KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Mid-Atlantic

Flexible Choice

Notice:

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

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

District of Columbia

Point of Service (POS)

Large Group

(*Non-Grandfathered Coverage)*

Certificate of Insurance

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza

Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverages funded through a Group Insurance Policy (Group Policy) issued to Your group by Kaiser Permanente Insurance Company. 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. 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 Participating and Non-Participating 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 Participating Provider directory.

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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****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.

Introduction to Your Plan

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

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

This Certificate is issued in conjunction with Health Plan's Evidence of Coverage (which will be sent to you under separate cover). KPIC and Health Plan issue these documents to explain the coverage available under the Point of Service plan which entitles a Covered Person to choose among three options when treatment or services are requested or rendered. The three options are the Kaiser Permanente Providers (Option 1) option which is underwritten by Health Plan and is explained in the Evidence of Coverage; and, Participating Providers (Option 2) option and the Out-of-Network Providers (Option 3) option both of which are underwritten by KPIC and are explained in this Certificate of Insurance which is part of the Group Policy.

For the Kaiser Permanente Providers option, Health Plan covers Covered Services provided, prescribed and/or directed by a physician employed by or affiliated with Mid-Atlantic Permanente Medical Group, P.C., (Health Plan's exclusive contractor for medical services) or by a facility or other health care provider which contracts with Health Plan or Kaiser Foundation Hospitals (Health Plan's exclusive contractor for hospital services). Under the Evidence of Coverage, Covered Services (as the term is defined herein) also include certain other medical and hospital services including, but not limited to Emergency Services, which are rendered by non-affiliated physicians, facilities and providers, as further described in the Evidence of Coverage. The Evidence of Coverage sets forth the terms of the coverage underwritten by Health Plan.

For the Participating Providers (Option 2) and Out-of-Network Providers (Option 3) options, KPIC is responsible for paying for the medical and hospital services described in this Certificate/Group Policy. Your coverage under the Group Policy includes coverage for certain Covered Services received from Participating Providers. To verify the current participating status of a provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Providers is available from your employer, or call the phone number listed on Your ID card, or you may visit the network's web site at: www.multiplan/kpmas. If You receive Covered Services from a Non-Participating Provider, benefits under the Group Policy will be payable by KPIC at the Non-Participating Provider level at the Out-of-Network Providers (Option 3) option level. Your financial responsibility is different for Covered Services rendered by Participating and Non-Participating Providers and you should consult the Schedule of Coverage to determine the amount which KPIC will pay for a Covered Service.

You many not have the option to choose among the three options for all Covered Services and therefore, you should review the Health Plan's Evidence of Coverage as well as this Certificate and KPIC's Schedule of Coverage to determine whether medical and hospital services are Covered Services, at which option the Covered Service may be accessed and whether any other specific coverage requirements must be met. All Covered Services must be Medically Necessary.

Neither Health Plan nor KPIC is responsible for any Covered Person's/Member's decision to receive treatment, services or supplies at any option level. Neither Health Plan or KPIC is liable for the qualifications of providers or

treatment, services or supplies rendered under the other payor's coverage. This Certificate and the Group Policy set forth the terms of the coverage underwritten by KPIC.

IMPORTANT: No payment will be made by KPIC under the Group Policy for treatment (including confinement(s)), services or supplies to the extent such treatment; services or supplies were arranged, paid for, or payable by Health Plan's coverage (Option 1). Payment will be made either under the Health Plan's coverage (Option 1) or under the KPIC levels of coverage (Option 2 or 3), but not under both.

This Certificate and the Schedule of Coverage form the remainder of the Group Policy. The provisions set forth herein, are incorporated and made part of, the Group Policy.

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, benefits and current eligibility: 1-800-392-8649

For name and address changes: 1-800-225-7202

Or You may write to the Administrator:

NTT DATA Services, LLC
2300 West Plano Parkway
Plano, Texas 75075

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

If You have any questions regarding services, facilities, or care You receive from a Participating Provider, please call the toll free number listed in the Participating Provider directory.

For Pre-certification of Covered Services or Utilization Review please call the number listed on Your ID card or 1-888-567-6847.

GENERAL DEFINITIONS

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.

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 of not less than twelve (12) months.

Administrator means NTT DATA Services,LLC, 2300 West Plano Parkway, Plano, Texas 75075 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 Health Plan is the administrator of Your employee benefit plan as that term is defined under Title I of the federal Employee Retirement Income Security Act of 1974 (ERISA), as then constituted or later amended.

Advanced Practice Registered Nurse means a person licensed as a RN and certified as an advanced practice RN by the District of Columbia or by the state or territory where the person practices as an advance practice registered nurse.

Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Benefit Maximum means a total 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 count toward satisfaction of any Deductible or Out of Pocket Maximum.

Biosimilar means FDA-approved biologics that are highly similar to a brand biologic product.

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 Maternity Services program to pregnant individuals who are considered normal to low risk patients;
3. Has organized facilities for Maternity Services on its premises;
4. Has Maternity Services performed by a Physician specializing in obstetrics and gynecology, or by a Licensed Midwife or Certified Nurse Midwife under the direction of a Physician specializing in obstetrics and gynecology; and
5. Have 24-hour-a-day Registered Nurse services.

Brand Name Drug means a prescription drug that has been patented and is only produced by a manufacturer under that name or trademark 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; 2) National Board of Pediatric Nurse Practitioners and Associates; or 3) Nurses' Association of the American College of Obstetricians and Gynecologists.

Clinically Significant means sufficient to impair substantially a person's judgment, behavior, capacity to recognize, or ability to cope with the ordinary demands of life.

Clinical Trials means clinical research studies, clinical investigations, and treatment studies on a life-threatening condition; or prevention, early detection, and treatment studies on cancer. Coverage for treatment studies shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial. To be eligible, a Clinical Trial must be approved by one or more of the following:

1. The National Cancer Institute;
2. An NCI cooperative group or an NCI center;
3. The FDA in the form of an investigational new drug application;
4. The federal Department of Veterans Affairs; or
5. The National Institutes of Health;
6. The Centers for Disease Control and Prevention;
7. The Agency for Health Care Research and Quality;
8. The Centers for Medicare and Medicaid Services;
9. A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS;
10. The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant; or
11. An investigation or study approved by an Institution Review Board registered with the Department of Health and Human Services (DHHS) that is associated with an institution which has a multiple project assurance contract or federal-wide assurance contract approved by the DHHS.

Coinsurance means the amount of a Covered Charge that You must pay in connection with receiving a Covered Service. The Coinsurance amount is the difference between the amount paid by KPIC and the Maximum Allowable Charge for that Covered Service. The Covered Person is also responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service.

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; 3) an act of rape of an insured which was reported to the police within 7 days following its occurrence. The 7-day requirement shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

Complications of Pregnancy will not include 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 a facility primarily engaged in providing diagnostic, therapeutic, and restorative services through licensed health care professionals to injured, ill or disabled individuals. The facility must be accredited for the provision of these services by the Commission on Accreditation for Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association.

GENERAL DEFINITIONS

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.

Co-payment means the predetermined amount, as shown in the Schedule of Coverage, which is to be paid by the Covered Person directly to a Provider. Co-payments are applied on a per visit or per service basis. Co-payments paid for Covered Services and those paid for prescription drugs under the Prescription Drug benefit do count toward satisfaction of the Out-of-Pocket Maximum and toward satisfaction of the Deductible.

Cosmetic Surgery means surgery that: 1) is performed to alter or reshape normal structures of the body in order to change the patient's appearance; and 2) will not result in significant improvement in physical function.

Cost Share means a Covered Person's share of Covered Charges. Cost Share is limited to the following: 1) Coinsurance; 2) Copayments; 3) Deductible; and 4) any Benefit Specific Deductible.

Covered Charge 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. No person may be covered as both an Insured Employee and a Dependent at the same time.

Covered Services means services as defined and listed under the section of this Certificate entitled **GENERAL BENEFITS**.

Creditable Coverage means

1. Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, 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 a Policy Year. The Deductible will apply to each Covered Person separately, and must be met within each Policy Year. When Covered Charges equal to the Deductible are incurred during that Policy Year, 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 satisfy the Deductible. Covered Charges applied to satisfy the Deductible will be applied toward satisfaction of the Out-of-Pocket Maximum. Charges in excess of the Maximum Allowable Charge, and additional expenses a Covered Person must pay because Pre-certification was not obtained, will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

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

Preventive Benefits required under the Patient Protection and Affordability Care Act (PPACA) that are received at the Non-Participating Provider level may be subject to Deductible.

Domestic Partner means an unmarried same or opposite sex adult who resides with the Covered Person and has registered in a state or local domestic partner registry with a Covered Person; or "your company's requirements".

Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

Drug Formulary means the listing of prescription medications, which are preferred, for use by Us and which will be dispensed through Participating and Non-Participating Pharmacies to Covered Persons. You may obtain a current copy of the drug formulary from Your employer or visit the following website: kp.org/formulary.

Durable Medical Equipment means medical equipment which:
1. Is designed for repeated use;
2. Is mainly and customarily 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 except for apnea monitors and breast pumps;
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. Is appropriate for use in the home; and
8. Serves a specific therapeutic purpose in the treatment of an illness or injury.

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

Emergency Medical Condition means a medical condition, including psychiatric conditions, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; and/or

3. Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) means all of the following with respect to an Emergency Medical Condition:
1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, and rendered therein, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient.

