remainder of that Accumulation Period.

Effect of Prior Coverage on Deductible and Out-of-Pocket Maximum Take-over
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 ninety (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 ninety (90) days before the Effective Date of the Group Policy; and
3. The expenses would be considered Covered Charges under the Group Policy.

As used in this provision, **"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.

Deductible Carry-over If a Covered Person incurs Covered Charges during the last three months of an Accumulation Period that are applied toward satisfaction of the Deductible for that Accumulation Period, those charges will also be applied toward the Covered Person's Deductible for the next Accumulation Period.

Maximum Allowable Charge
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 any amounts in excess of the Maximum Allowable Charge for a Covered Service. (Refer to the definition of Maximum Allowable Charge shown in the General Definitions section of the Certificate.

Other Maximums
To the extent allowed by law, certain treatments, services and supplies are subject to internal limits or maximums. These additional items are shown in the Schedule of Coverage.

GENERAL BENEFITS

This section describes the general benefits and benefit specific exclusions under the Group Policy. General limitations and exclusions are listed in the General Limitations and Exclusions section. Optional benefits are set forth under the sections entitled Optional Benefits, Limitations and Exclusions. Please refer to Your Schedule of Coverage to determine which, if any, optional benefits Your employer elected.

Insuring Clause
Upon receipt of satisfactory notice of claim and proof of loss, KPIC will pay the Percentage Payable up to the Maximum Allowable Charge (shown in the Schedule of Coverage) for the treatment of a covered Injury or Sickness, provided:

1) The expense is incurred while the Covered Person is insured for this benefit;
2) The expense is for a Covered Service that is Medically Necessary;
3) The expense is for a Covered Service prescribed or ordered by an attending Physician;
4) The Covered Person has satisfied any applicable Deductibles, Copayments, Coinsurance or other amounts payable;
5) The Covered Person has not exceeded any other Benefit Maximum shown in the Schedule of Coverage; and
6) The Covered Person has satisfied any Precertification requirements.

Payments under the Group Policy, to the extent allowed by law:
1) Will be subject to the limitations shown in the Schedule of Coverage;
2) Will be subject to the General Limitations and Exclusions;
3) May be subject to Precertification; and
4) Will not duplicate any other benefit paid or payable by KPIC.

Covered Services:

OUTPATIENT SERVICES
The following services are covered:

1) Physician' services, including office visits, real time integrated behavioral health consultation services to a treating provider.
2) Telemedicine and Telehealth when used as a mode of delivering otherwise Covered Services via audio, video or data communications methods.
3) Nursing services by an RN or LPN, or LVN, as certified by the attending Physician as Medically Necessary if an RN is not available.
4) 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.
5) Dressings; casts; and splints.
6) Radiation treatment limited to:
   a) radiation therapy when used in lieu of generally accepted surgical procedures or for the treatment of malignancy; or
   b) the use of isotopes, radium or radon for diagnosis or treatment.
7) Chemotherapy that are drugs administered by medical personnel to treat cancer.
8) Infusion Therapy that are drugs or fluids administered by medical personnel used to treat infections, diseases and other conditions.
9) Respiratory therapy.
10) X-ray, other imaging and laboratory tests.

11) Maternity Care for services in connection with pregnancy.
12) Outpatient surgery in a Free-Standing Surgical Facility, Hospital, or other licensed medical facility.
13) Hospital charges for a surgical room on an outpatient basis.
14) 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.
15) Coverage for management and treatment of diabetes which includes medically necessary equipment, supplies, pharmacologic agents and outpatient self-management training and education related to the care of diabetes, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items in accordance with applicable state 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.
16) Reimbursement for any covered surgical procedures performed on an outpatient basis when such procedures are performed by a licensed medical practitioner operating with the use of local anesthetic at a licensed outpatient surgical facility affiliated with a licensed hospital; and reimbursement for medical and surgical procedures performed on an outpatient basis in the case of a medical emergency.
17) Allergy testing and treatment, services, material and serums.
18) Treatment of Orofacial pain, including but not limited to craniomandibular and temporomandibular joint disorders (TMJ) and Orofacial pain for the following treatments:
    a. Health history (medical and dental) pertinent to symptoms;
    b. Clinical examinations related to presenting symptoms;
    c. Muscle injections;
    d. Temporary orthotics. Charges for splints or appliances once every three years with adjustments as necessary. Those appliances designed for orthodontic purposes are not covered, such as bite guards, functional regulators, frankel devices, etc.;
    e. Electromyographic studies of head and neck muscles. This does not include muscle testing or kinesiography;
    f. Physical medicine and physiotherapy, including: heat treatment; ultrasound; diathermy; high voltage galvanic stimulation; transcutaneous nerve stimulation; vapocoolant sprays;
    g. Medically necessary surgery on the Temporomandibular Joint.
19) Non-surgical treatment of craniomandibular and temporomandibular joint disorders.
20) Chiropractic service for manual manipulation of the spine.
21) Necessary Services and Supplies.
22) Coverage for a second medical opinion, limited to charges for Physician consultation, and charges for any additional x-rays, laboratory tests and other diagnostic studies. Benefits will not be payable for x-ray, laboratory tests, or diagnostic studies that are repetitive of those obtained as part of the original medical opinion and/or those for which KPIC paid benefits. For benefits to be payable, the second medical opinion must be rendered by a Physician who agrees not to treat the Covered Person's diagnosed condition. The Physician offering the second medical opinion may not be affiliated with the Physician offering the original medical opinion.
23) Second surgical opinion on the need for surgery. It must be given by a state board certified specialist: a) whose specialty is appropriate to the surgical procedure being evaluated; b) who has personally examined the Covered Person; and c) who does not perform the surgery. It must be given no later than 6 months after the initial surgical opinion indicating the need for the same surgery. It must be given in writing. This does not include repetition of any diagnostic test.
24) Observation Stays

INPATIENT SERVICES

The following services are covered:

1) Room and Board in a Hospital
2) Room and Board in a Hospital Intensive Care Unit.
3) Necessary Services and Supplies, including medication dispensed while confined in a Hospital
4) Dressings; casts; and splints
5) Physician services
6) Nursing services by an RN or LPN, or LVN, as certified by the attending Physician as Medically Necessary if an RN is not available.
7) 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.
8) Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.
9) Respiratory therapy.
10) Blood and blood derivatives, including plasma.
11) Diagnostic testing, including laboratory, x-ray and imaging.
12) Coverage for a second medical opinion, limited to charges for Physician consultation, and charges for any additional x-rays, laboratory tests and other diagnostic studies. Benefits will not be payable for x-ray, laboratory tests, or diagnostic studies that are repetitive of those obtained as part of the original medical opinion and/or those for which KPIC paid benefits. For benefits to be payable, the second medical opinion must be rendered by a Physician who agrees not to treat the Covered Person's diagnosed condition. The Physician offering the second medical opinion may not be affiliated with the Physician offering the original medical opinion.
13) 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. These charges will be subject to any Deductible, Copayment, and Coinsurance shown in the Schedule of Coverage.
14) Non-medically necessary circumcision for newborn within 31 days from birth
15) Birth Services/Maternity Care in connection with pregnancy including those performed in a Birth Center.

NEWBORN BABY AND MOTHER PROTECTION ACT NOTICE

The Newborn Baby and Mother Protection Act (Code Section 33-24-58.2 of the OCGA) requires that health benefit policies which provide maternity benefits must provide coverage for a minimum of 48 hours of inpatient care following a normal vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section for a mother and her newborn child. The care must be provided in a licensed health care facility. A decision to shorten the length of stay may be made only by the attending health care provider after conferring with the mother. If the stay is shortened, coverage must be provided for up to two follow-up visits with specified health care providers with the first visit being within 48 hours after discharge. After conferring with the mother, the health care provider must determine whether the initial visit will be conducted at home or at the office and whether a second visit is appropriate. Specified services are required to be provided at such visits.

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

AMBULANCE SERVICES

1) Emergency medical transportation provided through the 911 emergency response system.
2) Non-emergency ambulance transportation in connection with care that is Medically Necessary.

Ambulance Exclusions

Non-emergency medical transportation including, but not limited to, stretcher van, wheelchair vans (ambulettes), taxis, and buses are not covered.

AUTISM SPECTRUM DISORDER

We provide diagnosis and Medically Necessary health care treatment of Autism Spectrum Disorder as determined by a licensed physician or licensed psychologist. We may require that Medically Necessity be demonstrated annually. Services include the following:

1. Diagnostic Services including assessments, evaluations or tests.
2. Habilitative or Rehabilitative Services, including physical therapy, speech therapy, occupational therapy Applied Behavior Analysis or other professional or counseling services necessary to develop, maintain, and restore the functioning of an individual to the extent possible. These covered Services are also described in the sections regarding "Rehabilitation Services and Habilitation Services".
3. Counseling Services provided by a licensed psychiatrist, licensed psychologist, professional counselor or clinical social worker ; and
4. Therapy Services for the treatment of Autism Spectrum Disorder provided by a licensed or certified speech therapist, speech-language pathologist, occupational therapist, physical therapist or marriage and family therapist.

Autism Spectrum Disorder Exclusions

Any Services described in this Treatment of Autism Spectrum Disorder that are not specifically required to be covered by Kaiser Permanente Insurance Company pursuant to an individualized family service plan, an individualized education plan as required by the federal Individuals with Disabilities Education Act, or an individualized service plan are not covered.

CLINICAL TRIALS

We cover Services in connection with a clinical trial if all of the following conditions are met:

1) We would have covered the Services if they were not related to a clinical trial such as Routine Patient Care;
2) You are eligible to participate in the clinical trial according to the trial protocol with respect to the treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined by the following:
   a) A Provider has made this determination; or
   b) You provide Us with medical and scientific information establishing this determination.
3) The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
   a) The study or investigation is approved or funded (which may include funding through in-kind contributions) by at least one of the following:
      i. The National Institutes of Health.
      ii. The Centers for Disease Control and Prevention.
      iii. The Agency for Health Care Research and Quality.
      iv. The Centers for Medicare & Medicaid Services.
      v. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.

vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
vii. The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the HHS Secretary determines meets all of the following requirements:
A. It is comparable to the National Institutes of Health system of peer review of studies and investigations.
B. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

b) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
c) The study or investigation is a drug trial that is exempt from having an investigational new drug application.

Clinical Trial Exclusions
The following services are not covered:
1) The investigational item or service.
2) Items and services that are provided solely for data collection and analysis and that are not used in the direct clinical management of the patient.
3) Services that are clearly inconsistent with widely accepted and established standards of care for the patient's diagnosis.

Clinical Trials for Children with Cancer
Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and benefits to dependent children stricken with cancer in connection with approved clinical trial programs for the treatment of childrens cancer. Such dependent children should have been diagnosed with cancer prior to their nineteenth birthday; are enrolled in an approved clinical trial program for treatment of children's cancer; and are not otherwise eligible for benefits, payments, or reimbursements from any other third party payors or other similar sources.

DENTAL SERVICES
The following dental services are covered:
1) Extraction of impacted wisdom tooth embedded in the bone.
2) Accidental Dental services will be limited to services necessary to promptly repair, but not replace, teeth that have been injured as the result of an external force. For benefits to be payable all of the following conditions must be satisfied:
a)A licensed provider provides the dental services;
b) The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing; and
c)The Covered Services must be requested within 60 days of the injury.
Benefits are limited to the most cost-effective procedure available that would produce the most satisfactory result.
Services will not include Oral prostheses and appliances, including replacement of dentures and implants.
3) General anesthesia and associated facility charges for dental procedures rendered in a Hospital or surgery center setting are covered, when the clinical status or underlying medical condition of the Covered Person requires that the dental procedure be performed while the Covered Person is under general anesthesia in a Hospital or surgery center setting. Coverage shall not be provided unless the Covered Person is:
a) under seven (7) years of age; or
b) developmentally disabled; or

c) one whose health is compromised and for whom general anesthesia is medically necessary; or
d) one who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation.

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

Dental Services Exclusions
Dental care including dental x-rays; dental appliances; orthodontia; and dental services resulting from medical treatment, including surgery on the jawbone, and radiation treatment is not covered. This exclusion does not apply to Dental Services covered above.

DIALYSIS CARE
Coverage of dialysis Services related to acute renal failure and end-stage renal disease is covered when all of the following conditions are met:
a) You satisfy all the medical criteria developed by KPIC or its designee and by the facility providing the dialysis;
b) You receive the Services are provided in a hospital or facility certified by Medicare; and
c) You receive a written order for our dialysis treatment from a physician.

Equipment, training and medical supplies required for home dialysis are covered. Home dialysis includes home hemodialysis and peritoneal dialysis.

DURABLE MEDICAL EQUIPMENT (DME)
We cover DME prescribed in accordance with Medicare guidelines and approved for coverage under Medicare as of January of the year immediately preceding the year this COI became effective or last renewed. DME also includes infant apnea monitors and blood pressure monitors for individuals diagnosed with hypertension. Rental of Durable Medical Equipment is covered, unless otherwise indicated in the Schedule of Coverage. However, purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental. KPIC will repair the equipment without charge, unless the repair is due to loss or misuse.