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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.

Generic 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 Drug.

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

Health Plan means Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Home Health Care Agency means an agency or other Provider licensed under state law, if required, to provide Home Health Care.

Home Health Aide means a person, other than a RN or nurse, who provides maintenance or personal care services to persons eligible for Home Health Care Services.

Home Health Care Services means services and supplies that can be safely and effectively provided in the Covered Person's home by health care by a Home Health Care Agency when the Covered Person is bedridden or functionally limited due to a Sickness or Injury that restricts his or her ability to leave his or her residence. Home Health Care Services are limited to:

1. Part-time or intermittent skilled nursing care provide by or under the supervision of a Registered Nurse;
2. Part-time or intermittent care by a Home Health Aide, provide in conjunction with skilled nursing care; or
3. Therapeutic care services provided by or under the supervision of a speech, occupational, physical or respiratory therapist licensed under state law (if required).
4. Assistance with activities of daily living;
5. Respite care services and
6. Homemaker services.

Services by a private duty nurse are excluded under this benefit.

Hospice Care means a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed and/or accredited within the jurisdiction within which the care is provided. Hospice Care is limited to Covered Persons with a terminal illness whose condition has been diagnosed as terminal by a Physician, whose medical prognosis is death within six months, and who elect to receive palliative rather than curative care. Hospice Care will include Palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.

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 services 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.

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

Indemnity Plan means an insurance plan in which Covered Persons are reimbursed for Covered Charges.

In-Plan means those benefits covered and/or provided by Health Plan under a group agreement.

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

Insured Dependent means a Covered Person who is a Dependent of the 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 Registered Nurses or other specially trained Hospital personnel.

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

Maintenance drug means a drug anticipated to be required for 6 months or more to treat a chronic condition.

Maternity Services means prenatal or antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care in accordance with medical criteria outlined by the American College of Obstetricians and Gynecologists. 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.

Maximum Allowable Charge means:

1. For Participating Providers, 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 of Deductibles, Copayment, and Coinsurance by the Covered Person.

2. For Non-Participating Providers, the lesser of the following:
   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 charges actually billed by the provider for Covered Services.

In some instances, KPIC or its Administrator may negotiate rates and/or discounts with Non-Participating Providers for Covered Services. In such instances, the Maximum Allowable Charge will be limited to the Negotiated Rate.

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

Exception For Emergency Services rendered by Non-Contracted Providers:

If the amount payable for Emergency Services is less than the Actual Billed Charges submitted by the Non-Contracted Provider, KPIC must pay at least the greater of the following:

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

Under any of the above, KPIC may deduct from its payment: (1) any Contracted Provider Copayments and/or Coinsurance amounts that would have been paid had the Emergency Service been rendered by a Contracted Provider; and/or (2) any Non-Contracted Provider deductible amounts.

Medically Necessary means services that, in the judgment of KPIC, 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 covered by the Group Policy.

Medically or Psychologically Necessary means essential treatment of Drug Abuse, Alcohol Abuse, or Mental Illness, as determined by a Physician, Psychologist or Social Worker. The fact that a Physician, Psychological may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

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. If the Medical Review Program determines that the care is not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven 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.

Member means a person covered under the terms of the Health Plan Three Tier Point-of-Service Group Agreement.

Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

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.

Morbid Obesity means:

1. A weight that is at least 100 pounds over or twice the ideal weight for a patient's frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A body mass index (BMI) that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, a cardiopulmonary condition, sleep apnea, or diabetes; or
3. A BMI of 40 kilograms per meter squared without such comorbidity.

Multidisciplinary Rehabilitative Services means occupational therapy, speech therapy, and physical therapy, in a prescribed, organized, multidisciplinary rehabilitation program in a Hospital, Physician's office, or a Skilled Nursing Facility, or other appropriately licensed medical facility. Such services must be rendered for a condition that the attending Physician determines is subject to significant improvement in function within a two-month period. Multidisciplinary Rehabilitative Services does not include long-term rehabilitative therapy or cardiac rehabilitation.

Necessary Services and Supplies means Medically Necessary Services and Supplies actually administered during any covered Hospital Confinement or other covered treatment. Only drugs and materials that require administration by medical personnel during self-administration are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to surgically implanted prosthetic devices, oxygen, blood, blood products, 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. 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 rates and/or discounts negotiated by KPIC or its Administrator with providers or suppliers of Covered Services. Any such rate is referred to as the Negotiated Rate. If a Negotiated Rate applies to a Covered Service, benefit payments and calculation of Your financial responsibility for payment of deductibles, copayments and Coinsurance amounts will be based on the Negotiated Rate.

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

Non-hospital Residential Facility means a facility certified by the District of Columbia or by any state or territory of the United States as a qualified non-hospital provider of treatment for Drug Abuse, Alcohol Abuse, and Mental Illness, or any combination of these, in a residential setting. The term "non-hospital rehabilitation facility" includes any facility operated by the District of Columbia or by any state or territory or the United States, to provide these services in a residential setting.

Non-Participating Pharmacy means a pharmacy that does not have a Participating Pharmacy agreement with KPIC or its Administrator in effect at the time services are rendered. In most instances, You will be responsible for a larger portion of Your pharmaceutical bill when You fill prescriptions at a Non-participating Pharmacy.

Non-Participating Provider means a Hospital, Physician or other duly licensed health care Provider, supplier or facility that is not operating under an agreement with KPIC, its Administrator's or KPIC's designated preferred provider organization to provide Covered Services at Negotiated Rates. In some instances, KPIC or its Administrator may negotiate rates and/or discounts with Non-Participating Providers for Covered Services. In such instances, the Maximum Allowable Charge will be limited to the Negotiated Rate and the benefit levels will be those applicable to Non-Participating Providers. In most instances, You will be responsible for a larger portion of Your bill when You visit a Non-Participating Provider. Please consult Your group administrator for a list of participating providers or visit MultiPlan's website at www.multiplan.com/kpmas.

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

Occupational Therapy means those services necessary to achieve and maintain improved self-care and other customary activities of daily living.

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

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.

Orthotics means rigid and semi-rigid external Orthotic devices used to support a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured, part of the body.

Orthotic devices will not include:
1. Dental devices and appliances;
2. Comfort, convenience, or luxury equipment or features;
3. Shoes or arch supports, even if custom-made, except for severe diabetic foot disease in accord with Medicare guidelines.
4. More than one orthotic device for the same part of the body, except for replacements other than those necessitated because of misuse or loss.
5. Replacement of lost orthotic devices;
6. Repair, adjustments or replacements necessitated by misuse; and
7. Spare or alternate use appliances or apparatus.

Out-of-Plan means those benefits underwritten by KPIC and set forth in the Group Policy. Unless specifically stated otherwise in the Group Policy, KPIC will not pay for services arranged, provided or reimbursed under Health Plan's In-Plan coverage**.**

Out-of-Pocket Costs means a Covered Person's share of Covered Charges. For purposes of the Out of Pocket Maximum, a Covered Person's Out-of-Pocket costs means the difference between the amount payable by KPIC for Covered Charges and the Maximum Allowable Charge. Out-of-Pocket does not include any amount in excess of the Maximum Allowable Charge.

Out-of-Pocket Maximum means the total amount of Covered Charges a Covered Person will be responsible for in a Policy Year.

Outpatient Rehabilitative Services means occupational therapy, speech therapy, and physical therapy, provided to the Covered Person while receiving Home Health Care, Hospice Care and Skilled Nursing Care. The attending Physician must determine that the condition is subject to measurable improvement in function within a two-month period.

Outpatient Treatment Facility means a clinic, counseling center, or other similar location that is certified by the District of Columbia or by any state or territory of the United States as a qualified provide of outpatient services for the treatment of Alcohol Abuse, Drug Abuse of Mental Illness. The term "outpatient treatment facility" includes any facility operated by the District of Columbia, any state or territory or the United States to provide these services on an outpatient basis.

Partial Hospitalization means short term treatment of not more than 24 hours and not less than 4 hours for mental illness, emotional disorders, drug or alcohol abuse in a licensed or certified facility or program.

Participating Pharmacy means a pharmacy that has a Participating Pharmacy agreement in effect with KPIC or its Administrator at the time services are rendered. Please consult with Your group administrator for a list of Participating Pharmacies, or visit the company's web site at: www.medimpact.com.

Participating Provider means a Hospital, Physician or other duly licensed health care provider or facility that is operating under an agreement with KPIC, its Administrator, or KPIC's designated preferred provider organization to provide Covered Services at Negotiated Rates. A current copy of KPIC's Participating Providers is available from Your employer visit the company's web site at: www.multiplan.com/kpmas.

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

Preferred Provider Organization (PPO) means an organization of Hospitals, Physicians and other duly licensed health care providers or facilities designated by KPIC to provide Covered Services at Negotiated Rates. In most instances, Your Out-of-Pocket costs are lower when you receive Covered Services from Participating Providers. Please refer to Your Schedule of Coverage to determine if a PPO is applicable to Your plan.

Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable and the Covered Service to which it applies is set forth in the Schedule of Coverage. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services to calculate the benefit payable under the Group Policy.

Physical Therapy means those services limited to the restoration of an existing physical function, except as provided in the "Early Intervention Services" of the General Benefits section of this Certificate.