Durable Medical Equipment Exclusions
The following Durable Medical Equipment is not covered:
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) unless otherwise required by law;
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 including but not limited to theft;
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.

EMERGENCY SERVICES

Emergency Services are covered 24 hours a day 7 days a week and includes:

a) Emergency Medical Screening Exams; and
b) stabilization of an Emergency Medical Condition.

Emergency Services are covered 24 hours a day, 7 days a week, anywhere in the world. If You have an Emergency Condition, call 911 or go to the nearest emergency room. If You receive Emergency Care/Services and cannot, at the time of emergency, reasonably reach an In-Network Provider, that emergency care rendered during the course of the emergency will be paid for in accordance with the terms of the Group Policy, at benefit levels at least equal to those applicable to treatment by an In-Network Providers for emergency care.

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

FAMILY PLANNING SERVICES

Covered family planning services are limited to:

a) The charge of a Physician for consultation concerning the family planning alternatives available to You and Your spouse, including any related diagnostic tests;
b) Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control;
c) Voluntary termination of pregnancy; and
d) Vasectomies

Familly Planning Exclusions

The following services are not covered:

1) Artificial insemination;
2) Other assistive reproductive technologies;
3) Diagnostic procedures;
4) In vitro fertilization and other procedures involving the eggs;
5) Implantation of an embryo developed in vitro; and
6) Infertility diagnosis and treatment services.
7) Reversal of sterilization

HEARING SERVICES

The following hearing services are covered:

1) Hearing exams and tests needed to determine the need for hearing correction are covered.
2) Pediatric hearing aids and services:
   For Dependent children up to age 19, We provide one Hearing Aid for each hearing impaired ear when prescribed as Medically Necessary every 48 months up to the Benefit Maximum as specified in the Schedule of Benefits. You need not obtain hearing aids for both ears at the same time, and the 48 month periods run separately for each ear.

   The hearing aid(s) and all Medically Necessary Services and supplies count toward the Benefit Maximum including:
   a) Initial hearing aid evaluation;
   b) Fitting;
   c) Dispensing;
   d) Programming;
   e) Servicing, repairs, and follow-up maintenance;

f) Adjustments;
g) Ear molds
h) Ear mold impressions
i) Auditory training
j) Probe microphone measurements to ensure appropriate gain and output.

Please refer to the definition of "Hearing Aids" under the GENERAL DEFINITIONS section for more information.

If during the 48-month period, the hearing aid(s) no longer adequately meets the needs of the covered Dependent and the hearing aid(s) cannot be repaired or adjusted, we will provide a one-time replacement during the 48-month period up to a separate Benefit Maximum equal to the initial Benefit Maximum.

The devices and services outlined above are subject to any Benefit Maximums, Accumulation Periods, Deductible, Copayment, and Coinsurance shown in the Schedule of Coverage.

Pediatric Hearing Aid Exclusions
The following services are not covered:
1) Hearing aids prescribed or ordered before you were a Covered Person under this policy are not covered.
2) Replacement parts for repair of a hearing aid are not covered except as outlined above.
3) Replacements of lost, stolen, or broken hearing aids are not covered except as outlined above.
4) Hearing aid batteries.
5) Hearing aids for non-hearing impaired ears.
6) Hearing aids for Covered Persons who are 18 years old or older unless purchased separately by your Group.

Hearing Services Exclusions
Hearing therapy, or hearing aids for adults age 19 and over are not covered. This exclusion includes hearing exams to determine appropriate hearing aid, as well as hearing aids or tests to determine their efficacy.

HOME HEALTH CARE
Home Health Care Services are covered.
Covered Home Health Care Services are limited to 4 hours of treatment within any 24-hour period.

Home Health Care Exclusions
The following Home Health Care services are not covered:
1) meals, personal comfort items,
2) housekeeping services.
3) services provided by a Home Health Aide.
4) Applied Behavioral Analysis please see **AUTISM SPECTRUM DISORDER** for description of coverage.

HOSPICE CARE
Covered Hospice Care is limited to:
a) Physician services;
b) nursing care;
c) physical, speech or occupational therapy;
d) medical social services;
e) services of home health aides and homemakers;

f) medical supplies, drugs and Durable Medical Equipment;
g) short-term inpatient care, including respite care and care for pain control and acute and chronic symptom management;
h) counseling and bereavement services; and
i) services of volunteers.

Covered Persons who elect to receive Hospice Care are not entitled to any other benefits under the Group Policy for the terminal illness.

INFERTILITY SERVICES

Services for diagnosis of involuntary infertility that are limited to diagnostic imaging and laboratory tests to determine whether urological or non-gynecological medical conditions are the cause of the infertility are covered. Tests include fasting blood glucose, fasting insulin, hormone level tests and tests to rule out sexually transmitted diseases. Benefits are also available for services to treat the underlying medical conditions that cause infertility (e.g., endometriosis, obstructed fallopian tubes, and hormone deficiency). Treatment must be consistent with prevailing standards for efficacy. Benefits payable for diagnosis of infertility will be covered on the same basis as a Sickness.

Infertility Services Exclusions

The following services are not covered:
1) Artificial insemination and advanced reproductive techniques such as IVF, ZIFT and GIFT for the treatment for infertility.
2) Treatment for infertility.

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

The following services are covered:
1) Mental Health Services for the treatment of a Mental Illness are covered, including:
   a) Inpatient Mental Health Services including:
      1) evaluation,
      2) crisis intervention
      3) psychiatric hospitalization including coverage for Room and Board,
      4) Residential Treatment in a licensed residential treatment facility.
   b) Outpatient Mental Health Services
      1) diagnostic evaluation such as neurophysiological and psychological testing,
      2) psychiatric treatment such as electroconvulsive treatment,
      3) individual and group therapy visits,
      4) hospital alternative services such as partial hospitalization and intensive outpatient psychiatric treatment programs,
      5) visits for the purpose of monitoring drug therapy.

2) Chemical Dependency Services for the treatment of Substance Abuse or Chemical Dependency are covered including:
   a) Detoxification Services in an inpatient or outpatient setting for the medical treatment of withdrawal symptoms.
   b) Inpatient Chemical Dependency Treatment Services such as
      1) Hospital Services,
      2) Residential Treatment in a licensed residential treatment facility,
      3) Medical treatment for withdrawal symptoms,
      4) individual and group counseling, and
      5) inpatient specialized treatment programs.

c) Outpatient Chemical Dependency Treatment Services such as
   1) individual and group counseling; Medical treatment for withdrawal symptoms,
   2) hospital alternative services, such as partial hospitalization and intensive outpatient treatment programs; and
   3) aftercare support visits, when provided as part of a covered program.

PREVENTIVE VISITS AND 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. Please refer to Your Schedule of Coverage regarding each benefit in this section:

Preventive Care Exams and Services:

As shown in the Schedule of Coverage, the following preventive services are not subject to Deductibles, Copayments or Coinsurance if received from an In-Network Provider. When performed as part of preventive exam for children through age five (5) urinalysis will not be subject to Deductibles regardless of provider participating status. The preventive services indicated with an (*) asterisk below will not be subject to Deductibles if received from an Out-of-Network Provider. Consult with Your physician to determine what preventive services are appropriate for You.

Exams:

1) Well-Baby, Child, Adolescent Exam according to the Health Resources and Services Administration (HRSA) guidelines*.
2) Well woman exam visits including preconception counseling, routine prenatal care and post partum office visits. Routine prenatal office visits include the initial and subsequent histories, physical examinations, recording of weight, blood pressure, fetal heart tones and routine chemical urinalysis.

Screenings:

1) Abdominal aortic aneurysm screening
2) Anxiety screening in adolescent and adult women, including those who are pregnant or postpartum
3) Asymptomatic bacteriuria screening
4) Breast cancer mammography screening
5) Behavioral/Social/Emotional Screening for children newborn to 21 years
6) Cervical cancer and dysplasia screening including HPV screening
7) Colorectal cancer screening using fecal occult blood, sigmoidoscopy or colonoscopy. Colonoscopies after a positive non-invasive stool-based screening test or direct visualization screening test. This includes anesthesia required for colonoscopies, pathology for biopsies resulting from a screening colonoscopy, over the counter and prescriptions drugs necessary to prepare the bowel for the procedure, and a specialist consultation visit prior to the procedure.
8) Depression screening including suicide risk as an element of universal depression screening for children ages 12-21.
9) Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus
10) Gestational and post partum diabetes screening
11) Hepatitis B and Hepatitis C virus infection screening
12) Hematocrit or Hemoglobin screening in children*
13) Hypertension (High blood pressure) screening

14) Lead screening
15) Lipid disorders screening
16) Lung cancer screening with low-dose computed tomography including a counseling visit to discuss the screening in adults who have a 20- pack-year smoking history and currently smoke or have quit within the past 15 years. One pack year is equal to smoking one pack per day for one year, or two packs per day for half a year.
17) Newborn congenital hypothyroidism screening*
18) Newborn hearing loss screening*
19) Newborn metabolic/hemoglobin screening*
20) Newborn phenylketonuria screening*
21) Newborn sickle cell disease screening*
22) Obesity screening
23) Osteoporosis screening
24) Pre-eclampsia screening with blood pressure measurements throughout pregnancy
25) Rh (d) incompatibility for pregnant women screening
26) Sexually transmitted infection screening such as chlamydia, gonorrhea , syphilis and HIV screening.
27) Sudden cardiac arrest and sudden cardiac death risk assessment in children 12-21.
28) Type 2 diabetes mellitus screening
29) Tuberculin testing*
30) Urinary incontinence screening in women
31) Visual impairment in children screening*

Health Promotion:

1) Screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
2) Unhealthy alcohol and drug use assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse.
3) Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease.
4) Offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children.
5) Counseling for midlife women with normal or overweight body mass index to maintain weight or limit weight gain to prevent obesity.
6) Offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
7) Sexually transmitted infections counseling.
8) Tobacco use screening and tobacco-caused disease counseling and interventions. FDA approved tobacco cessation prescription or over-the-counter medications prescribed by a licensed health care professional authorized to prescribe drugs for men and women who are not pregnant.
9) Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and referral for BRCA mutation testing.
10) Discuss use of risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, with women who are at increased risk for breast cancer and at low risk for adverse medication effects.
11) When prescribed by a licensed health care professional authorized to prescribe the following drugs:
    a) Aspirin in the prevention of cardiovascular disease, colorectal cancer, preeclampsia in pregant women and colorectal cancer.
    b) Iron supplementation for children for 6 months to 12 months of age.

c) Oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
d) Topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.
e) Folic acid supplementation for women planning or capable of pregnancy for the prevention of neural tube defects.

12) Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and counseling by a provider provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the post partum period; breast milk storage supplies; any equipment and supplies as clinically indicated to support women and babies with breast feeding difficulties; and the purchase of a breast pump. A hospital-grade electric breast pump, including any equipment that is required for pump functionality, is covered when Medically Necessary and prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.
13) All prescribed FDA-approved contraceptive methods for women with reproductive capacity, including but not limited to drugs and cervical caps, vaginal rings, continuous extended oral contraceptives and patches. This includes all FDA-approved cleared or granted contraceptive products that are determined by an individual's medical Provider to be medically appropriate. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, sterilization procedures, follow-up and management of side effects; counseling for continued adherance, device removal, patient education and counseling. Over the counter FDA-approved female contraceptive methods are covered only when prescribed by a licensed healthcare professional authorized to prescribe drugs. In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, are covered for women desiring an alternative method. A non-preferred contraceptive or drug will be covered at the preferred cost share level when Your physician determines a generic or preferred contraceptive drug or device is not medically appropriate.
14) Screening, counseling and other interventions such as education, harm reduction strategies and referral to appropriate supportive services for interpersonal and domestic violence.
15) Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions.
16) Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.
17) Counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.

Disease Prevention:

1) Immunizations as recommended by the Centers for Disease Control and HRSA*. Certain immunizations may be available at a pharmacy.
2) Prophylactic gonorrhea medication for newborns to protect against gonococcal ophthalmia neonatorum
3) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met: 1) individuals are aged 40-75 years;

2) they have 1 or more cardiovascular risk factors; and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.

4) Preexposure prophylaxis (PrEP) with at least one drug providing effective antiretroviral therapy to persons who are at high risk of HIV acquisition as well as the following baseline and monitoring services:
    a) HIV testing – to confirm the absence of HIV infection before PrEP is started and testing for HIV every 3 months while PrEP is being taken.
    b) Hepatitis B testing before PrEP is started.
    c) Hepatitis C testing before PrEP is started and periodically during treatment according to CDC guidelines.
    d) Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) is covered as follows:
    e) eCrCl or eGFR testing before starting PrEP to assess kidney function.
    f) Creatinine and eCrCL or eGFR testing periodically consistent with CDC guidelines during treatment.
    g) Pregnancy testing for persons of childbearing potential before PrEP is started and periodically during treatment consistent with CDC guidelines.
    h) Sexually transmitted infection screening and counseling before PrEP is started and periodically during treatment consistent with CDC guidelines.
    i) Adherence counseling for assessment of behavior consistent with CDC guidelines.

Preventive Care Exams and Services Exclusions

The following services are not covered:

1) Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases unless clinically indicated.
2) Upgrades of breast-feeding equipment, unless determined to be medically necessary and prescribed by Your physician.

Preventive services may change upon Policy renewal according to federal guidelines in effect as of January 1 of each year in the Calendar Year in which this Group Policy renews. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of covered services.

For a complete list of current preventive services required under the Affordable Care Act (ACA) for which cost share does not apply, please call: 1-855-364-3185, 711 (TTY). You may also visit: www.healthcare.gov/center/regulations/prevention.html. Please note, however, for recommendations that have been in effect for less than one year, KPIC will have one year from the effective date to comply.

Note: The following services are not Covered Services under this Preventive Exams and Services benefit but may be Covered Services elsewhere in this General Benefits section:

1) Lab, Imaging and other services associated with prenatal care not inclusive to routine prenatal care
2) Non-routine prenatal care visits
3) Non-preventive services performed in conjunction with a sterilization
4) Lab, Imaging and other services associated with sterilizations
5) Treatment for complications that arise after a sterilization procedure

Other Preventive Care not required by PPACA

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

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

1) Annual Routine Physical Exam for adults
2) Prostate specific antigen (PSA) test for males
3) FDA approved tobacco cessation prescription or over-the-counter medications by a licensed health care professional authorized to prescribe drugs for women who are pregnant.
4) Iron deficiency anemia screening for pregnant women.
5) Venipuncture for ACA preventive lab screenings. If a venipuncture is for the purpose of drawing blood for both ACA preventive and Non-ACA preventive labs, a cost share may apply.
6) Behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease (CVD) prevention in adults with CVD risk factors and type 2 diabetes mellitus.
7) The following services and items are covered as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
   a. Hemoglobin A1C testing for individuals diagnosed with diabetes.
   b. Retinopathy Screening for individuals diagnosed with diabetes.
   c. Low Density Lipo-Protein testing for individuals diagnosed with heart disease.
   d. International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders.
   e. DME items:
      i. Peak flow meters for individuals diagnosed with Asthma.
      ii. Glucometers including lancets, strips, control solution and batteries for individuals diagnosed with Diabetes.
      iii. Blood pressure monitors for individuals diagnosed with Hypertension.

PROSTHETIC DEVICES (External and Internally Implanted) AND ORTHOTICS

The following services are covered:

1) Internally implanted Prosthetic Devices and External Prosthetic Devices.
2) Orthotics and their initial placement.
3) Medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry including a disease for which the State screens newborn babies. Coverage is provided if the medical foods and low protein food products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Physician.

Prosthetic Device Limitations and Exclusions

The following services are limited or not covered:

1) Repair or replacement of braces and prosthetic devices is limited to that needed because of growth;
2) Repair or replacement necessitated by loss or misuse;
3) Dental prostheses, devices, implants and appliances;
4) Internally implanted hearing devices;
5) Comfort, convenience, or luxury equipment or features;
6) Electronic voice-producing machines;
7) Shoes or arch supports, even if custom-made, except for severe diabetic foot disease in accord with Medicare guidelines.

8) More than one orthotic or prosthetic device for the same part of the body, except for replacements other than those necessitated because of misuse or loss.
9) Replacement of lost prosthetic or orthotic devices;
10) Repair, adjustments or replacements necessitated by misuse;
11) Spare or alternate use equipment; and
12) Prosthetics and devices for the treatment of sexual dysfunction disorders.

RECONSTRUCTIVE SURGERY

Reconstructive Surgery. Coverage is limited to a surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities or significant disfigurement resulting from an Injury or covered surgery to do either of the following:
1) to significantly improve function; or
2) to create a normal appearance to the extent possible.

Reconstructive Surgery includes, but is not limited to craniofacial reconstruction, reconstructive breast surgery following a mastectomy including reconstruction of the other breast to produce a symmetrical appearance; treatment of complications at all stages of the mastectomy, including lymphedemas..

REHABILITATION SERVICES AND HABILITATIVE SERVICES

The following services are covered when provided by a provider acting within the scope of their license:
1) Habilitative Services in a Hospital or any other licensed medical facility, unless otherwise indicated in the Schedule of Coverage. Habilitation services include those provided in an organized, multidisciplinary habilitation program. The following services are covered:
   a) Physical therapy.
   b) Speech therapy.
   c) Occupational therapy.
   d) Medically Necessary health care services.
2) Rehabilitative Services in a Hospital or any other licensed medical facility, unless otherwise indicated in the Schedule of Coverage. Rehabilitation services include those provided in an organized, inpatient multidisciplinary rehabilitation program or outpatient program such as those provided in a Comprehensive Rehabilitation Facility. The therapy must be progressive therapy and not maintenance therapy. It must be rendered for a condition which the attending Physician determines is subject to significant improvement within two (2) months. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time. The following services are covered:
   a. Physical therapy.
   b. Speech therapy. To be eligible for coverage the speech disorder must be a result of an Injury or Sickness of specific organic origin.
   c. Occupational therapy. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living.
   d. Pulmonary therapy to restore respiratory function after an illness or injury.
3) Cardiac rehabilitation following a heart transplant, bypass surgery or myocardial infarction is covered if significant improvement is achievable with treatment.
4) Cognitive Rehabilitation for Traumatic Brain Injury.

Rehabiliation and Habilitative Services Exclusions

The following services are not covered:
1) Maintenance therapy for rehabilitation. Maintenance therapy is defined as ongoing therapy after the patient has reached maximum rehabilitation potential, or functional level has shown no significant improvement, and initial instruction in a maintenance program is completed.

SKILLED NURSING FACILITY CARE

Room and Board and other Skilled Nursing Services in a Skilled Nursing Facility or other licensed medical facility are covered. Care in a Skilled Nursing Facility must be in lieu of Hospital Confinement, and is limited to: a) the maximum number of covered days shown in the Schedule of Coverage; b) care in a licensed Skilled Nursing Facility; c) care under the active medical supervision of a Physician; and d) services consistent with medical needs. Covered Services will include Durable Medical Equipment furnished during a Confinement in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish such Durable Medical Equipment.

TRANSPLANT SERVICES

Transplant services in connection with an organ or tissue transplant procedure are covered. This coverage must be in accordance with a plan of care duly prepared and/or recommended by KPIC case management. Transplant services in connection with an organ or tissue transplant procedure, including charges incurred by a donor or prospective donor who is not insured under the Group Policy will be paid as though they were incurred by the insured provided that the services are directly related to the transplant. The Group policy will not cover any donor expenses if the donor has coverage elsewhere that covers donor expenses. The donor need not be a Covered Person.

Transplant Services Exclusions

Charges incurred or in connection with non-human and artificial organs and their implantation are not covered under the transplant benefit.

URGENT CARE

Treatment in an Urgent Care Facility is covered.

VISION SERVICES

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

Vision Services Exclusions

The following services are not covered:

1) Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
2) Vision hardware, including glasses, contact lenses or the fitting of glasses or contact lenses.

PHARMACY SERVICES

Outpatient Prescription Drug Benefit

Kaiser Permanente Insurance Company uses an open Formulary. For information about Our drug Formulary or whether a particular drug is included in Our drug Formulary or obtaining a Formulary brochure that lists the Formulary drugs or whether a drug requires Precertification, please call MedImpact Monday through Friday from 7 a.m. to 7 p.m. at 1-800-788-2949. A copy of the Formulary for 2022 Georgia Choice Formulary may be obtained from the following website https://healthy.kaiserpermanente.org/georgia/health-wellness/drug-formulary .

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

Outpatient prescription drugs can be obtained from In-Network or Out-of-Network Pharmacies. If You use an Out-of-Network Pharmacy You may have to pay a higher cost share.

Deductible, Coinsurance and Copayment: See the Schedule of Coverage, for the Copayment or Coinsurance per prescription for Preventive Generic, Generic Brand, Non-Preferred or Specialty Drugs. Copayments are applied per 30 day supply.

In the event of a state of emergency by executive order of the Govenor of Georgia or a hurricane warning issued by the National Weather Service a 30 day supply prescription may be refilled in advance of Your refill date. In order to receive an advance refill the following must be met:

1) The executive order or hurricane warning must be issued for the county or area of the state You reside in; and
2) The prescription has refills remaining and a refill is requested within 30 days of the conditions above.

Dispensing Limitation: There is a 90-day supply dispensing limitation at a Kaiser Permanente Pharmacy and a 30-day supply dispensing limitation at any other pharmacy. Benefits are subject to the Copayment, coinsurance, deductibles and Limitations and Exclusions (Please refer to Your Schedule of Coverage). The 90-day supply dispensing limitation at a Kaiser Permanente Pharmacy does not apply to birth control pills. Birth control pills are subject to a 6 month dispensing limitation at a Kaiser Permanente Pharmacy. Please refer to Your Schedule of Coverage for the dispensing limitation, if any, of specific drugs including birth control pills.

Mandatory Generic Drug Requirement

Unless otherwise specified by Your Provider, generic drugs may be used to fill a prescription. If You request a brand name drug that has a generic equivalent, You pay the full cost difference between the generic drug and the brand name drug, in addition to the applicable Copayment, Coinsurance and deductible shown in "Schedule of Coverage".

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).

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

Step Therapy Process

Selected prescription drugs require step therapy. Step therapy defines how and when a particular outpatient prescription drug can be dispensed and establishes the specific sequence in which prescription drugs for a specified condition are deemed medically appropriate. Step therapy requires the use of one or more prerequisite drugs (1st line agents), as identified through Your drug history, prior to the use of another drug (2nd line agent) when prescribed for Your condition. The step therapy process encourages safe and cost-effective medication use. Under this process, a "step" approach is required to receive coverage for certain medications. This means that to receive coverage You may first need to try a proven, cost-effective medication. Treatment decisions are always between You and Your Prescribing Provider.

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 if You qualify for a step therapy exception.

Refer to the formulary for a complete list of medications requiring step therapy. You may access the Formulary for 2022 Georgia Choice Formulary at https://healthy.kaiserpermanente.org/georgia/health-wellness/drug-formulary or by calling ,MedImpact Monday through Friday from 7 a.m. to 7 p.m. at1-800-788-2949.

Step Therapy Exception and Appeal Process

A step therapy exception may be granted if Your prescribing provider's submits justification and supporting clinical documentation that meets KPIC's criteria for such exception. The exception process may be initiated by calling the MedImpact at 1-800-788-2949. This exception process only applies to prescription drugs that are covered under this Plan.

Non-Urgent Exception

We will respond to Your exception request within two (2) business days from the date such request is submitted in a nonurgent health care situation.

Urgent Exception

We will respond to Your urgent exception request within 24 hours from the time such request is submitted in an urgent health care situation.

If We fail to respond within the stated time frame, Your step therapy exception will be deemed approved.

If Your exception request is denied, You may appeal Our decision.

Send Your Appeal to:

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

or fax Your information to: 1-858-790-6060
Attn: KPIC Pharmacy Administrator Grievance and Appeals Coordinator

Non-Urgent Appeal
We will respond to Your appeal within two (2) business days from the date of the appeal is submitted in a nonurgent health care situation.

Urgent Appeal
We will respond to Your urgent appeal within 24 hours from the time of the appeal is submitted in an urgent health care situation.

If We fail to respond to Your appeal within the stated time frame, Your appeal will be deemed approved.

Nothing in this provision shall be construed to prevent KPIC from (1) requiring a member to try a generic equivalent prior to providing coverage for the equivalent branded prescription drug; (2) requiring a member to try an interchangeable biological product prior to providing coverage for the biological product; or (3) substituting a generic drug for a brand name drug.

Precertification
Precertification is a review and approval procedure that applies to some outpatient prescription drugs and is used to encourage safe and cost-effective medication use. Precertification is generally applied to outpatient prescription drugs that have multiple uses, are higher in cost, or have a significant safety concern.

The purpose of Precertification 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 Precertification, the medication must be reviewed by the utilization management program to determine Medical Necessity before the prescription is filled. Precertification reviews address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.

If a drug requires precertification, You or Your Prescribing Provider must work with Us to authorize the drug for Your use. Drugs requiring Precertification have specific clinical criteria that You must meet for the prescription to be eligible for coverage.

If Your prescription is written by a Kaiser Permanente Provider, in most cases the Kaiser Permanente Provider will arrange for any necessary Precertification on Your behalf. Otherwise your Kaiser Permanente Provider may call: 1-800-788-2949, 711 (TTY)

To obtain Precertification for a prescription written by a Kaiser Permanente Provider your physician may call: 1-800-788-2949 , 711 (TTY)

To obtain Precertification for a prescription written by any other physician have your physician may call 1-800-788-2949 711 (TTY):

Refer to the formulary for a complete list of medications requiring Precertification. The most current Formulary for 2022 Georgia Choice Formulary can be obtained by visiting https://healthy.kaiserpermanente.org/georgia/health-wellness/drug-formulary . If You have questions about the Precertification or about outpatient prescription drugs covered under Your plan, you can call 1-855-364-3185 711 (TTY) 24 hours a day, 7 days a week (closed holidays).