Physician means a health practitioner who is duly licensed as such 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.

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

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 Group Policy. 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.

Pre-certification/Pre-certified 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 Brand Name Drug means a drug that KPIC has designated on its preferred drug list.

Preventive Services means medical services rendered to prevent diseases. Preventive Services are limited to those services set forth in the General Benefits section.

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

Prosthetics means internally implanted devices and/or external prosthetic devices that are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person in the absence of a Sickness or Injury. Internally implanted devices include, but are not limited to, devices implanted during surgery, such as pacemakers, ocular lens implants, artificial hips and joints, breast implants and cochlear implants that are approved by the Federal Food and Drug Administration. External devices are limited to ostomy and urological supplies as well as breast prosthesis, including a mastectomy bra needed following a mastectomy and custom-made prosthetics, and an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

Prosthetic devices will not include:
1. Internally implanted breast prosthetics for cosmetic purposes;
2. Dental prosthetics, devices, implants and appliances. This exclusion does not include treatment of children with congenital and genetic birth defects to enhance the child's ability to function, such as cleft lip, cleft palate, or both;
3. Hearing aids;
4. Corrective lenses and eyeglasses, except as provided under the "Vision Care" benefit;
5. Repair or replacement of prosthetics due to misuse or loss;
6. More than one prosthetic device for the same part of the body, except for replacements, spare devices or alternative use device;
7. Non-rigid supplies, such as elastic stockings, and wigs;
8. Electronic voice producing machines;
9. Hair prosthesis;
10. Replacement of lost prosthetic devices;
11. Repair, adjustments or replacements necessitated by misuse;
12. Spare or alternate use equipment; and
13. Prosthetics for the treatment of sexual dysfunction disorders.

Provider means a health practitioner who is duly licensed as such 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.

Psychologist means a person licensed to practice psychology by the District of Columbia or by the state or territory of the United States where the person practices psychology.

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.

Rehabilitation 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 60 days.

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 Prenatal Care means an office visit that includes one or more of the following:
1. The initial and subsequent histories;
2. Physical examinations;
3. Recording of weight, blood pressures;
4. Fetal heart tones; and
5. Routine chemical urinalysis.

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

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

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

Social Worker means a person licensed as an independent clinical social worker by the District of Columbia or who is licensed to practice social work with authority to engage in the independent practice of psychotherapy by the state of territory where the person practices social work.

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

Specialty Drug includes a prescription drug prescribed for a condition that may have no known cure, is progressive, or can be debilitating or fatal if left untreated, and affects fewer than 200,000 persons in the United States.

Speech Therapy means those services limited to the treatment for speech impairments due to a sickness or injury.

Spouse means a person of the same or opposite sex who is legally married to the insured under the laws of the state or jurisdiction in which the marriage took place.

Stabilize means 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).

Surrogacy Arrangement means an arrangement 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" provision under the GENERAL PROVISIONS section for information about Your obligations to Us in connection with a Surrogacy Arrangement, including Your obligation to reimburse Us for any Covered Services that baby (or babies) receive.

Telemedicine means the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment; provided that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included.

Urgent Care means non-life threatening medical and health services for the treatment of a Covered Sickness or Injury.

Urgent Care Center 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
The following persons will be eligible for insurance:

Insured Employees and their dependents who meet the eligibility requirements set forth in the Health Plan's Evidence of Coverage and who are enrolled in Health Plan as Point-of-Service Members in a timely manner. Eligibility for benefits under the Group Policy will terminate when coverage under the Health Plan's Evidence of Coverage terminates. Health Plan, on behalf of KPIC, will make all decisions regarding eligibility and termination.

Effective Date of an Eligible Employee's or Dependent's Insurance
The Effective Date of an eligible employee's or Dependent's insurance will be the date the person becomes covered by Health Plan as a Point-of-Service Member.

Special Enrollment due to Reemployment After Military Service: If You terminated Your health care coverage because You were called to active duty in the military service, You may be able to be re-enrolled in Your Group's health plan if required by state or federal law. Please ask Your Group for more information.

Termination of a Covered Person's Insurance
A Covered Person's insurance will automatically terminate on the earlier of:
1. The date the Covered Person ceases to be covered by Health Plan as a Point-of-Service Member;
2. The date the Group Policy terminates;
3. The date a Covered Person, or the Covered Person's representative, commits a fraudulent act or knowingly makes a misrepresentation of a material fact;
4. The end of the grace period after the employer group fails to pay any required premium to KPIC, Health Plan, or its Administrator when due or KPIC does not receive the premium payment in a timely fashion;
5. The date the Insured employee and/or his/her Dependents cease to be eligible for under Health Plan's Evidence of Coverage;
6. The date You no longer live or work in Health Plan's Service Area (as that term is defined in the Evidence of Coverage and is hereby incorporated by reference); or
7. The date the Group Agreement between Your group and Health Plan terminates.

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

The Health Plan Point-of-Service Evidence of Coverage more fully explains eligibility, effective date and termination.

Note: A dependent's coverage under this COI will terminate at the end of the calendar year (December 31st) during which the dependent turns 26 years of age.

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.

You have the right to request an appeal from Us for the rescission of your coverage. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the claims and appeals process.

PRE-CERTIFICATION

Pre-certification through the Medical Review Program
This section describes:
1. The Medical Review Program and Pre-certification procedures;
2. How failure to obtain pre-certification affects coverage;
3. Pre-certification administrative procedures;
4. Which clinical procedures require Pre-certification;

A Covered Person must obtain Pre-certification of all Hospital stays and certain other services and procedures. Request for Pre-certification 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 Pre-certification is required, it must be obtained to avoid a reduction in benefits.

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

If Pre-certification is not obtained when required, or obtained but not followed, benefits otherwise payable for all Covered Charges incurred in connection with the treatment or service will be reduced by (30) percent. However, the reduction will be limited to $5,000. Any such reduction in benefits will not count toward satisfaction of any Deductible, Coinsurance or Out-of-Pocket Maximum applicable under the Group Policy.

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. If the Medical Review Program determines that the care is not Medically Necessary, pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven days per week.

The following treatment or services must be pre-certified by the Medical Review Program
1. Inpatient admissions
2. Inpatient Rehabilitation Therapy admissions
3. Inpatient Skilled Nursing Facility, long-term care, and sub-acute admissions
4. Inpatient mental health and chemical dependency admissions
5. Inpatient Residential Treatment
6. Non-Emergent (Scheduled) Air or Ground Ambulance
7. Pediatric Medically Necessary contact lenses
8. Amino Acid-Based Elemental Formulas
9. Low Protein Modified Foods
10. Clinical Trials
11. Medical Foods
12. Applied Behavioral Analysis (ABA)
13. Bariatric Surgery
14. Cardiac Rehabilitation
15. Dental & Endoscopic Anesthesia
16. Durable Medical Equipment (DME)
17. Genetic Testing
18. Habilitative Therapy (physical therapy, occupational therapy, and speech therapy)
19. Home Health & Home Infusion Services
20. Hospice (home, inpatient)
21. Infertility Procedures
22. Imaging Services (Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT), Computerized Tomography Angiography(CTA), Positron Emission Tomography (PET), Electronic Beam Computed Tomography (EBCT), SPECT, not including x-ray or ultrasound)

23. Outpatient Injectable Drugs
24. Outpatient Surgery (performed at hospital, ambulatory surgery center of licensed facility)
25. Orthotics/Prosthetics
26. Implantable prosthetics (includes breast, bone conduction, cochlear)
27. Pain Management services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)
28. Radiation Therapy Services
29. Reconstruction Surgery
30. Outpatient Rehab Therapy (physical, occupational, speech, pulmonary)
31. TMJ/Orthagnathic Surgery
32 Transgender Surgery & Services (sexual re-assignment)
33. The following outpatient procedures:
    a) Hyperbaric oxygen
    b) Sclerotherapy
    c) Plasma Pheresis (MS)
    d) Anodyne Therapy
    e) Sleep Studies
    f) Vagal Nerve Stimulation
    g) Hemispherectomy
    h) Implants
    i) Pill Endoscopy
    j) Stab phlebotomy
    k) Radiofrequency abalation
    l) Enhanced External Counterpulsation (EECP)
    m) Resection
    n) Corpus Colostomy surgery
    o) Uvulo-palato-pharyngoplasty (UPPP) & laser-assisted UPPP

IMPORTANT: If pre-certification is not obtained, benefits will be reduced even if the treatment or service is deemed Medically Necessary. If the treatment or service is deemed not to be Medically Necessary, the treatment or service will not be covered. If a Hospital Confinement or other Confinement is extended beyond the number of days first pre-certified without further pre-certification (concurrent review), benefits for the extra days: (1) will similarly be reduced; or (2) will not be covered if deemed not to be Medically Necessary.

Pregnancy Pre-certification: When a Covered Person is admitted to a Hospital for delivery of a child, the Covered Person is authorized to stay in the hospital 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 cited above.

A shorter length of stay may be Pre-certified if the Physician, in consultation with the mother, determines that the newborn and the mother meet the criteria for medical stability in accordance with the Guidelines for Prenatal Care or the Standards for Obstetric-Gynecologic Services. In all such cases of early discharge, We will provide coverage for post-delivery care within the above-stated minimum time periods. The postpartum care may be delivered in the patient's home or the provider's office, as determined by the Physician in consultation with the mother.

The at-home post-delivery care shall be provided by a Physician, RN, Certified Nurse Practitioner, Certified Nurse-Midwife or Licensed Midwife or Physician assistant. Postpartum care includes
1. Parental education
2. Assistance and training in breast or bottle feeding; and
3. Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening

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

Pre-certification Procedures
The Covered Person, or Provider acting on behalf of the Covered Person, 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 Pre-certified.
3. Other treatments or procedures requiring pre-certification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring pre-certification but at least three days prior to performance of any other treatment or service requiring pre-certification.
4. During the first trimester of pregnancy if the Covered Person intends to have Maternity Services covered under this plan.

A Covered Person, or Provider acting on behalf of the 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, or Provider acting on behalf of 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 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, pre-certification will be denied.

DEDUCTIBLES AND MAXIMUMS

Individual Deductible
The Deductible for an individual, as shown in the Schedule of Coverage, applies to all Covered Services incurred by a Covered Person during a Policy Year, unless otherwise indicated in the Schedule of Coverage. The Deductible may not apply to some Covered Services, as shown in the Schedule of Coverage. When Covered Charges equal to the Deductible are incurred during the Policy Year and are submitted to Us, the Deductible will have been met for that Covered Person for that Policy Year. Benefits will not be payable for Covered Charges applied to the Deductible.

In addition, some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles do not contribute toward the satisfaction of the Individual Deductible and Family Deductible.

NOTE: The Deductible does not apply to Preventive Benefits required under the Patient Protection and Affordable Care Act (PPACA) received at the Participating Provider level. Preventive Benefits required under the Patient Protection and Affordability Care Act (PPACA) that are received at the Non-Participating Provider level, however, are subject to the Policy Year Deductible.

Family Deductible Maximum
The Deductible for a family has been satisfied for a Policy Year 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, shown in the Schedule of Coverage, is satisfied in any one Policy Year by covered family members, then the Individual Deductible will not be further applied to any other Covered Charges incurred during the remainder of that Policy Year.

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

Benefit-Specific Deductibles
Some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles contribute toward the satisfaction of the Individual Deductible and the Family Deductible**.**

Common Accident
A Deductible must be satisfied only once with respect to Covered Charges incurred due to one common accident involving two or more Covered Persons of a family. This will only apply to Covered Charges incurred due to accident. The Covered Charges used to satisfy this common accident Deductible must be incurred: (1) in the Policy Year in which the accident occurs; or (2) in the next Policy Year.

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

Out-of-Pocket Maximums
Any part of a charge that does not qualify as a Covered Charge will not be applied toward satisfaction of the Out-of-Pocket Maximum. Covered Charges applied to satisfy any Deductibles under the Group Policy are also applied toward satisfaction of the Out-of-Pocket Maximum. The Out-of Pocket Maximum may not apply to all Covered Charges. See the Schedule of Coverage for specific exceptions. Charges in excess of the Maximum Allowable Charge, any Benefit Maximum, or additional expenses a Covered Person must pay because Precertification was not obtained**,** will not be applied toward satisfaction of the Deductible or the Out-of-Pocket Maximum.

DEDUCTIBLES AND MAXIMUMS

Individual Out-of-Pocket Maximum*:* When a Covered Person's share of Covered Charges equals the Out-of-Pocket Maximum (shown in the Schedule of Coverage) during a Policy Year, the Percentage Payable will increase to 100% of further Covered Charges incurred by that same Covered Person during the remainder of that Policy Year.

Family Out-of-Pocket Maximum*:* When the family's share of Covered Charges equals the Out-of-Pocket Maximum (shown in the Schedule of Coverage) during a Policy Year, the Percentage Payable will increase to 100% of further Covered Charges incurred by all family members during the remainder of that Policy Year.

The Cost Share for all Essential Health Benefits applies toward satisfaction of the Out-of-Pocket Maximum at the participating provider level.

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.)

Maximum Benefit While Insured
KPIC will pay benefits under the Group Policy up to the Maximum Benefit While Insured as shown in the Schedule of Coverage. The limit applies individually to each Covered Person. When benefits in such amount have been paid or are payable for a Covered Person under the Group Policy, all insurance for that person under the applicable benefit or benefits will terminate, except as provided under the Reinstatement of Your Maximum Benefit While Insured provision.

Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured or any dollar Benefit Maximum specified under the Policy. Unless otherwise prohibited by applicable law, day or visit limits may be imposed on Essential and non-Essential Health Benefits.

Other Maximums
In addition to the Maximum Benefit While Insured, certain treatments, services and supplies are subject to benefit-specific limits or maximums. These additional limits or maximums items are shown in the Schedule of Coverage.

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

Benefit levels for Participating Providers or Non-Participating Providers (For PPO Plans only).

Your coverage provided under the Group Policy may include coverage for Covered Services that are received from either Participating Providers or Non-Participating Provider. See Your Schedule of Coverage to determine if Your coverage includes Participating Providers. Generally, benefits payable are greater for Covered Services received from Participating Providers than those benefits payable for Non-Participating Providers. In order for benefits to be payable at the Participating Provider level, the Covered Person must receive care from a Participating Provider. A current copy of KPIC's Participating Provider Directory is available from Your employer, or You may call the phone number listed on Your ID card or You may visit KPIC's contracted provider network web site at: www.Multiplan.com/Kaiser. To verify the current participation status of any provider, please call the toll-free number listed in the provider directory. If the Covered Person receives care from a Non-Participating Provider, benefits under the Group Policy are payable at the Non-Participating Provider level.

Reinstatement of Your Maximum Benefit While Insured

After Covered Charges have been paid for a Covered Person in an amount equal to the Maximum Benefit while Insured shown in the Schedule of Coverage, KPIC will automatically reinstate benefits for such Covered Person each year in an amount equal to the lesser of:

1. $5,000; or
2. the amount paid for all Covered Charges incurred in the prior Policy Year.

Reinstatement does not apply to benefits payable under the Extension of Benefits provision.

GENERAL BENEFITS

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

Insuring Clause

If KPIC receives satisfactory notice of claim and proof of loss, KPIC will pay the Percentage Payable of the Covered Charges 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 or by a Provider duly licensed to provide medical services without the referral of a Physician;
4. The Covered Person has satisfied the applicable Deductibles, Co-payments, and other amounts payable; and
5. The Covered Person has not exceeded the Maximum Benefit While Insured or any other maximum shown in the Schedule of Coverage, subject to the Reinstatement of Your Maximum Benefit While Insured provision.

Payments under the Group Policy:

1. Will be subject to the limitations shown in the Schedule of Coverage;
2. Will be subject to the General Limitations and Exclusions and all terms of the Group Policy;
3. May be subject to Pre-certification; and
4. Does not duplicate any other benefits paid or payable by KPIC.

Covered Services

1. Room and Board in a Hospital.
2. Room and Board in a Hospital Intensive Care Unit.
3. Room and Board and other Skilled Nursing services in a Skilled Nursing Facility or other licensed medical facility. 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. A Benefit Period specific to care in a Skilled Nursing Facility begins when a Physician admits a Covered Person to a Hospital or Skilled Nursing Facility and ends when the Covered Person has not been a patient in either a Hospital or Skilled Nursing Facility for sixty (60) consecutive days.
4. Necessary Services and Supplies, including medication dispensed while confined in a Hospital.
5. Emergency Services for medical emergencies anywhere in the world. If a Covered Person is admitted to a Non-Participating Hospital, the Covered Person, or someone acting on behalf of the Covered Person, must notify the Medical Review Program within 48 hours, or as soon as reasonably possible. Upon such notification, a decision will be made as to whether the Covered Person can be safely transferred to a facility We so designate. Failure to provide such notification may result in the loss of coverage that would otherwise have been covered after transfer would have been possible.
6. Physicians' services, including office visits.
7. Ambulance service of a licensed ground or air ambulance only if, the judgment of a physician, your medical condition requires either the basic life support, advance life support, or critical care life support capabilities of an ambulance for interfacility or home transfer and the ambulance transportation has been ordered by a physician.

8. Nursing services by an RN, LVN, or LPN, as certified by the attending Physician if a RN is not available. Outpatient private duty nursing will only be covered for the period for which KPIC validates a Physician's certification that: a) the services are Medically Necessary and b) that, in the absence of such nursing care, the Covered Person would be receiving Covered Services as an inpatient in a Hospital or Skilled Nursing Facility. Private duty nursing will not be covered unless otherwise indicated in the Schedule of Coverage.
9. Services by a Certified Nurse Practitioner; Clinical Nurse Specialist; Licensed Midwife; Physician's Assistant or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
10. 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.
11. Chemotherapy.
12. Coverage for one hair prosthesis for hair loss as a result of chemotherapy or radiation treatment for cancer. Limited to a Benefit Maximum of $350 per course of chemotherapy and/or radiation therapy per Policy Year.
13. Outpatient X-ray, laboratory tests and other diagnostic services.
14. Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.
15. Home Health Care provided in a Covered Person's home when:
    a. The institutionalization of the Covered Person in a Hospital or related institution or Skilled Nursing Facility would otherwise have been required if home health care were not provided, and
    b. The plan of treatment covering the home health care service is established and approved in writing by the health care practitioner; and.
    c. as an alternative to otherwise covered services in a hospital or related institution; or for Covered Persons who receive less than 48 hours of inpatient hospitalization following a mastectomy or removal of a testicle on an outpatient basis:
        i. one home visit scheduled to occur 24 hours after discharge from the hospital or outpatient health care facility, and
        ii. an additional home visit if prescribed by the covered person's attending physician.
16. Outpatient surgery in a Free-Standing Surgical Facility, other licensed medical facility or in a doctor's office.
17. Hospital charges for use of a surgical room on an outpatient basis.
18. 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.
19. Maternity Services including those performed in a Birth Center.
20. Services and supplies for the diagnosis and treatment of involuntary infertility for females and males including artificial insemination.
21. Rental of Durable Medical Equipment as prescribed by a Physician for use in Your home (or an institution used as Your home). We also cover Durable Medical Equipment used during a covered stay in a hospital or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment. Coverage is limited to the standard item of equipment that adequately meets Your medical needs.