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

"**Precertification**" 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 Precertification 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 Precertification:
(1) Could seriously jeopardize the life or health of the covered person or the ability to regain maximum function; or
(2) The Covered Person is subject to severe pain that cannot be adequately managed without the drug benefit that is the subject of request for Precertification.

"**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.

Mail Service
A Covered Person may use the Mail Service if the Covered Person takes maintenance medications to treat an acute or chronic health condition, such as high blood pressure, ulcers or diabetes. Benefits are subject to any limitations, Copayments, coinsurance, and the Deductibles shown in the Schedule of Coverage.

Kaiser Permanente Pharmacy
When a Kaiser Permanente Pharmacy is used there is no shipping charge and no additional fees for mail service prescriptions, unless You request special handling, such as overnight delivery.

To use a Kaiser Permanente Pharmacy You can order prescriptions for mail service two ways:

1) Register online at kp.org. Once you have registered you may order refills online. Online prescription orders must be paid for in advance by credit card.
2) Call the number listed on your prescription label 24 hours 7 days a week. Prescription orders must be paid for in advance by credit card.

Network Pharmacy
When a Network Pharmacy is used there is no shipping charge and no additional fees for mail service prescriptions, unless You request special handling, such as overnight delivery.

To use a Network Pharmacy You can order prescriptions for mail service three ways:

1) Register online at walgreens.com/mailservice. Once you have registered you may order refills online. Online prescription orders must be paid for in advance by credit card.

2) Call the Customer Care Center at 866-304-2846 Monday through Friday 8am to 10pm (EST), Saturday and Sunday 8am to 5pm (EST). Prescription orders must be paid for in advance by credit card.
3) Fill out and send in a Walgreens Registration Form and Prescription Order form. When You use this method of ordering, You can pay by check or credit card. Mail Form to: Walgreens Mail Service P.O. Box 29061 Phoenix, AZ 85038-9061.

For more information and a current Walgreens Mail Service Pharmacy brochure, call our Network Pharmacy Administrator, MedImpact at (800) 788-2949, 711 (TTY).

Keep in mind that not all drugs are available through the mail service. Examples of drugs that cannot be mailed include:

- Controlled substances as determined by state and/or federal regulations;
- Medications that require special handling;
- Medications administered by or requiring observation by medical professionals; and
- Medications affected by temperature.

Payments and reimbursement for drugs obtained through the mail service are substantially the same as for drugs obtained at In-Network and Out-of-Network Provider Pharmacies.

Direct Reimbursement

When You obtain a prescription at an Out-of-Network Pharmacy or order a prescription through an Out-of-Network mail service, You may be required to pay the full cost of the drug and submit a claim to MedImpact for reimbursement for the portion covered by the plan. When a Covered Person fills a prescription, he may obtain reimbursement by submitting a claim and proof of loss. You may access the direct member reimbursement form via http://www.kp.org/dualchoice-georgia "Quick Documents and Links", "Claim Forms". Benefits are subject to any limitations and to any Deductible, Coinsurance and Copayment, shown in the Schedule of Coverage.

For outpatient prescription drugs dispensed by Out-of-Network Pharmacy, the amount payable by KPIC is the lesser of the charges billed by the provider or the same amount paid to an In-Network Pharmacy for the same service or item.

Prescription Drug Copayment Coupons

For outpatient prescription drugs and/or items that are covered under the Outpatient Prescription Drug section and obtained at a Kaiser Permanente Pharmacy owned and operated by KFHP, You may be able to use approved manufacturer copay coupons as payment for the prescription Cost Sharing that You owe, as allowed under KFHP's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of Your Cost Sharing for Your prescription. When You use an approved copay coupon for payment of Your Cost Sharing, the coupon amount and any additional payment that you make will accumulate to Your Cost Sharing Maximum Amount. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente copay coupon program rules and limitations at www.kp.org/rxcoupons.

Drugs Covered

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

1) A prescription legend drug for which a written prescription is required;
2) Prescribed drug or device approved by the United States Federal Drug Administration (FDA);

3) Compounded medication of which at least one ingredient is a legend drug;
4) Prescription inhalants required to enable persons to breathe when suffering from asthma or other life-threatening bronchial ailments;
5) Prescription contraceptives are covered under Your Preventive Care benefits;
6) Coverage of off-label use of covered prescription drugs.
7) Prescription drugs and prescribed over the counter drugs for smoking cessation including aids are covered under Your Preventive Care benefits.
8) Time-released drugs, limited to implantable or injectable drugs no refund is given if the implant is removed).
9) Self-administered Injectable Medications. Coverage for Self-administered Injectable medications must meet the following criteria:
   a) does not require administration by medical personnel;
   b) administration does not require observation;
   c) patient's tolerance and response to the drug does not need to be tested, or has already been satisfactorily tested; and
   d) prescribed for self-administration by the patient at home.
10) Over the counter drugs listed on the formulary.

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 the medical offices).

For the most current Forumlary, please visit https://healthy.kaiserpermanente.org/georgia/health-wellness/drug-formulary or call Customer Service at 1-800-364-3785.

Drugs Not Covered

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

1) Administration of a drug or medicine.
2) Any drug or medicine administered as Necessary Services and Supplies. (See the General Definitions section.)
3) Supplies, drugs, medications, injections or intravenous therapies:
   a) provided at a hospital; or
   b) provided in connection with any home care benefit.
4) Non-prescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician unless otherwise required by state or federal law.
5) Any medication whose label is required to bear the legend "Caution: federal law prohibits dispensing without a prescription"; except experimental drugs that are used to treat cancer if one or more of the following conditions is met:
   a) The drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or
   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.
6) Drugs labeled "caution - limited by federal law to investigational use", or experimental drugs, even though a charge is made to the Insured Employee or Insured Dependent. Except experimental drugs that are used to treat cancer if one or more of the following conditions is met:

a) The drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or
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;

7) Therapeutic or other prosthetic devices, appliances, supports, and other non-medical appliances.
8) Biological serums.
9) Immunization agents. However, Immunizations are covered under the Preventive Visits and Services benefit when administered at a pharmacy.
10) Refills in excess of the number specified by the Physician or refills dispensed after one year from the Physician's order.
11) Allergens or allergy serums.
12) Drugs when used for cosmetic purposes, including Ioniten (Minoxidil) compounded for hair growth and Tretinon (Retin A).
13) DESI drugs: drugs determined by the Food and Drug Association as lacking substantial evidence of effectiveness.
14) Growth hormones and all synthetic analogs.
15) Androgens and anabolic steroids.
16) Experimental Drugs and Medicines, except experimental drugs that are used to treat cancer if one or more of the following conditions is met:
    a) The drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or
    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;
17) Any drugs associated with services that are not a covered under this Policy.

Outpatient Prescription Drug Benefit Exception:

The list of drugs We cover is called a Formulary. You, Your designee, or Your physician may request access to clinically appropriate drugs not otherwise covered by Us (non-Formulary) through a special exception process. If the exception request is granted, We will provide coverage of the non-Formulary drug for the duration of the prescription. If the exception request is denied, You, Your designee, or Your physician may request an external review of the decision by an independent review organization. For additional information about the prescription drug exception processes for non-Formulary drugs, please contact MedImapact at 1-800-788-2979, 711 TTY.

Extension of Benefits

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

1) The Covered Person becomes Totally Disabled while insured for that insurance under the plan; and
2) The Covered Person is still Totally Disabled on the date this Group Policy terminates.

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

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

A Covered Person other than a Dependent minor is totally disabled only if, in the judgment of a Physician, a Sickness or Injury: a) is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and b) makes the person unable, even with training, education and experience, to engage in any employment or occupation.
A Covered Person who is a Dependent minor is totally disabled only if, in the judgment of a Physician, a Sickness or Injury: a) is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and b) makes the person unable to engage in most of the normal activities of persons in good health of like age.

GENERAL LIMITATIONS AND EXCLUSIONS

Unless specifically stated otherwise in the Group Policy or elsewhere in this Certificate, or in the Schedule of Coverage, or any Rider or Endorsement that may be attached to the Group Policy, no payment will be made under any benefit of the Group Policy for Expenses Incurred in connection with the following:

1) Charges in excess of the Maximum Allowable Charge.
2) Charges for non-Emergency Care in an Emergency Care setting to the extent that they exceed the charge that would have been incurred for the same treatment in a non-Emergency Care setting.
3) Weekend admission charges for non-Emergency Care Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
4) Confinement, treatment, services or supplies not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically covered under the Group Policy.
5) Non-Emergency Services, received outside the United States.
6) Injury or Sickness for which benefits are payable under any state or federal workers' compensation, employer's liability, occupational disease or similar law.
7) Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third-party coverage.
8) 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.
9) Services for military service-related conditions regardless of service in any country or international organization.
10) Treatment, services, or supplies provided by the Covered Person; his or her spouse; a child, sibling, or parent of the Covered Person or of the Covered Person's spouse; or a person who resides in the Covered Person's home.
11) 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.
12) Cosmetic services, plastic surgery or other services that:
    a) are indicated primarily to change the Covered Person's appearance; and
    b) will not result in significant improvement in physical function.

    This exclusion does not apply to:
    a) treatment to correct a significant disfigurement caused by medically necessary surgery or by an injury;
    b) service that is rendered to a Dependent child due to congenital disease or anomaly; or
    c) Reconstructive breast surgery following a mastectomy; or are necessary for treatment of a form of congenital hemangioma known as port wine stains on the face of Covered Persons 18 years or younger.
    d) Gender Affirming surgeries determined to be medically necessary to treat gender dysphoria.
13) Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This exclusion does not apply to Services covered under Clinical Trials in the **GENERAL BENEFITS** section and to experimental or investigational drugs that are used to treat cancer if one or more of the following conditions is met:
    a) The drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or The American Hospital Formulary Service Drug Information publication; or

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.
c) Coverage for Routine Patient Care Costs incurred in connection with the provision of goods, services, and benefits to such dependent children in connection with approved clinical trial programs for the treatment of children's cancer with respect to those dependent children who:
   i) Have been diagnosed with cancer prior to their nineteenth birthday;
   ii) Are enrolled in an approved clinical trial program for treatment of children's cancer; and
   iii) Are not otherwise eligible for benefits, payments, or reimbursements from any other third-party payors or other similar sources.

14) Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems, except as otherwise provided for the treatment of Autism Spectrum Disorder. This applies whether or not the services are associated with manifest Mental Illness or other disturbances.
15) Services, supplies or drugs rendered for the treatment of obesity or weight management including Bariatric Surgery; 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.
16) Confinement, treatment, services or supplies that are required: a) Only for insurance, travel, employment, school, camp, government licensing, or similar purposes; or b) Only by a court of law except when medically necessary and otherwise covered under the plan.
17) Personal comfort items such as telephone, radio, television or grooming services.
18) Custodial care. Custodial care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
19) Care in an intermediate care facility. This is a level of care for which a Physician determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.
20) Routine foot care such as trimming of corns and calluses.
21) Confinement or treatment that is not completed in accordance with the attending Physician's orders.
22) Services of a private duty nurse.
23) Medical social services except those services related to discharge planning in connection with: a) a covered Hospital Confinement; b) covered Home Health Care Services; or c) covered Hospice Care.
24) Living expenses or transportation, except as provided under Covered Services.
25) Services provided in the home except when otherwise specified in the General Benefits section.
26) Biotechnology drugs and diagnostic agents. The following biotechnology drugs are excepted from this exclusion: Human insulin, vaccines, biotechnology drugs administered for the treatment or diagnosis of cancer, and Dornase for the treatment of cystic fibrosis, human growth hormones prescribed or administered for the treatment of documented human growth hormone deficiency such as Turner's Syndrome.
27) Services in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Covered Person who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and 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. Please refer to "Surrogacy arrangements" under the General 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.

28) 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.
29) Chiropractic manipulation other than manual manipulation of the spine.
30) Acupuncture; massage therapy; or hypnotherapy.
31) Health education, including but not limited to: a) stress reduction; b) smoking cessation; or c) weight reduction.
32) Services for which no charge is normally made in the absence of insurance.
33) Medically Necessary Bariatric Surgery for the treatment of morbid obesity.
34) Computed tomographic colonography screening except when endoscopic colonoscopy screening cannot be safely performed, such as in anatomical blockage of the colon.
35) Terminal Illness services, including but not limited to drugs or devices, regardless of where actually prescribed, dispensed or administered, which if prescribed, dispensed or administered in the State of Georgia would constitute assisted suicide in violation of applicable Georgia law. For the purpose of this exclusion, terminal illness means any disease, illness or health condition that a Plan Physician has diagnosed as expected to result in death in 24 months or less.

OPTIONAL BENEFITS, LIMITATIONS AND EXCLUSIONS

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

I. Chiropractic care

Medically Necessary Chiropractic manipulative treatment to treat a diagnosed medical condition is covered.