    The following items of Durable Medical Equipment do not require prior Confinement or receipt of an outpatient surgical procedure:
    a. Apnea Monitors for infants up to age 3 for a period not to exceed 6 months;
    b. Asthma Equipment for pediatric and adult asthmatics limited to the following:
        i. Spacers;
        ii. Peak-flow meters; or
        iii. Nebulizers
    c. Bilirubin Lights for infants up to age 3 for a period not to exceed 6 months;
    d. Oxygen and Equipment when your medical condition meets Medicare guidelines and is prescribed by a Physician. A Physician must certify the continued medical need for oxygen and equipment every 30 days;
    e. Continuous Positive Airway Pressure Equipment when your medical condition meets Medicare's guidelines and is prescribed by a Physician. A Physician must certify the continued medical need every 30 days.

    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.

We decide whether to rent or purchase the equipment, and We select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse. You must return the equipment to Us or pay Us the fair market price of the equipment when it is no longer prescribed.

22. Diabetes equipment, supplies, and other outpatient self-management training and education, when prescribed by a Physician, including: medical nutritional therapy for the treatment of insulin-dependent diabetes; insulin-using diabetes; gestational diabetes; non-insulin using diabetes; glucometers; or elevated blood glucose levels induced by pregnancy, including gestational diabetes. if prescribed by a health care professional legally authorized to prescribe such item. Diabetic supplies are limited to the following:
    a. Insulin;
    b. Blood/urine testing agents, including glucose tests tablets, glucose test tape, diabetic test strips and acetone test tablets.
    c. Disposable needles and syringes in quantities needed for injecting prescribed insulin.
23. Multidisciplinary Rehabilitative Services.
24. Physical therapy rendered by a certified physical therapist. To be eligible for coverage the therapy must be 1) progressive therapy (not maintenance therapy); 2) rendered according to the attending Physician's written treatment plan; 3) for a condition that the attending Physician determines is subject to significant improvement in the level of functioning within 60 days; and 4) completed by the Covered Person as prescribed. As used in this provision "maintenance therapy" means ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
25. Speech therapy rendered by a certified speech therapist or certified speech pathologist. To be eligible for coverage the speech disorder must be a result of an Injury or Sickness of specific organic origin. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within 60 days.
26. Habilitative services for medically necessary speech therapy, occupational therapy, and physical therapy that help a person keep, learn or improve skills and functioning for daily living, including but not limited to, applied behavioral analysis for the treatment of autism spectrum disorder. Habilitative services delivered through early intervention or school services are not covered.
27. Occupational therapy rendered by a certified occupational therapist. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. To be eligible for coverage the therapy must be progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan for a condition that the attending Physician determines is subject to significant improvement within 60 days. As used in this provision "maintenance therapy" is defined as ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
28. Respiratory therapy rendered by a certified respiratory therapist. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within 60 days and may not be maintenance therapy.
29. Rehabilitation services while confined in a Hospital or any other licensed medical facility. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program including those provided in a Comprehensive Rehabilitation Facility. To be eligible for coverage the therapy must be: 1) progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan for a condition that the attending Physician determines is subject to significant improvement within 60 days. As used in this provision, "maintenance therapy" is defined as ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
30. Treatment, services, or supplies covered under the Group Policy if received as an inpatient or outpatient in a Hospital, other Non-hospital Residential Facility or an Outpatient Treatment Facility in connection with Clinically Significant Mental Illness. This includes treatment or services rendered according to a prescribed treatment plan by a state regulated, board-certified Social Worker, or certified marriage and family therapist.

Inpatient services, outpatient services, or any combination thereof, must be certified as necessary by a Physician, Psychologist, Advanced Practice Registered Nurse, or Social Worker. All Coverage for Mental Illness is subject to the limitations set forth in the Schedule of Coverage.

31. Treatment, services, or supplies covered under the Group Policy if received as an inpatient or outpatient in a Hospital, Non-hospital Residential Facility or Outpatient Treatment Facility, according to a prescribed treatment plan in connection with Clinically Significant substance abuse, the disorders of which are identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association. For purposes hereof, "substance abuse" means: a) Alcohol Abuse; and b) Drug Abuse. Inpatient services, outpatient services, or any combination thereof, must be certified as necessary by a Physician, Psychologist, Advanced Practice Registered Nurse, or Social Worker. Two days of partial hospitalization may be substituted for 1 inpatient day. Medical complications of alcoholism, which include, but are not limited to: a) cirrhosis of the liver; b) gastrointestinal bleeding; c) pneumonia; and d) delirium tremens are otherwise covered under the plan. All coverage for substance abuse is subject to the limitations set forth in the Schedule of Coverage.
32. Detoxification in a hospital or related institution, subject to the level of benefits set forth in the Schedule of Coverage.
33. Blood, blood products and its derivatives and components, the collection and storage of autologous blood for elective surgery, and as well as cord blood procurement and storage. In addition, benefits will be payable for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center. Covered services will not include directed blood donations.
34. Inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending physician in consultation with the patient. If the period of stay if less than forty-eight (48) hours, then coverage will include:
    a. one home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and
    b. an additional home visit if prescribed by the patient's attending physician
35. Allergy testing and treatment, services, materials and serums.
36. Musculoskeletal Therapy
37. Cardiac Rehabilitation
38. Pulmonary Rehabilitation
39. Dialysis
40. Urgent Care
41. Sleep Studies
42. Sleep Labs
43. Reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast. Coverage also includes prostheses and physical complications, including lymphedes.
44. Vision services, including routine exams from an optometrists or ophthalmologist, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses.
45. Special contact lenses for aniridia for adults age 19 and over. Coverage is limited to up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris)
46. Prosthetics. Coverage will include fitting and adjustment of these devices, repair or replacement, and services and supplies to determine whether you need the prosthetic. Covered Services will be limited to the standard device that adequately meets your medical needs. Coverage will include internally implanted and external Breast Prosthetics following a mastectomy. Breast Prosthetics will also be provided for the non-diseased breast to achieve symmetry with the diseased breast.

47. Orthotic Devices. Coverage will include rigid and semi-rigid external Orthotic Devices that are used for the purpose of supporting a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured part of the body. Examples of covered Orthotic Devices include, but are not limited to leg, arm, back and neck braces.
48. Covered services rendered as part of an approved Clinical Trial.
49. Other services or treatment approved through the Medical Review Program.
50. Diagnostic and surgical treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.
51. Hospice Care is limited to:
    a. Nursing care;
    b. Physical, speech or occupational therapy;
    c. Medical social services;
    d. Services of home health aides and homemakers;
    e. Medical supplies, drugs and appliances;
    f. Physician services;
    g. Short-term inpatient care, including respite care and care for pain control and acute and chronic symptom management;
    h. Palliative drugs in accord with our preferred drug formulary listing;
    i. Counseling and bereavement services.

    Hospice Care benefit is provided in lieu of continued hospitalization.

52. Diagnosis and treatment of Morbid Obesity, including Bariatric surgery methods that are recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity.
53. 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.
54. Medical Nutrition Therapy and Counseling. Medically necessary nutritional counseling provided by a licensed dietician-nutritionist, physician assistant or nurse practitioner for an individual at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition.
55. Medically Necessary early intervention services related to speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices for Dependents, from birth to age three, who were born with congenital birth defects, and who are eligible for Services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Early intervention services are Medically Necessary when such services are designed to help a Dependent attain or retain the capability to function age-appropriately within his or her environment, and shall include services that enhance functional ability without affecting a cure. Benefits payable are limited to $5,000 per Dependent per Policy Year. These Services are provided in addition to the Physical, Occupational, Speech Therapy and Multidisciplinary Rehabilitation Services described in this Certificate of Insurance.
56. Inpatient and outpatient services arising from orthodontics, oral surgery and otologic, audiological and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.
57. Anesthesia for dental services, limited to general anesthesia and Hospital or outpatient surgery facility charges for outpatient surgical procedures for dental care provided to a Covered Person who is determined by a licensed dentist, in consultation with the Covered Person's treating Physician, to require general anesthesia and admission to a Hospital or outpatient surgery facility to effectively and safely provide dental care. For the purpose of this Covered Service, a determination of medical necessity will include but not be limited to a consideration of whether the age, physical condition or mental condition of the Covered Person or mental condition of the Covered Person requires the utilization of general anesthesia and the admission to a Hospital

or outpatient surgery facility to safely provide the underlying dental care. This provision does not provide coverage for any dental procedure or the professional fees or services of the dentist.

58. Accidental Dental Injuries are limited to restorative services necessary to promptly repair, but not replace, Sound Natural Teeth that have been injured as the result of an external force. For benefits to be payable all of the following conditions must be met:
    a. 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;
    b. The injury was sustained to sound natural teeth;
    c. The Covered Services must begin within 60 days of the injury;
    d. The Covered Services are provided during the 12 consecutive month period commencing from the date that the injury occurred.

    Benefits are limited to the most cost-effective procedure available that would produce the most satisfactory result.

    For purposes of this benefit, Sound Natural Teeth are defined as tooth or teeth that:
    a. Have not been weakened by existing dental pathology such as decay or periodontal disease;
    b. Have not been previously restored by a crown, inlay, onlay, porcelain restoration, or treatment by endodontics.

    Restorative Services will not include:
    a. Services provided after 12 months from the date the injury occurred; and
    b. Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Participating Provider, restoration is impossible.

59. Artificial insemination
60. Physician services, including diagnosis, consultation and treatment appropriately provided via Telehealth. Telehealth shall be subject to the same Deductible, Coinsurance and/or Copayments as are otherwise applicable to Physician office visits, except maternity related ACA preventive care services.
61. Transgender benefit includes sexual reassignment surgery and mastectomy/chest reconstruction services, in addition to behavioral health and hormone therapy services to treat a diagnosis of gender dysphoria. Medical necessity of sexual reassignment services will be determined in accordance with the World Professional Association for Transgender Health Standards of Care ("WPATH Standards"). Covered services will include the following Medically Necessary services if the surgery is pre-certified and the member participates in case management: a) Pre-surgery consultations and post-surgery follow-up exams; b) Outpatient surgery and other outpatient procedures; and c) Hospital inpatient care (including room and board, imaging, laboratory, special procedures, drugs, and Physician services).
62. Routine foot care limited to medically necessary treatment of patients with diabetes or other vascular disease.
63. Surgery to correct temporomandibular joint (TMJ) pain dysfunction syndrome that is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part.
64. Removable appliances for TMJ repositioning

Pediatric Vision (children up to the end of the month the child turns age 19)

Exams

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

Eyewear

The following eyewear is covered:

1) Lenses
    a. Single vision
    b. Conventional (Lined) Bifocal

Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal). Polycarbonate lenses are covered in full. All lenses include scratch resistant coating.

2) Eyeglass frames -non-deluxe (designer) frames
3) Contact lenses including evaluation, fitting, or follow-up care relating to contact lenses
4) Medically necessary contact lenses in lieu of other eyewear for the following conditions:
   a. Keratoconus,
   b. Pathological Myopia,
   c. Aphakia,
   d. Anisometropia,
   e. Aniseikonia,
   f. Aniridia,
   g. Corneal Disorders,
   h. Post-traumatic Disorders,
   i. Irregular Astigmatism.

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

Preventive 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:

The following preventive services are covered under this Group Policy as required by the Patient Protection Affordable Care Act (PPACA) and are not subject to Deductibles, Copayments or Coinsurance as described in the Schedule of Coverage.

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 visit including preconception counseling and routine prenatal 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 in accordance with the latest screening guidelines issued by the American Cancer Society (including adjuvant breast cancer screening, including MRI ultrasound screening or molecular breast imagining of the breast if: a mammogram demonstrates a Class C or D breast density classification or if a woman is believed to be at an increased risk for cancer).
5. Cervical cancer and dysplasia screening including Human Papillomavirus Screening (HPV)
6. Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy. This includes anesthesia required for colonoscopies, pathology for biopsies resulting from a screening colonoscopy, and a specialist consultation visit prior to the procedure.
7. Diagnostic examination which shall include a digital rectal exam and a blood test called the prostate-specific antigen (PSA) test:
   a. For men who are between 40 and 75 years of age;

b. When used for the purpose of guiding patient management in monitoring the
c. response to prostate cancer treatment;
d. When used for staging in determining the need for a bone scan in patients with
e. prostate cancer; or
f. When used for male patients who are at high risk for prostate cancer.

This coverage does not cover the surgical and other procedures known as radical prostatectomy, external beam radiation therapy, radiation seed implants, or combined hormonal therapy.

8. Depression screening
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 diabetes screening
11. Hepatitis B and Hepatitis C virus infection screening
12. Hematocrit or Hemoglobin screening in children
13. High blood pressure screening
14. Lead Screening
15. Lipid disorders screening
16. Lung cancer screening with low-dose computed tomography in adults who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
17. Newborn congenital hypothyroidism screening
18. Newborn hearing loss screening
19. Newborn metabolic/hemoglobin screening
20. Newborn sickle cell disease screening
21. Newborn Phenylketonuria screening
22. Obesity screening and management
23. Osteoporosis screening
24. Pre-eclampsia screening with blood pressure measurements throughout pregnancy
25. Rh (D) incompatibility screening for pregnant women
26. Sexually transmitted infection screening such as chlamydia, gonorrhea, syphilis and HIV screening
27. Type 2 diabetes mellitus screening
28. Tuberculin (TB) Testing
29. Urinary incontinence screening in women
30. Visual impairment in children screening
31. Emergency Department HIV screening test
32. High-risk human papillomavirus (HPV) DNA testing every three years for women age 30 years or older with normal cytology results.

Health Promotion

1. Alcohol and drug misuse assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse
2. Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease
3. Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children
4. 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 are also covered for individuals who are not pregnant
5. Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and BRCA mutation testing
6. Sexually transmitted infections counseling

7. Discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention and when prescribed by a physician for asymptomatic women, with an increased risk of breast cancer and no history of breast cancer, the risk reducing medication such as aromatase inhibitors, tamoxifen and raloxifene.
8. When prescribed by a licensed health care professional authorized to prescribe drugs:
   a) aspirin in the prevention of cardiovascular disease and preeclampsia in pregnant women.
   b) iron supplementation for children from 6 months to 12 months of age.
   c) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
   d) topical fluoride varnish treatments applied in a primary care setting by primary care Providers, within the scope of their licensure, for the prevention of dental caries in children
   e) folic acid supplementation for women planning or capable of pregnancy for the prevention of neural tube defects.
   f) Vitamin D to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls
9. Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and counseling by a Provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the post-partum period, and the purchase of a breast pump. A manual breast pump is one that does not require a power source to operate. In lieu of purchase of a manual breast pump, rental of 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.
10. All prescribed FDA-approved contraceptive methods for women with reproductive capacity, including but not limited to drugs, cervical caps, vaginal rings, continuous or extended oral contraceptives and patches. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, female sterilization procedures, follow-up and management of side effects; counseling for continued adherence, device removal and patient education and counseling. Over the counter FDA approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs.
11. Screening and counseling for interpersonal and domestic violence.
12. 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.
13. Low-to-moderate dose statins for adults without a history of cardiovascular disease (CVD) who meet the USPSTF criteria.
14. Counseling of young adults, adolescents, children and parents of young children, children, adolescents, and young adults aged 6 months to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce their risk for skin cancer.
15. Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.

Disease Prevention

1. Immunizations as recommended by the Centers for Disease Control and HRSA.
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. Pre exposure prophylaxis (PrEP) effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

Exclusions for Preventive Care

The following services are not covered as Preventive Care:

- Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases
- 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 Policy 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 Patient Protection Affordable Care Act for which cost share does not apply, please call: 1-800-392-8649. 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 the Preventive Exams and Services benefit but are Covered Services elsewhere in this General Benefits section:

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

Other Preventive Care

This Benefit section contains preventive care not required by the Patient Protection and Affordable Care Act. These preventive care services are not subject to the Medical Necessity requirement but are subject to the Deductible and coinsurance requirements unless otherwise stated below or in the Schedule of Coverage. In the event of a duplication of benefits, duplicate benefits will not be paid but the higher of the applicable benefits will apply.

1. Adult routine physical examinations. Covered Services at each examination are limited to: a) examination; and b) history. Any X-rays or laboratory tests ordered in connection with the examination will be subject to your plan's Deductibles, Copayments, and/or Coinsurance requirements as set forth in the Schedule of Insurance;
2. Other identified labs and screenings. The following services and items are treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
   a) Hemoglobin A1C testing for individuals diagnosed with diabetes.
   b) Retinopathy Screening for individuals diagnosed with diabetes.
   c) Low Density Lipo-Protein testing for individuals diagnosed with heart disease.
   d) International Normalized Ratio (INR) testing for individuals diagnosed with liver disease of bleeding disorders.
3. Double contrast barium enema as an alternative to colonoscopy;
4. Family planning limited to:
   a) The charge of a Physician for consultation concerning the family planning alternatives available to a male Covered Person, including any related diagnostic tests;
   b) Vasectomies;
   c) Services and supplies for diagnosis and treatment of involuntary infertility for females and males unless otherwise excluded, and;
   d) Voluntary termination of pregnancy.

   Benefits payable for diagnostic procedures will be covered on the same basis as a Sickness. Additional family planning benefits under PPACA are listed under Preventive Services.

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

a) The cost of donor semen and donor eggs including retrieval of eggs;
b) Storage and freezing of eggs and/or sperm;
c) Services to reverse voluntary, surgically induced infertility;
d) Services other than artificial insemination, related to conception by artificial means, including, but not limited to, in vitro fertilization, gamete intrafallopian tube transfer; ovum transplant; zygote intrafallopian transfer, and prescription drugs related to such services.
e) Other assistive reproductive technologies;
f) Diagnostic procedures;
g) Treatment or any infertility diagnosis services.