Note: Musculoskeletal therapy involving manual manipulation of the spine to correct subluxation is covered under Your Medical Plan.

Chiropractic Care Exclusions

1) Vitamins and supplements are not covered.
2) Vax-D is not covered.
3) Structural supports are not covered.
4) Massage therapies are not covered.
5) Maintenance/preventative care is not covered.
6) Non-acute medically necessary treatment is not covered.
7) Neurological testing is not covered.

II. Hearing Aids

The following term when capitalized and used with this section means:

Hearing Aid means an electronic device worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold if necessary.

The following services are covered for Adults 19 and over:

1) Hearing tests to determine the need for hearing correction.
2) Hearing tests to determine the appropriate hearing aid and follow up care.
3) Internally implanted hearing devices when medically necessary.
4) Visits to verify that the hearing aid conforms to the prescription.
5) Visits for fitting, counseling, adjustment, cleaning, and inspection.

The price of a hearing aid for each ear up to the Benefit Maximum when prescribed by a physician or audiologist, but only if we have not covered a hearing aid for that ear within the previous 36 months. Hearing aids for both ears are covered only if both are required to provide significant improvement that is not obtainable with only one hearing aid. You need not obtain both aids at the same time, and the 36 months runs separately for each ear.

The total expenses of an item that is covered is subject to the Benefit Maximum. You are responsible for the cost of the item which exceeds the Benefit Maximum.

Hearing Aids Exclusions

1) Hearing aids prescribed or ordered before You were insured under this Policy are not covered.
2) Replacement parts for repair of a hearing aid are not covered.
3) Replacement of lost, stolen or broken hearing aids are not covered.

4) Hearing aid batteries are not covered.
5) Repair of hearing aids after the end of the one-year warranty period is not covered.

III. Infertility Treatment Services

The following services related to the treatment of involuntary infertility once a condition of infertility has been diagnosed are Covered Services. This includes services for further diagnosis to determine the cause of infertility.

Artificial Insemination

Services for artificial insemination, including laboratory and radiology tests and procedures.

Administered Drugs

Infertility drugs only if they require administration or observation by medical personnel and they are administered to you in a hospital, Medical Center, Medical Office, outpatient facility. Skilled Nursing Facility or during covered home visits.

Infertility Treatment Services Exclusions

1) Services to reverse voluntary, surgically induced infertility are not covered.
2) Outpatient prescription drugs for the treatment of involuntary infertility are covered only if your Group has purchased the Outpatient prescription drug benefit. Refer to Your Schedule of Coverage for more information.
3) Ovum transplants are not covered.
4) In Vitro Fertilization (IVF) is not covered.
5) Gamete intrafallopian transfer (GIFT) is not covered.
6) Services related to the collection, procurement, washing, preparation or storage of sperm or eggs, including donor fees or cryopreservation are not covered.
7) Zygote intrafallopian transfer (ZIFT) is not covered.

IV. Morbid Obesity

The following term when capitalized and used within this section means:

Morbid Obesity means: 1) a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance Tables; and 2) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes, or a BMI equal to or greater than 40 kilograms per meter squared with or without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.

The following services related to the diagnosis and treatment of Morbid Obesity are Covered Services, if prescribed by a Physician. Surgical treatment requires prior authorization as described under "**PRECERTIFICATION**" section.

1) Office visits for the medical treatment of morbid obesity.
2) Nutritional assessment and counseling.
3) Behavioral assessment and counseling.
4) Surgical treatment provided, prescribed, authorized or directed by a Physician.

Outpatient prescription drugs for the treatment of obesity, only if Your Group has purchased the Outpatient prescription drug benefit. Refer to the Your Schedule of Coverage for more information.

Morbid Obesity exclusions
The following services are excluded from this Morbid Obesity coverage:

1) Chiropractic services are not covered except where specifically noted to the contrary in this Certificate of Insurance.
2) Alternative medicine treatments are not covered.
3) Hypnotherapy is not covered.
4) Services rendered or billed by commercial weight loss centers are not covered.
5) Cosmetic surgery related to bariatric surgery or weight loss is not covered.

V. Vision Services - Optical Hardware Plan

Pediatric Optical Hardware

The following Covered Services are provided to children up to the end of the month he or she turns age 19.

Eyeware

The following eyewear is covered

1) Lenses:
   a) Single vision
   b) Conventional (Lined) Bifocal
   c) Conventional (Lined) Trifocal
   d) Lenticular

Note: Lenses include choice of polycarbonate, glass or plastic lenses. All lenses include scratch resistant coating and ultraviolet protection covered in full.

1) Eyeglass frames
2) Contact lenses including evaluation, fitting, and dispensing are covered.

   Contact Lenses in lieu of frames and lenses are limited to a combined Benefit Maximum per Accumulation Period of:
   - Standard (one pair annually) = 1 contact lens per eye (total 2 lenses)
   - Monthly (six-month supply) = 6 lenses per eye (total 12 lenses)
   - Bi-weekly (three-month supply) = 12 lenses per eye (total 24 lenses)
   - Dailies (one-month supply) = 90 lenses per eye (total 180 lenses)
   - Contact lenses are in lieu of frame and lenses

3) Medically necessary contact lenses in lieu of other eyeware for the following conditions are covered
   a) Keratoconus
   b) Pathological Myopia
   c) Aphakia
   d) Anisometropia
   e) Aniseikonia
   f) Aniridia
   g) Corneal Disorders
   h) Post-traumatic Disorders
   i) Irregular Astigmatism

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

Vision Services Exclusions:

1) Laser Vision Correction and Progressive Lens Options.
2) Replacement of lenses, frames or contacts
3) Orthoptics, vision training or supplemental testing

Items not covered under the contact lens coverage:

1) Insurance policies or service agreements
2) Additional office visits for contact lens pathology
3) Contact lens modification, polishing or cleaning

Adult Vision Services

The following Covered Services are provided to adults 19 and older:

This optical plan can be used when You purchase prescription eyeglasses and contact lenses.

The price of eyeglass lenses, frames, and cosmetic contact lenses up to the benefit maximum when prescribed by a Physician or optometrist, but only if We have not covered eyeglass lenses, frames, or contact lenses for either eye within the previous 24 months.

The total expenses of an item that is covered is subject to the benefit maximum. You are responsible for the cost of the item which exceeds the benefit maximum, You will pay the difference.

The mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment of the frame is also covered.

Medically necessary contact lenses are covered. Medically necessary means one or more of the following conditions are met:

1) Refractive error of 12 diopters or greater in any meridian
2) Keratoconus which corrects to 20/30 or worse with best glasses
3) Anisometropia where the difference of power between the two eyes is greater than 5 diopters
4) After cataract surgery
5) When vision with contact lens and compared with best glasses is improved by greater than two lines; i.e. 20/70 to 20/40
6) When corneal problems require bandage soft contact lenses.

If You must wear regular glasses and contact lens(es) at the same time to provide a significant improvement in visual acuity or binocular vision not obtainable with regular lenses or contact lenses alone, then both are covered. Covered Services include the fitting of the contact lenses.

If You have a change in prescription of at least .50 diopter within 12 months of Your initial exam, We will provide an additional allowance toward the price of a new eyeglass lens or cosmetic contact lens for the affected eye(s) without requiring You to wait 24 months. The replacement lens must be for the same product type as Your original order.

Optical Services Exclusions

1) Tinted lenses are not covered, except when medically necessary.
2) Industrial and athletic safety frames and lenses are not covered.
3) Eyeglass lenses and contact lenses with no refractive value are not covered.
4) Replacement of lost, stolen, damaged or broken lenses, contact lenses or frames are not covered.
5) Low-vision devices are not covered.
6) Lenses adornment, such as engraving, faceting, or jeweling is not covered.
7) Plano lenses or sunglasses are not covered.
8) Eye exercises (orthoptics) are not covered.
9) Over the counter products are not covered.
10) Visual training is not covered.

FEDERAL CONTINUATION OF COVERAGE PROVISIONS (COBRA)

This section describes the different continuation of coverage options available to You and Your Dependents.

Federal Continuation of Health Insurance (COBRA)

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

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

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

Qualifying Events

1. If Your health insurance coverage ends due to (a) termination of employment; or (b) a reduction in hours, You may continue health coverage under the policy for the continuation of coverage period. The right to continue coverage under this provision will not be allowed if KPIC is informed by the employer that Your employment was terminated due to gross misconduct.

2. If Your Dependent's insurance coverage ends due to: (a) Your death; (b) Your legal divorce or legal separation from Your spouse; or (c) Your child reaching the limiting age for a Dependent, the terminated Dependent has the option to continue health coverage under the policy for the continuation of coverage period.

3. If You retired from employment with the employer and Your health insurance coverage, or the health insurance coverage of Your Dependents, including Your surviving spouse:
   1. is substantially eliminated as a result of the employer's filing of a Title XI bankruptcy; or
   2. was substantially eliminated during the Accumulation Period preceding the employer's filing of a Title XI bankruptcy;

   You and Your Dependents may continue health coverage under the policy for the continuation of coverage period.

4. If You become entitled to Medicare benefits under Title XVIII of the Social Security Act, Your Medicare ineligible spouse and Dependent eligible children may continue health coverage under the policy for the continuation of coverage period.

Continuation of Coverage Period

Continuation of Coverage Period means the period of time ending on the earlier of:

1. 18 months following qualifying event (A) except if a qualifying event (B) occurs during this 18 months, the continuation of coverage period will be extended an additional 18 months for a total period of 36 months.
2. 36 months following qualifying event (B);
3. for a qualifying event (C):
   a) The date of Your death, at which time Your Dependents (other than Your surviving spouse in (i) below) will be entitled to continue coverage on the same basis as if a qualifying event (B) had occurred.

   b) If You died before the occurrence of a qualifying event (C), Your surviving spouse is entitled to lifetime coverage.
4. The end of a 36-month period following an event described in qualifying event (D), without regard to whether that occurrence is a qualifying event, or for any subsequent qualifying event;
5. The date You or Your Dependents become covered under any other group coverage providing hospital, surgical or medical benefits, insured or self-insured, which does not contain any limitation with respect to any preexisting condition;
6. The date a Covered Person, other than those provided continuation of coverage under qualifying event (C) becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
7. The date the employer ceases to provide any group health coverage for its employees;
8. The date any premium for continuation of coverage is not timely paid; or
9. The date that the privilege for conversion to an individual or family policy is exercised.

Requirements

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

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

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

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

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

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

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

Extension for Disabled Covered Persons

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

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

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

Continued Health Coverage from a Prior Plan

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

CONTINUATION OF MEDICAL EXPENSE BENEFITS DURING AN APPROVED LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA):

Insured Persons have the option to continue insurance during an approved leave under the Family and Medical Leave Act (FMLA) upon payment of the required contribution.

Continued insurance terminates when a required contribution is not made when due. Medical insurance under the Group Policy will be reinstated, as required under the Act, upon returning from an approved leave under the FMLA for an Insured Person whose insurance terminated during an approved leave under the FMLA.

For more details regarding the Continuation of Medical Benefit required by Federal law, please call KPIC or its Administrator at 1-888-865-5813, 711 (TTY)

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 EXPENSE BENEFITS REQUIRED BY STATE LAW

Optional State Continuation

Continuation of Medical Expense Benefits may be available to a Covered Person upon termination of insurance unless:

1) Termination of insurance was due to termination of employment for cause.
2) Termination of insurance was due to nonpayment of premium.
3) Coverage is immediately replaced by similar group coverage.
4) Termination of insurance was due to termination of the Group Policy or termination of a class of individuals to which the Covered Person belonged.

Such continued insurance shall be available to Covered Persons:
1) Who have been continuously covered under the Group Policy and under any contract or plan providing similar benefits which this Group Policy replaces, for at least six months immediately prior to such termination; and
2) Who elects insurance in writing and pay required premium within 31 days from the date coverage would otherwise terminate. The required premium will include any amount normally paid by Group.

Continued coverage will terminate on the earliest of:
1) The last day for which the Covered Person has paid the required premium.
2) The date the Covered Person becomes eligible for insurance under another group policy for medical benefits.
3) The date this Group Policy terminates.
4) The end of the Policy Month in which insurance would otherwise terminate plus three additional Policy Months.
5) With respect to any one Covered Person, the date that Covered Person no longer qualifies as an Eligible Dependent.

If the Covered Person was 60 years of age or older at the time insurance would otherwise have terminated, coverage may be continued beyond the period of coverage shown above unless:
1) Termination of insurance was due to voluntary termination of employment for other than health reasons.
2) Termination of insurance was due to termination of employment for reasons, which would cause a forfeiture of unemployment compensation.
3) Termination of insurance was due to nonpayment of premium.
4) Coverage is immediately replaced by similar group coverage.
5) Termination of insurance was due to termination of the Group Policy or termination of a class of individuals to which the Covered Person belonged.

Such continuation coverage will terminate on the earliest of:
1) The last day for which the Coverage Person paid the required premium.
2) The date the Covered Person becomes eligible for insurance under another group policy for medical benefits.
3) The date this Group Policy terminates.
4) With respect to any one Covered Person, the date that Covered Person no longer qualifies as an Eligible Dependent.

For more details regarding the Continuation of Medical Benefit required by state law, please call KPIC or its Administrator at 1-855-364-3185, 711 (TTY).

COORDINATION OF BENEFITS

Application

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

The benefits of this Group Policy:

1. Will not be reduced when this Group Policy is primary;
2. May be reduced when another Plan is primary and This Group Policy is secondary. The benefits of This Group Policy are reduced so that they and the benefits payable under all other Plans do not total more than 100 percent of the Allowable Expenses during any Accumulation Period; and
3. Will not exceed the benefits payable in the absence of other coverage.

Order of Benefit Determination Rules

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

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

   However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the primary Plan. This paragraph does not apply with respect to any Accumulation Period during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the provider, if the custodial parent so requests.
5. Active/Inactive Service: The primary Plan is the Plan which covers the person as a Covered Person who is neither laid off or retired (or as that employee's Dependent). The secondary Plan is the Plan which covers that person as a laid off or retired Covered Person (or as that Covered

Person's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

6. Longer/Shorter Length of Coverage: If none of the above rules determines the order of benefits. the primary Plan is the Plan which covered a Covered Person, or subscriber the longer time. The secondary Plan is the Plan which covered that person the shorter time.

Effect of Medicare

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

Reduction in this Plan's Benefits

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

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

Right to Receive and Release Information

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

Facility of Payment

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

Right of Recovery

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

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

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

COORDINATION OF BENEFITS

Definitions Related to Coordination of Benefits

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

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

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

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

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Plan does not include any:

1. Individual or family insurance contracts;
2. Individual or family subscriber contracts;
3. Individual or family coverage through Health Maintenance Organizations (HMOs);
4. Individual or family coverage under other prepayment, group practice and individual practice plans;
5. Group or group-type hospital indemnity benefits of $100 per day or less;
6. School accident-type coverages. These contracts cover grammar, high school and college students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis; and
7. A State plan under Medicaid, may shall not include a law or plan when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

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

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

CLAIMS AND APPEALS PROCEDURES

This section explains provisions for filing Claims and Appeals arising from decisions made regarding benefit Claims under Your KPIC Preferred Provider Organization (PPO) health coverage plan.

This section contains the following:

- Definitions of Terms unique to this section
- Claims and Appeals provisions
- Claims Processes for:
  - Post Service Claims
  - Pre-service Claims
    - Urgent Pre-service Claims
    - Non-Urgent Pre-service Claims
  - Concurrent Care Claims
    - Urgent Concurrent care Claims
    - Non-Urgent Concurrent care Claims
- Internal Appeals Process
  - Appeal
  - Time Frame for Resolving Your Appeals
    - Post Service
    - Pre-service
      - Urgent Pre-service Claims
      - Non-Urgent Pre-service Claims
    - Concurrent- Care Claims
      - Urgent Concurrent Care Claims
      - Non-Urgent Concurrent Care Claims
- Help With Your Appeal
- The External Appeals Process

A. Definitions Related to Claims and Appeals Procedures

The following terms have the following meanings when used in this **Claims and Appeals Procedures** section:

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

1. Deny Your Claim, in whole or in part, such as a reduction of benefits or a failure or refusal to cover an item or service resulting from a determination that such an item or service is experimental or investigational, or not Medically Necessary.
2. Terminate Your coverage retroactively except as the result of non-payment of premiums (also known as rescission), or
3. Uphold its previous Adverse Benefit Determination when You Appeal.

Appeal means a request for Us to review Our Adverse Benefit Determination.

Claim means a request for Us to: 1) pay for a Covered Service that You have not received (Pre-service claim); 2) continue to pay for a Covered Service that You are currently receiving (Concurrent Care Claim); or 3) pay for a Covered Service that You have already received (Post-Service claim).

Proof of Loss means sufficient information to allow KPIC or Our Administrator to decide if a Claim is payable under the terms of the Group Policy. The information needed to make this determination may include but is not limited to: reports of investigations concerning fraud and misrepresentation, necessary consent forms, releases and assignments, medical records, information regarding

provider services, information regarding medical necessity or other necessary information requested by KPIC.

We may use medical experts to help Us review claims and appeals

Language and Translation Assistance

If We send You an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then Your notice of Adverse Benefit Determination will include a notice of the availability of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population of that county is literate only in the same federally mandated non-English language. You may request language assistance with Your Claim and/or Appeal by calling Customer Service Department Monday through Friday from 7 a.m. to 7 p.m. at 1-855-364-3185, 711 (TTY).

If We send You an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then You may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request translation of the specific notice by calling Customer Service Department Monday through Friday from 7 a.m. to 7 p.m. at 1-855-364-3185, 711 (TTY).

Appoint a Representative

If You would like someone to act on Your behalf regarding Your Claim or appeal, You may appoint an authorized representative. You must make this appointment in writing. Please send Your representative's name, address and telephone contact information to the following address:

Kaiser Permanente
Appeals Department
P.O. Box 939001
San Diego, CA 92193-9001
(800) 788-9710

You must pay the cost of anyone You hire to represent or help You.

Reviewing Information Regarding Your Claim

If You want to review the information that We have collected regarding Your Claim, You may request, and We will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request that We provide You with any diagnosis and treatment codes and their meanings that are the subject of Your Claim. To make a request, You should contact our Customer Service Department Monday through Friday from 7 a.m. to 7 p.m. at 1-855-364-3185, 711 (TTY).

Other Information Available
A Summary of the number, nature, and outcome results of appeals filed in the previous three years shall be available for inspection. Copies of such summary shall be made available at reasonable costs.

B. The Claims Process

There are several types of Claims, and each has a different procedure as described below:

- Post-service Claims
- Pre-service Claims (urgent and non-urgent)

- Concurrent Care Claims (urgent and non-urgent)

Please refer to the subsection **Internal Appeals Process** provision under this section for a detailed provision regarding Your right to Appeal Our Adverse Benefit Determination. Our Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding Your appeal rights, including external review, that may be available to You.

In addition, there are specific procedures for appealing Adverse Benefit Determinations due to a retroactive termination of coverage (rescission). Please refer to the subsection on Appeals of retroactive coverage termination (rescission) provision under this section for a detailed explanation.

Questions about claims: For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when You call 1-855-364-3185, 711 (TTY). You may write to the address listed above. Claim forms are available from Your employer.

1) Post-Service Claim
Post-Service Claim means a Claim involving the payment or reimbursement of costs for Covered Services that has already been received.

All Post-Service Claims under this Policy will be administered by:

Kaiser Foundation Health Plan, Inc.
National Claims Administration - Georgia
P.O. Box 370010
Denver, CO 80237-9998

The following procedures apply to Post-Service Claims:

- **Submitting a Post-Service Claim**
  - Within 12 months after the date you received the services or as soon as reasonably possible, You may file a claim (request for payment/reimbursement):

    - By visiting kp.org, completing an electronic form and uploading supporting documentation;
    - By mailing a paper form that can be obtained by visiting kp.org or calling the Member Services Contact Center; or
    - If you are unable access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claim:
      - Member/Patient Name and Medical/Health Record Number
      - The date you received the services
      - Where you received the services
      - Who provided the services
      - Why you think we should pay for the services
      - A copy of the bill, your medical record(s) for these services, and your receipt if you paid for the services

  - Your letter and the related documents constitute Your Claim. You must mail Your medical Claim to Our Administrator at:

Kaiser Permanente
National Claims Administration - Georgia
P.O. Box 370010

Denver, CO 80237-9998

Or, you can fax your claim to (303) 925-6644.

For prescription drugs claims:

MedImpact Healthcare Systems, Inc
PO Box 509098
San Diego, CA 92150-9098

Or fax Your Claim to 1-858-549-1569

- In accordance with the **Proof of Loss** subsection this **CLAIMS AND APPEALS PROCEDURES**, We will not accept or pay for claims received from you more than 12 months from the date of services, unless it shall be shown not to have been reasonably possible to submit a claim and that the claim was submitted as soon as reasonably possible.

- We will review Your claim, and if We have all the information We need We will send You a written decision within 15 business days for electronic claims and 30 calendar days for paper claims after We receive Your written Proof of Loss or Claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if We notify You within 15 days after We receive Your claim. We may ask You for more information. If we tell You We need more information, We will ask You for the information, and We will give You 45 days to send us the information before the end of the initial 15-day decision period ends. and We will make a decision within 15 working days after We receive the first piece of information (including documents) We requested. You should send all the requested information at one time, so that We will be able to consider it all when We make our decision. If We do not receive any of the requested information (including documents) within 45 days after We send our request, We will make a decision based on the information We have following the end of the 45-day period.

- If we deny Your claim (if we do not pay for all the Services You requested), Our Adverse Benefit Determination will tell You why We denied Your claim and include information regarding the mandatory appeal rights, including external review that may be available to You. Please refer to the subsection **The Internal Appeals Process** provision under this section for details regarding the mandatory internal appeal process and Your appeal rights.

In-Network Provider Claims
If You receive services from an In-Network Provider, that provider will file the claims on Your behalf. Benefits will be paid directly to the provider. You need to pay only Your Deductible, if any, and any Coinsurance or Copayment.

For Out-of-Network Provider claims
If You receive services from any other licensed provider, You may need to file the claim yourself and will be reimbursed in accordance with the terms set forth under the Schedule of Coverage subject to the Assignment Provision in the **GENERAL PROVISION** section.

Notice of Claims

CLAIMS AND APPEALS PROCEDURES

You must give Us written notice of claim within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon as reasonably possible. You may give notice or may have someone do it for You. The notice should give Your name and Your policy number. The notice should be mailed to Us at Our mailing address or to Our Claims Administrator. at:

Kaiser Foundation Health Plan, Inc.
National Claims Administration - Georgia
P.O. Box 370010
Denver, CO 80237-9998

Or, you can fax your claim to (303) 925-6644.

For prescription drugs claims:

MedImpact Healthcare Systems, Inc
PO Box 509098
San Diego, CA 92150-9098

Or fax Your Claim to 1-858-549-7659

Claim Forms
When We receive Your notice of claim, We will send You forms for filing Proof of Loss. If We do not send You these forms within 10 days after receipt of Your notice of claim, You shall be deemed to have complied with the Proof of Loss requirements by submitting written proof covering the occurrence, character and extent of the loss, within the time limit stated in the Proof of Loss section.

Proof of Loss
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 date of the loss. 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 date of loss, except in the absence of legal capacity.

Time for Payment of Benefits
In accordance with the terms of Your coverage, benefits will be paid immediately upon receipt of proper written Proof of Loss. If the benefits payable are not paid in whole or in part, We will mail to the covered person, within 15 working days for electronic and 30 calendar days for paper claims of receipt of the written Proof of Loss, a letter that states the: (1) reason(s) why the benefits payable cannot be paid; and (2) lists of information and/or documentation that We need to process the claim. We will complete the processing of the Claim within 15 working days of Our receipt of all of the additional information and/or documentation requested.

Unless the Covered Person has asked Us not to do so, We may pay all or any part of the benefits provided by the Group Policy directly to the service provider. Any such payment made by Us in good faith will fully discharge Our obligation to the extent of the payment.

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

Contested Claims

If We are unable to pay Your claim after receiving proper Proof of Loss, We will notify You of any contest to or denial of the claim within 15 working days for electronic and 30 calendar days for paper claims of the date the Proof of Loss was received by Us. The written notice will specify:

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

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

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

Legal Action

No action may be brought more than three (3) years after the date written Proof of Loss is given to Us.

Time Limitations

If any time limitation provided in the plan for giving notice of claims, or for bringing any action at law or in equity, is in conflict with that permitted by applicable federal or state law, the time limitation provided in this policy will be adjusted to conform to the minimum permitted by the applicable law.

2) Pre-service Claim

Pre-service Claim is a request for approval of benefit(s) or treatment(s) that You have not received. When the terms of the Group Policy, condition the receipt or provision of the Covered Services, in whole or in part, on authorization (in advance of obtaining medical care) failure to receive authorization before receiving a Covered Service that is subject to Precertification in order to be a covered benefit may be the basis for reduction of Your benefits or Our denial of Your Pre-service Claim for payment. If You receive any of the Covered Services You are requesting before we make Our decision, Your Pre-Service Claim will become a Post-Service Claim with respect to those services. If You have any general questions about Pre-Service Claims, please call 1-855-364-3185, 711 (TTY). Or submit your questions in writing to:

Kaiser Permanente
Quality Resource Management Department
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736

Please refer to the **PRECERTIFICATION** section of this Certificate of Insurance for a more detailed provision of the Precertification process.

The following are the procedures for filing a Pre-Service Claim:

- **Pre-Service Claim**

- Send your request in writing to Us that You want to make a Claim for Us to precertify a service that You have not yet received. Your request and any related documents You give Us constitute Your Claim.