5. Iron deficiency anemia screening for pregnant women

Extension of Benefits

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

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

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

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

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.

Benefits for Inpatient Maternity Care

Hospital Confinements in connection with childbirth for the mother or newborn child will not be limited to less than 48 hours following normal vaginal delivery and not less than 96 hours following a Caesarean section, unless, after consultation with the mother, the attending Provider discharges the mother or newborn earlier.

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.

For stays shorter than 48 hours following normal vaginal delivery and 96 hours following a Caesarean section, one home visit within 24 hours of hospital discharge will be scheduled, and an additional home visit if prescribed by the attending physician.

Coverage for additional hospitalization, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, will be provided for the newborn up to 4 days.

GENERAL LIMITATIONS AND EXCLUSIONS

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

1. Charges for services approved by or reimbursed by Health Plan.
2. Charges in excess of the Maximum Allowable Charge.
3. Charges for non-Emergency Care in an Emergency Care setting to the extent that they exceed charges that would have been incurred for the same treatment in a non-Emergency Care setting. Final determination as to whether services were rendered in connection with an emergency will rest solely with KPIC.
4. Weekend admission charges for non-Emergency Care Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
5. Confinement, treatment, services or supplies not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically set forth in this Certificate as a Covered Service.
6. Confinement, treatment, services or supplies received outside the United States, if such confinement, treatment, services or supplies are of the type and nature that are not available in the United States.
7. Injury or Sickness for which benefits are payable under any state or federal workers' compensation, employer's liability, occupational disease or similar law, or any motor vehicle no-fault law.
8. Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third party coverage.
9. 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.
10. Services for military service related conditions regardless of service in any country or international organization.
11. 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.
12. 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
13. Dental care and treatment, dental x-rays, dental appliances; orthodontia; and dental surgery. This exclusion includes, but is not limited to: services to correct malocclusion; extraction of wisdom teeth (third molars); injury to teeth resulting from chewing; Dental appliances; dental implants; orthodontics; dental services associated with medical treatment.
14. 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 services that: a) will correct significant disfigurement resulting from a non-congenital Injury or Medically Necessary surgery; or b) are incidental to a covered mastectomy; or c) are necessary for treatment of a form of congenital hemangioma known as port wine stains.
15. Non-prescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician.
16. Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This means that one of the following is applicable:
    a. The service is not recognized as efficacious as the term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technology that is current when care is rendered; or
    b. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

    Experimental or investigational procedures do not include Clinical Trials.

17. Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems. This applies whether or not the services are associated with manifest Mental Illness or other disturbances.

18. Confinement, treatment, services or supplies that are required: a) by a court of law; or b) for insurance, travel, employment, school, camp, government licensing, or similar purposes.
19. Personal comfort items such as telephone, radio, television, or grooming services.
20. 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.
21. 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.
22. Routine foot care except as set forth under the Covered Services.
23. Confinement or services that are not Medically Necessary or treatment that is not completed in accordance with the attending Physician's orders.
24. Services of a private duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility, or in the Covered Person's home;
25. 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.
26. Living expenses or transportation, except as provided under Covered Services.
27. Reversal of sterilization.
28. Services provided in the home other than Covered Services provided through a Home Health Care Agency.
29. Maintenance therapy for rehabilitation.
30. The following Home Health Care Services:
    a. treatment of Mental Illness and substance abuse disorders,
    b. meals,
    c. personal comfort items,
    d. housekeeping services.
31. 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.
32. Services in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Covered Person who is a surrogate.
33. 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.
34. Biofeedback or hypnotherapy.
35. Health education, including but not limited to: a) stress reduction; b) smoking cessation; c) weight reduction; or d) the services of a dietitian. This exclusion will not apply to treatment of Morbid Obesity.
36. Hearing exams; hearing therapy; or hearing aids. This exclusion includes hearing exams to determine appropriate hearing aid, as well as hearing aids or tests to determine their efficacy. Internally implanted hearing aids are also excluded. This exclusion does not apply to newborn hearing screenings.
37. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
38. Services for which no charge is normally made in the absence of insurance.
39. Purchases of Durable Medical Equipment. 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.
40. Rehabilitation services while confined in a Hospital or any other licensed medical facility.
41. Transplants, including acquisition and/or donor costs.
42. Acupuncture.
43. Chiropractic Services, unless otherwise elected by the Policyholder as an optional benefit offered under the Group Policy and set forth on the Schedule of Coverage.

44. Treatment for in vitro fertilization such as: a) gamete intrafallopian tube transfer; b) ovum transplants; c) zygote intrafallopian transfer; d) cryogenic or other preservation techniques used in these or similar techniques.
45. Family planning services except as a limited benefit as set forth in the General Benefit section of this Certificate;
46. Treatment of craniomandibular, myofascial pain and temporomandibular joint disorders. Coverage is limited to medically necessary surgical treatment only.
47. Second medical opinion, except when required under the Medical Review Program.
48. Treatment of infertility limited to artificial insemination.
49. Early Intervention Services shall not include services provided through federal, state or local early intervention programs, including school programs.
50. Outpatient Prescription Drugs, unless otherwise elected by the Policyholder as an optional benefit offered under the Group Policy and set forth on the Schedule of Coverage.
51. Cardiac Rehabilitation, except as a limited benefit as set forth in the Schedule of Coverage for Covered Persons with: a) history of acute myocardial infarction; b) surgery for coronary artery bypass; c) percutaneous therapeutic coronary artery intervention; d) heart or heart/lung transplant; or e) repair or replacement of a heart valve.

OPTIONAL OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

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

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 Plan; 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; and e) do not exceed: an amount equal to 150 percent of the average wholesale price of the ingredients contained in the prescription, plus a dispensing fee. The part of a charge that does not exceed this limit will not be considered a Covered Charge.

Covered outpatient prescription drugs may be subject to certain utilization management protocols such as prior authorization and step therapy described below in this section. Refer to the Formulary for a complete list of medications requiring prior authorization or step therapy protocols. The most current Formulary can be obtained by visiting: kp.org/formulary.

Outpatient Prescription Drugs Covered

Charges for the items listed below are also considered Covered Charges. Except as specifically stated below, such Covered Charges are subject to the Outpatient Prescription Drug Benefit Percentage Payable and may be subject to Precertification. Please refer to the section entitled **PRECERTIFICATION** for complete details.

1. Prescription drugs listed as Generic Drugs;
2. Prescription drugs listed as Preferred and Non-Preferred Brand Drugs;
3. Internally implanted time release medications;
4. Insulin and the following diabetic supplies:
   a. syringes and needles
   b. blood glucose and ketone test strips or tablets and glucose ketone test strips or tablets
5. Compounded dermatological preparations which must be prepared by a pharmacist in accord with a Physician's prescription;
6. Antacids;
7. Up to a 90-day supply of a Maintenance Drug in a single dispensing of the prescription.
8. Oral or nasal inhalers. The standard prescription amount for oral and nasal inhalers is the smallest standard package unit.
9. Compounded dermatological preparations which must be prepared by a pharmacist;
10. Spacer devices;
11. Migraine medications, including injectables. The standard prescription amount for migraine medications is the smallest package size available.
12. Opthalmic, optic and topical medications. The standard prescription amount for opthalmic, optic and topical medications is the smallest package available.
13. Any contraceptive drug or device that is approved by the United States Food and Drug Administration (FDA).
14. Hormone Replacement Therapy prescribed for treating symptoms and conditions of menopause.
15. Oral chemotherapy medication.

OPTIONAL OUTPATIENT PRESCRIPTION DRUGS BENEFITS, LIMITATIONS, AND EXCLUSIONS

Outpatient Prescription Drugs Limitations and Exclusions

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

1. All office injectable drugs (except insulin and migraine).
2. Administration of a drug or medicine.
3. Any drug or medicine administered as Necessary Services and Supplies. (See the General Definitions section.)
4. Drugs not approved by the Federal Drug Administration (FDA).
5. Drugs and injectables for the treatment of sexual dysfunction disorders.
6. Drugs or injectables for the treatment of involuntary infertility.
7. Drugs and injectables for the treatment of cosmetic services.
8. Drugs and injectables for the treatment of obesity, except as otherwise required to treat Morbid Obesity;
9. Replacement of lost or damaged drugs and accessories.
10. Experimental Drugs and Medicines. This exclusion will not apply if such experimental or investigational drug, device or procedure, as certified by the Physician is the only procedure, drug or device medically appropriate to the Covered Person's condition. In addition, this exclusion will not apply to routine patient care costs related to Clinical Trial if the Covered Person's treating Physician recommends participation in the Clinical Trial after determining that participation in such Controlled Clinical Trial has a meaningful potential to benefit the Covered Person.
11. All Biotechnology drugs and diagnostic agents, except as stated in the General Exclusions section, if any.
12. Drugs associated with non-covered services;
13. Infant formulas, except for amino acid-modified products used to treat congenital errors of amino acid metabolism. Such coverage for formula and special food products are limited to the extent that the cost of such formulas or special food products exceed the cost of a normal diet;
14. Human Growth Hormone (HGH), except for children with either Turner's syndrome or with classical growth hormone deficiency; and
15. Anorectic Drugs (any drug used for the purpose of weight loss unless prescribed in the treatment of morbid obesity.