  For medical services claims:
  You must either mail Your Claim to Us at the address below or call our Member Services Department at 1-855-364-3185, 711 (TTY) at:

  Kaiser Permanente
  Quality Resource Management Department
  Nine Piedmont Center
  3495 Piedmont Road, NE
  Atlanta, GA 30305-1736

  Or fax Your Claim to Us at: 1-404-364-4743

  For prescription drugs claims:

  MedImpact Healthcare Systems, Inc
  Utilization Management Department
  PO Box 90932
  San Diego, CA 92150-9098
  (858) 566-2949

  Or fax Your Claim to Us at: 1-858-549-7568

  If You want us to consider Your Pre-Service claim on an urgent basis, Your request should tell Us that. We will decide whether Your Claim is urgent or non-urgent unless Your attending health care provider tells us Your claim is urgent. If we determine that Your Claim is not urgent, We will treat Your Claim as non-urgent. Generally, a Claim is urgent only if using the procedure for non-urgent claims (a) could seriously jeopardize Your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the services You are requesting.

- We will review Your claim and, if We have all the information We need, We will make a decision within a reasonable period of time but not later than 15 days after We receive Your Claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond Our control delay Our decision, if We notify You prior to the expiration of the initial 15 day period. If We tell You We need more information, We will ask You for the information within the initial 15 day decision period, and We will give You 45 days to send the information. We will make a decision within 15 days after We receive the first piece of information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within 45 days after We send Our request, We will make a decision based on the information We have within 15 days following the end of the 45 day period.

- We will send written notice of Our decision to You and, if applicable to Your provider.

- If Your Pre-Service Claim was considered on an urgent basis, We will notify You of Our decision orally or in writing within a timeframe appropriate to Your clinical condition but not later than 72 hours after We receive Your Claim. Within 24 hours after we receive Your claim, We may ask You for more information. We will notify You of Our decision within 48 hours of receiving the first piece of requested information. If We do not receive any of the requested information, then We will notify You of Our decision within 48 hours after making Our request. If We notify You of Our decision orally, we will send You written confirmation within 3 days after that.

- If We deny Your claim (if We do not agree to provide or pay for all the Covered Services You requested), its Adverse Benefit Determination notice will tell you why KPIC denied Your Claim and will include information regarding Your appeals rights, including external review, that may be available to You. Please refer to the **The Internal Appeals Process** provision under this section for a detailed provision regarding the mandatory internal appeal process and Your appeal rights.

- **Concurrent Care Claim**
  - Concurrent Care Claim is a request that We continue to pay for, or authorize an ongoing course of covered care to be provided over a period of time or number of sessions, when the ongoing course of covered care already being received is scheduled to end. Failure to receive authorization before continuing to receive Covered Services beyond the number of days or number of sessions initially authorized may be the basis of Your denial of coverage for some or all of the Covered Services. If You receive any of the Covered Services You are requesting before We make Our decision, Your Concurrent Care Claim will become a Post-Service Claim with respect to those Covered Services. Concurrent claims can be either Urgent Care Claims or non-Urgent Care Claims. If You have any general questions about Concurrent Care Claims, please call 1-855-464-3785, 711 (TTY).

  - If We either (a) deny Your request to extend Your current authorized ongoing care (Your concurrent care Claim) or (b) inform You that authorized care that You are currently receiving is going to end early and You appeal Our Adverse Benefit Determination at least 24 hours before Your ongoing course of covered treatment will end, then during the time that We are considering Your Appeal, You may continue to receive the authorized Covered Services. If You continue to receive these Covered Services while We consider Your Appeal and Your Appeal does not result in Our approval of Your concurrent care Claim, then You will have to pay for the services that We decide are not covered.

Please refer to the **PRECERTIFICATION** section of this Certificate for details regarding the Precertification process of Concurrent Care Claims.

Here are the procedures for filing a Concurrent Care Claim.

- **<u>Concurrent Care Claim</u>**
  - Tell Us in writing that You want to make a concurrent care Claim for an ongoing course of Covered Services. Inform Us in detail of the reasons that Your authorized Covered Services should be continued or extended. Your request and any related documents You give Us constitute Your Claim.

    For medical services claims:
    You must either mail or deliver Your Claim to Us at the address below:

    Kaiser Permanente

Quality Resource Management Department
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736

or fax Your Claim to us at: 1-404-364-4743.

For prescription drugs claims:

MedImpact Healthcare Systems, Inc
Utilization Management Department
PO Box 509098
San Diego, CA 92150-9098
(800) 788-2949

Or fax Your Claim to Us at: 1-858-549-1569

- If You want Us to consider Your Claim on an urgent basis and You contact Us at least 24 hours before Your care ends, You may request that We review Your Concurrent Claim on an urgent basis. We will decide whether Your Claim is urgent or non-urgent unless Your attending health care provider tells Us Your Claim is urgent. If We determine that Your Claim is not urgent, We will treat Your Claim as non-urgent. Generally, a Claim is urgent only if using the procedure for non-urgent Claims (a) could seriously jeopardize Your life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without extending Your course of covered treatment.

- We will review Your Claim, and if We have all the information We need We will make a decision within a reasonable period of time. If You submitted Your Claim 24 hours or more before Your care is ending, We will make Our decision before Your authorized Covered Services actually ends. If Your authorized Covered Services ended before You submitted Your Claim, We will make Our decision but no later than 15 days after We receive Your Claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond Our control delay Our decision, if We send You notice before the initial 15 day decision period ends. If We tell You We need more information, We will ask You for the information before the initial decision period ends, and We will give You until Your care is ending or, if Your care has ended, 45 days to send Us the information. We will make Our decision as soon as possible, if Your care has not ended, or within 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 t all the information 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 15 days following the end of the timeframe We gave You for sending the additional information.

- We will send written notice of Our decision to You and, if applicable to Your provider.

- If We consider Your Concurrent Care Claim on an urgent basis, We will notify You of Our decision orally or in writing as soon as Your clinical condition requires, but not later than 24 hours after We received Your Claim. If We notify You of Our decision orally, We will send You written confirmation within 3 days after deciding Your Claim.

- If We deny Your Claim (if We do not give authorization extending the ongoing course of care), please refer to **The Internal Appeals Process** provision under this section for a detailed provision regarding the mandatory internal appeal process and Your appeal rights. Likewise, Our 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.

C. The Internal Appeals Process

In order to afford You the opportunity for a full and fair review of an Adverse Benefit Determination, the Policyholder has designated KPIC as the "named fiduciary" for appeals arising under the Group Policy. You may appeal an Adverse Benefit Determination (Denial) to Us.

If We deny Your Claim in whole or in part, or send You an Adverse Benefit Determination informing You that Your current authorized care is going to end early or that We are retroactively terminating Your coverage, You have the right to request a review of Our decision.

You must submit Your Appeals in writing except for urgent Pre-Service and urgent Concurrent Care Claim Appeals. We must receive all Appeal requests within 180 days of You receiving notice of Our Adverse Benefit Determination. Please note that we will count the 180 days starting 5 business days from the date of the notice to allow for delivery time, unless You can prove that You received the notice after that 5 business day period.

Such appeals will be subject to the following:

If We deny Your Claim (Post-Service, Pre-Service or Concurrent Care Claims), in whole or in part you have the right to request an Appeal of such decision. Our 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.

We must receive Your review request within 180 days of Your receiving this notice of Our initial Adverse Benefit Determination. Please note that We will count the 180 days starting 5 business days from the date of the notice to allow for delivery time, unless You can prove that You received the notice after that 5 business day period.

Providing Additional Information Regarding Your Claim

When You Appeal, You may send Us additional information including comments, documents, and additional medical records that You believe support Your Claim. If We asked for additional information and You did not provide it before We made Our initial decision about Your Claim, then You may still send Us the additional information so that We may include it as part of Our review of Your Appeal.

Please send all additional appeal information for medical services and prescription drugs to the address listed under each type of appeal (Post-Service, Pre-Service or Concurrent Care Appeal).

When You Appeal, You may give testimony in writing or by telephone. Please send Your written testimony to the address set forth under each type of appeal (Post-Service, Pre-Service or Concurrent Care Appeal). To arrange to give testimony by telephone, You should contact Kaiser Permanente Appeals Department at 888-865-5813, 711 (TTY) for your appeal.

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

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

Time frame for Resolving Your Appeal

There are several types of Claims, and each has a time frame in resolving Your Appeal.

- Post-service Claims
- Pre-service Claims (urgent and non-urgent)
- Concurrent Care Claims (urgent and non-urgent)

In addition, there are separate Appeals procedures for Adverse Benefit Determinations due to a retroactive termination of coverage (rescission).

1) Post-service Appeal

- Within 180 days after You receive Our Adverse Benefit Determination, tell Us in writing that You want to Appeal Our denial of Your Post-service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) the specific Covered Services that You want Us to pay for, (4) all of the reasons why You disagree with Our Adverse Benefit Determination, and (5) include all supporting documents. Your request and the supporting documents constitute Your Appeal. You must mail or deliver a letter of Your appeal for medical services and prescription drugs to:

  Kaiser Foundation Health Plan of Georgia Member Relations, Appeals
  Three Piedmont Center
  3495 Piedmont Rd
  NE Atlanta, GA 30305-1736
  (855) 364-3185

  or fax Your Appeal to Us at: 1-404-949-5001

  You must mail Your appeal for prescription drugs to:

  KPIC Pharmacy Administrator
  Grievance & Appeals Coordinator
  10181 Scripps Gateway Court
  San Diego, CA 92131
  (800) 788-2949

  or fax Your information to 1-858-790-6060 Attn: KPIC Pharmacy Administrator Grievance and Appeals Coordinator.

- We will review Your Appeal as follows:
  - We will review Your Appeal and send you a written decision of your appeal within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive your request for our review unless we inform you otherwise in advance.

- 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) <u>Non-urgent Pre-service Appeal</u>

- Within 180 days after You receive Our Adverse Benefit Determination notice, You must tell Us in writing that You want to Appeal Our denial of Your pre-service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) the specific Service that You are requesting, (4) all of the reasons why You disagree with Our adverse benefit denial, and (5) any supporting documents. Your request and the supporting documents constitute Your Appeal.

  You must mail Your appeal for medical services to:

  Kaiser Permanente
  Appeals Department
  Nine Piedmont Center
  3495 Piedmont Road, N.E.
  Atlanta, GA 30305-1736

  or fax Your Appeal to Us at: 1-404-949-3000

  You must mail Your appeal for prescription drugs to:

  KPIC Pharmacy Administrator
  Grievance & Appeals Coordinator
  10181 Scripps Gateway Court
  San Diego, CA 92131
  (800) 788-2949

  or fax Your information to 1-858-790-6060 Attn: KPIC Pharmacy Administrator Grievance and Appeals Coordinator

- We will review Your appeal as follows:
  - Because You have not yet received the services or equipment that You requested, we will review Your Appeal and send You a written decision of Your appeal within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive Your request for our review unless we inform You otherwise in advance.

- 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.

3) <u>Urgent Pre-service Appeal</u>

- Tell Us that You want to urgently Appeal Our Adverse Benefit Determination regarding Your Pre-Service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) the specific Service that You are requesting, (4) all of the reasons why You disagree with Our Adverse Benefit Determination, and (5) all supporting documents. Your request and the supporting documents constitute Your Appeal.

  You must submit Your Appeal by calling Our Appeals Unit at 1-404-364-7320, 711 (TTY) or fax Your request to 1-404-949-5001. You may also mail Your appeal for medical services to:

  Kaiser Permanente
  Appeals Department
  Nine Piedmont Center
  3495 Piedmont Road, NE, Atlanta, GA
  30305-1736

- You must submit Your Appeal for prescription drugs by calling the Appeals Unit at 1-800-788-2949, 711 (TTY). You may also mail Your appeal for prescription drugs to:

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

  or fax Your information to 1-858-790-2960 Attn: KPIC Pharmacy Administrator Grievance and Appeals Coordinator

- 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 Pre-Service 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 **D. External Review** provision under this 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 You Appeal as non-urgent. Generally, an Appeal is urgent only if using the procedure for non-urgent Claims or Appeals (a) could seriously jeopardize Your life, health, or ability to regain maximum function, or (b) 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 will review Your Appeal and notify You of Our decision orally or in writing as soon as Your clinical condition requires, but not later than 72 hours after We received Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within 3 days after that.

- If We deny Your Appeal, You may be able to request external review after We make Our decision regarding Your Appeal (see **External Review** provision under this section), 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.

4) Non-urgent Concurrent Care Appeal

- Within 180 days after You receive Our Adverse Benefit Determination notice, You must tell Us in writing that You want to Appeal Our Adverse Benefit Determination. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) the ongoing course of covered treatment that You want to continue or extend, (4) all of the reasons why You disagree with Our Adverse Benefit Determination, and (5) all supporting documents. Your request and all supporting documents constitute Your Appeal.

  You must mail Your appeal for medical services to:

  Kaiser Permanente
  Appeals Department
  Nine Piedmont Center
  3495 Piedmont Road, NE, Atlanta, GA
  30305-1736

  or fax Your Appeal to Us at: 1-404-949-5001.

  You must mail Your appeal for prescription drugs to:

  KPIC Pharmacy Admi[illegible]ator
  Grievance & Appea[illegible] Coo[illegible]inato
  10181 Scripps Gat[illegible]way C[illegible]urt
  San Diego, CA [illegible]2131
  (800) 788-2949

  or fax Your information to 1-85[illegible]-606[illegible] Att[illegible]: KPIC Pharmacy Administrator Grievance and Appeals Coordinator

- We will review Your appe[illegible]l as [illegible]ows.
  - We will review You[illegible] Appeal and send You a written decision of Your appeal within a reasona[illegible]e period [illegible] time appropriate to the circumstances, but in no event later than 3[illegible] days f[illegible] th[illegible] date that we receive Your request for our review at that level unless [illegible]inform[illegible]ou otherwise in advance.

- If We deny Your Appe[illegible]al, 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.

5) Urgent Concurrent Care Appeal

- Tell Us that You want to urgently Appeal Our Adverse Benefit Determination regarding Your urgent Concurrent Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or symptoms, (3) the ongoing course of covered treatment that You want to continue or extend, (4) all of the reasons why You disagree with Our Adverse Benefit Determination, and (5) all supporting documents. Your request and the supporting documents constitute Your Appeal.

  You must submit Your Appeal for medical services by calling Our Appeals Unit at 1-404-364-7320, 711 (TTY) or fax Your request to 1-404-949-5001.

  You may also mail Your appeal for medical services to:

Kaiser Permanente
Appeals Department
Nine Piedmont Center
3495 Piedmont Road, N.E.
Atlanta, GA 30305-1736

You must submit Your Appeal for prescription drugs by calling the Appeals Unit at 1-800-788-2949, 711 (TTY).

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

or fax Your information to 1-858-790-6060 Attn: KPIC Pharmacy Administrator Grievance and Appeals Coordinator

- We will review Your appeal as follows:

- 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 Appeal qualifies as urgent. If You do not request simultaneous external review in Your Appeal, then You may be able to request external review after We make Our decision regarding Your Appeal (see **External Review** provision under this 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) would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without continuing Your course of covered treatment.

- We will review Your urgent Appeal and notify You of Our decision orally or in writing as soon as Your clinical condition requires, but no later than 72 hours after We receive Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within 3 days after that.

- If We deny Your Appeal, You may be able to request external review after We make Our decision regarding Your Appeal (see **D. External Review** provision under this section), 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.

6) <u>Appeals of retroactive coverage termination (rescission)</u>

- We may terminate Your coverage retroactively (see subsection: Rescission for Fraud or Intentional Misrepresentation provision under **ELIGIBILITY, EFFECTIVE DATE, &**

TERMINATION DATE section). We will send You written notice at least 30 days prior to the termination. If You have general questions about retroactive coverage terminations or Appeals, please call 1-855-364-3185, 711 (TTY).

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

Appeal of retroactive coverage termination

- Within 180 days after You receive Our Adverse Benefit Determination that Your coverage will be terminated retroactively, You must tell Us in writing that You want to Appeal Our termination of Your coverage retroactively. Please include the following: (1) Your name and Medical Record Number, (2) all of the reasons why You disagree with Our retroactive coverage termination, and (3) all supporting documents. Your request and the supporting documents constitute Your Appeal. Your must mail Your Appeal to:

  Kaiser Permanente
  Georgia Member Relations, Appeals
  Nine Piedmont Center
  3495 Piedmont Road, NE
  Atlanta, GA 30305-1736

  or fax Your appeal to 1-404-949-5001.

  We will review Your Appeal and send You a written decision within 60 days after We receive Your Appeal.

- If We deny Your Appeal, You may be able to request external review after We make Our decision regarding Your Appeal (see **Independent External Review Process** provision of this section), Our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.

Help With Your Appeal
You may contact the state ombudsman:

Georgia Office of Insurance and Safety Fire Commissioner
Consumer Services Division
2 Martin Luther King, Jr. Drive
West Tower, Suite 716
Atlanta, Georgia 30334
Toll Free: 800- 656-2298
Telephone: 404-656-2070
(TTY):711
Fax: 404-657-8542
http://www.oci.ga.gov/ConsumerService/Home.aspx

D. External Review

If You are dissatisfied with Our final Appeal decision, You may have a right to request an external review by an independent third-party. You will not have to pay for this independent party's review of Our decision regarding Your Appeal. For more information about how to obtain this review, please call KPIC toll free number at: 1-855-364-3185, 711 (TTY).

Please refer to: **YOUR RIGHT TO AN INDEPENDENT REVIEW under the INDEPENDENT EXTERNAL REVIEW PROCESS** section**,** for a more detailed explanation of Your right to an External Review.

INDEPENDENT EXTERNAL REVIEW PROCESS

IMPORTANT NOTICE

YOUR RIGHT TO AN INDEPENDENT REVIEW

If You believe that health care services have been improperly denied, modified, or delayed You may have the right to an independent review. For more information about how- to obtain this review, please call KPIC toll free number at 1-855-364-3185, 711 (TTY).

After We have rendered a final Adverse Benefit Determination upon Your completing Our internal appeal process, as described above, You may have a right to request an independent review of Our final Adverse Benefit Determination.

You have the right to an independent review by an independent third-party when our final adverse benefit determination:

1. relies on medical judgment (including but not limited to medical necessity, appropriateness, health care setting, level of care, or effectiveness of a benefit);
2. concludes that a treatment is experimental or investigation;
3. concludes that parity exists in the nonquantitative treatment limitations applied to behavioral health care (mental health and/or substance abuse) benefits;
4. involves consideration of whether We are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130); or
5. involves a decision related to rescission of your coverage.

External Review
If You are dissatisfied with Our final internal Adverse Benefit Determination regarding Your appeal, You or Your authorized representative may have the right to request an external review by an independent third-party organization. Within four (4) months after the date on which You receive Our final internal Adverse Benefit Determination, send Your written request for external review to:

MAXIMUS Federal Services
States Appeals East
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

Or You may fax Your request to 1-888-866-6190 or submit Your request online at www.externalappeal.com "Request for Review" tab. You will not be required to bear the costs of the External Review. You must submit the HHS-Administered Federal External Review Request Form with your request, as well as a copy of our decision letter. In some cases, an Appointment of Representative form may also be required. The Appointment of Representative form and the HHS-Administered Federal External Review Request Form can be accessed through the following website: https://externalappeal.cms.gov/ferpportal/#/forms. If You have any questions or concerns on the external review process, You may call toll free 1-888-866-6205, 711 (TTY). If You need copies of any of these forms or Our letter, please contact 1-855-364-3185, 711 (TTY). You can download a copy of the Privacy Act Statement form at: https://www.cms.gov/CCIIO/Resources/Forms-reports-

and-other-resources/index.html. If You have any questions or concerns on the external review process, You may call toll free 1-888-866-6205 ext. 3326, 711 (TTY).

You may submit additional information to the external reviewer by sending it to the mailing address or fax number for the Federal External Review set forth above. Please note that any additional information that You submit will be shared with Us so that We may reconsider Our final internal adverse benefit determination.

The Federal External Reviewer will first determine whether You are entitled to external review and will notify You and Us in writing if You are not eligible for external appeal. The Federal External Reviewer will then review all of the information and documents timely received *de novo* and will provide written notice of a final external review decision as soon as possible and no later than 45 days after the federal external reviewer receives Your request for external review. This written notice will be sent to You and Us.

You may make a written or oral request for an expedited external review if (1) the time frame for completion of an expedited internal appeal would seriously jeopardize Your life or health or would jeopardize the claimant's ability to regain maximum function but only when You have also filed a timely request for an expedited internal appeal related to Your urgent pre-service or concurrent care claim, or (2) You have received Our final internal adverse benefit determination and You have a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the Your life or health or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care supply or service for which You have received services, but have not been discharged from a facility.

To make a request for expedited external review You may select "expedited" if submitting the review request online, or by emailing FERP@maximus.com, asking for expedited review in Your written request for external review or calling the Federal External Review Process at 888-866-6052 ext. 3326.

If the external reviewer determines that You are not eligible for expedited external review, then the external reviewer will notify You and Us as soon as possible. The external reviewer must provide notice of the final expedited external review decision as soon as the medical circumstances require but no later than 72 hours after the external review receives Your request for expedited external review unless You are within an ongoing course of treatment for that condition and then the external review decision will be provided within 24 hours. This notice may be provided orally but must be followed in writing to You and Us within 48 hours of the oral notification.

If the external reviewer overturns our decision, We will provide coverage or payment for Your health care service or supply as directed.

Except when external review is permitted to occur simultaneously with Your internal urgent Pre-Service or urgent Concurrent Care Appeal, You must exhaust Our internal Claims and Appeals procedures applicable to Your Claim before You may request external review unless We have failed to comply with federal requirements regarding Our Claims and Appeals procedures.

You may have certain additional rights if You remain dissatisfied after You have exhausted all levels of review including external review. If You are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), You may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, You should check with Your benefits office or contact the 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. There may be time limitations on when you need to file your action in either federal or state court.

IMPORTANT NOTICE REGARDING YOUR HEALTH INSURANCE COVERAGE

Disclosure of Your Rights and Responsibilities under the Georgia Patient Protection Act

1. You have the right to receive medically appropriate care in a timely and convenient manner.
2. You have the right to participate in decision making regarding treatment, care and services.
3. You have the right to receive information about Your health plan, services and providers.
4. You have the right to voice Your complaints or request appeals and have them addressed in a timely manner.
5. You have the right to designate a person of Your choice to facilitate care, if You are unable to do so.
6. You are responsible to provide necessary information to facilitate effective medical care.
7. You are responsible in keeping Your appointments with Your health care provider and to call Your provider at least 24 hours prior to the appointment date if You are unable to keep Your appointment.
8. You are responsible in following the medical care as prescribed by Your health care provider.
9. You are responsible in following the rules promulgated under Your health insurance plan.

GENERAL PROVISIONS

Assignment

Payment of benefits under the Group Policy for treatment or services that are provided prescribed or directed by an In-Network Provider are made directly to the In-Network Provider.

Payment of benefits under the Group Policy for treatment or services that are provided prescribed or directed by an Out-of-Network Provider are assignable when requested in writing by the insured.

Payment of benefits shall be made by KPIC directly to the Out-of-Network Provider.

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 Covered Person can be used in a contest.

Legal Action

No legal action may be brought to recover on this policy before 60 days from the date written Proof of Loss has been given to Us. as required under the Proof of Loss section. No such action may be brought more than three (3) years after the date written proof of loss is given to Us.

Misstatement of Age

If the age of any person insured under this Group Policy 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).

Money Payable

All sums payable by or to KPIC or its Administrator must be paid in the lawful currency of the United States.

Physical Examination and Autopsy

KPIC, at its own expense, shall have the right and opportunity to examine the person of any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

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

In the absence of fraud, any statement made by the Policyholder or a Covered Person in applying for insurance under This Group Policy will be considered a representation and not a warranty. Only statements that are in writing and signed by the Covered Person can be used in a contest.

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,

Order means a valid court or administrative order that:

1) Determines custody of a minor child; and
2) Requires a non-custodial parent to provide the child's medical insurance coverage or to pay any portion of the medical expenses resulting from medical treatment of the child.

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.

Right of Recovery

If You or Your covered dependent has a claim for damages or a right to recover damages from a third party or parties for any illness or Injury for which benefits are payable under this plan, KPIC may have a right of recovery. Our right of recovery shall be limited to the recovery of any benefits paid for identical covered medical expenses under this plan, but shall not include non-medical items. Money received for future medical care or pain and suffering may not be recovered. KPIC's right of recovery shall include compromise settlements. You or Your attorney must inform KPIC of any legal action or settlement agreement at least 10 days prior to settlement or trial. KPIC will then notify You

of the amount it seeks to recover for covered benefits paid. Our recovery may be reduced by the pro-rata share of Your attorney's fees and expenses of litigation.

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"). A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. **Note**: This "Surrogacy arrangements" provision does not affect Your obligation to pay Your Cost Share for these Covered Services. After You surrender a baby to the legal parents, You are not obligated to reimburse Us for any Covered Services that the baby receives after the date of surrender (the legal parents are financially responsible for any 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
Fax: 502-214-1291

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 1-855-364-3185, 711 (TTY).

Time Effective

The effective time for any dates used is 12:01 A.M. at the address of the Policyholder.

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 1-855-364-3185, 711 (TTY) to learn more about the value added services which may be available to You.

1. Wellness Coaching
2. Healthy Living Classes
3. Online resources including symptom checker, healthy recipes, and drug encyclopedia.
4. Healthy lifestyle online program
5. Total Health Assessment
6. Discounts on chiropractic, massage therapy services, fitness club memberships and vitamins

For purposes of this section "wellness program" 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.

Victims of Family Violence or Sexual Abuse

The laws of the State of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence or sexual assault.

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, California 94612

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