Direct Member Reimbursement

If you purchased a covered medication without the use of your identification card or at a Non-Participating Pharmacy, and paid full price for your prescription, you may request a direct member reimbursement.

To submit a claim for direct member reimbursement you may access the direct member reimbursement form via www.MedImpact.com. For assistance you may call the MedImpact Customer Contact Center 24 hours a day 7 days a week at 1- 800-788-2949 or email via customerservice@medimpact.com.

OPTIONAL BENEFITS, LIMITATIONS, AND EXCLUSIONS

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

1. Chiropractic Services rendered by a Physician for chronic pain management or chronic illness management. Chiropractic Services shall be limited to musculoskeletal therapy involving manual manipulation of the spine to correct subluxation.

FEDERAL CONTINUATION OF COVERAGE PROVISIONS

This section only applies to Participating Employers who are subject to Public Law 99-271 (COBRA)
You or a covered Dependent may have a right to have health coverage continued under the Policy when coverage terminates under the provisions of the Policy. Continued coverage will be: (A) available only to those Covered Persons who qualify at the time a qualifying event occurs; and (B) subject to the terms and conditions of the Policy.

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

Qualifying Events

A. If Your health insurance coverage ends due to (1) termination of employment; or (2) a reduction in hours, You may continue health coverage under the policy for the continuation of coverage period. The right to continue coverage under this provision will not be allowed if KPIC is informed by the employer that Your employment was terminated due to gross misconduct.

B. If Your Dependent's insurance coverage ends due to: (1) Your death; (2) Your legal divorce or legal separation from Your spouse; or (3) Your child reaching the limiting age for a Dependent, the terminated Dependent has the option to continue health coverage under the policy for the continuation of coverage period.

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

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

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

Continuation of Coverage Period

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

1. 18 months following qualifying event (1) except if a qualifying event (2) 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 (2) had occurred.
   b) if You died before the occurrence of a qualifying event (3), Your surviving spouse is entitled to lifetime coverage.
4. the end of a 36-month period following an event described in qualifying event (4), 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 (3) 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.

FEDERAL CONTINUATION OF COVERAGE PROVISIONS

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

Extension for Disabled Covered Persons

If Social Security, under its rules, determines that a Covered Person was disabled when a qualifying event set forth in "2" 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.

STATE CONTINUATION OF COVERAGE PROVISIONS

Eligibility

A former employee who: a) worked for an employer for at least five years prior to the date of termination of employment; b) is 60 years of age or older on the date employment ends, c) and is entitled to and so elects to continue benefits under COBRA for himself or herself and for any spouse, may further continue benefits for himself or herself and for any spouse beyond the date coverage under COBRA ends. (See the "FEDERAL CONTINUATION OF HEALTH INSURANCE (COBRA)" section of Your Certificate.)

Electing this State Continuation

It is the responsibility of the former employer to notify the former employee or spouse of the availability of this continuation. To elect this continuation, the individual must notify KPIC in writing within 30 days prior to the date continuation coverage under COBRA is scheduled to end.

Individuals not eligible for continuation under COBRA, whichever is applicable, are not eligible for this continuation. Also, individuals who are eligible for COBRA but have not elected or exhausted the continuation coverage provided under COBRA are not entitled to coverage under this provision.

Termination of this State Continuation

This continuation coverage shall end automatically on the earlier of:

1. the date the individual reaches age 65;
2. the date the individual is covered under any group plan not maintained by the former employer, or any other insurer or health care service plan, regardless of whether that coverage is less valuable
3. the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act;
4. for a spouse, five years from the date the spouse's continuation of coverage under COBRA was scheduled to end; or
5. the date on which the former employer terminates its group contract with KPIC and ceases to provide coverage for any active employees through KPIC, in which case the former employee or spouse or both may apply for coverage under a conversion policy through KPIC. (See the "CONVERSION" section of this Certificate.)
6. the date required premiums are not submitted to KPIC under the terms of the Group Policy.

Benefits and Premium Under this State Continuation

The benefits under this continuation will not differ from those provided under the COBRA continuation.

If the rates charged to the former employer by KPIC are age-specific, the premium charged for the former employee will not exceed 102% of the premium charged by KPIC to the employer for an employee of the same age as the former employee electing this continuation for those individuals who were eligible for COBRA.

If the rates charged to the former employer by KPIC are not adjusted for age, the rate for this continuation of coverage shall not exceed 213% of the applicable current group rate.

"Applicable current group rate" is the total premiums charged by KPIC for coverage of the group divided by the relevant number of covered persons, with no consideration of the claims experience of the former employee or any spouse.

COORDINATION OF BENEFITS

Application

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

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

Order of Benefit Determination Rules

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

1. General: A Plan that does not coordinate with other Plans is always the primary Plan.
2. Non-dependent\Dependent: The benefits of the Plan which covers the person as a Covered Person, or subscriber (other than a Dependent) is the primary Plan; the Plan which covers the person as a Dependent is the secondary Plan.
3. Dependent Child--Parents Not Separated or Divorced: When This Plan and another Plan cover the same child as a Dependent of different parents, benefits for the child are determined as follows:
   a) the primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The secondary Plan is the Plan of the parent whose birthday falls later in the year.
   b) if both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the primary Plan; the Plan, which covered the parent the shorter time, is the secondary Plan.
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) the Plan covering the custodial parent;
   b) the Plan covering the custodial parent's spouse;
   c) the Plan of the parent covering the non-custodial parent, and then
   d) the Plan covering the non-custodial parent's spouse.

   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 Policy Year during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the Provider, if the custodial parent so requests.

5. Active/Inactive Service: The primary Plan is the Plan, which covers the person as a Covered Person who is neither laid off nor retired (or as that employee's Dependent). The secondary Plan is the Plan, which covers that person as a laid off or retired Covered Person (or as that Covered Person's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
6. Longer/Shorter Length Of Coverage: If none of the above rules determines the order of benefits. the primary Plan is the Plan, which covered a Covered Person, or subscriber the longer time. The secondary Plan is the Plan, which covered that person the shorter time.

COORDINATION OF BENEFITS

Effect of Medicare
This Plan will be primary to Medicare for an active employee and Dependent spouse of such active employee. This Plan will not be primary to Medicare if the Covered Person is eligible for Medicare as primary. 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.

Effect of No-fault Auto Coverage
No-fault auto coverage is considered the primary Plan.

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

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.

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.

COORDINATION OF BENEFITS

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

1. This Plan.
2. Any group, blanket, or franchise health insurance.
3. A group contractual prepayment or indemnity plan.
4. A health maintenance organization (HMO), whether a group practice or individual practice association.
5. A labor-management trustee plan or a union welfare plan.
6. An employer or multi-employer plan or employee benefit plan.
7. A government program.
8. Insurance required or provided by statute.

Plan does not include any:

1. Individual or family policies or contracts, except no-fault auto coverage.
2. Public medical assistance programs.
3. Group or group-type Hospital indemnity benefits of $100 per day or less.
4. School accident-type coverages.

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.

Closed Panel Plan means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other Providers, except in the cases of emergency or referral by a panel Covered Person.

- If the primary plan is a closed panel plan with no Out-of-Network benefits and the secondary plan is not a closed panel plan, the secondary plan must pay or provide benefits as if it were primary when no benefits are available from the primary plan because the covered person used a non-panel Provider, except for emergency services that are paid or provided by the primary plan
- If, however, the two plans are closed panels, the two plans will coordinate benefits for services that are covered services for both plans, including emergency services, authorized referrals, or services from Providers that are participating in both plans. There is no COB if there is no covered benefit under either plan.

GENERAL PROVISIONS

All claims under This Plan will be administered by:

NTT DATA Services, LLC
2300 West Plano Parkway
Plano, Texas 75075

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

Participating Provider claims
If You receive services from a Participating Provider, that Provider will file the claims on Your behalf. Benefits will be paid to the Provider. You need pay only Your deductible and Percentage Payable or Co-payment.

For Non-Participating 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.

Notice of Claims
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 account number shown in Your Schedule of Coverage. The notice should be mailed to Us at Our mailing address or to Our Administrator.

Kaiser Permanente Insurance Company
P.O. Box 201130
Plano, TX 75026
Fax: 1-972-767-3950

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

Proof of Loss
Written proof of loss must be sent to Us at the address shown on the preceding page or Our Administrator 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 time proof is otherwise required, except in the absence of legal capacity.

"Proof of Loss" means sufficient information to allow KPIC 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.

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.

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

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

Contested Claims
If KPIC is unable to pay Your claim after receiving proper Proof of Loss, KPIC will notify You of any contest to or denial of the claim within 30 working days of the date the Proof of Loss was received by KPIC. The written notice will specify:
1. The parts of the claim that are being contested or denied;
2. The reasons the claim is being contested or denied; and
3. the pertinent provisions of the Group Policy on which the contest or denial is based.

If the Covered Person is dissatisfied with the result of the review, the Covered Person may request reconsideration. The request must be in writing and filed with KPIC's Administrator at the address specified above.

The request for reconsideration shall be filed in writing within 60 days after the notice of denial is received. A written decision on reconsideration will be issued within 60 days after KPIC's Administrator receives the request for reconsideration, unless the Covered Person is notified that additional time is required, but in no event later than 120 days from the time KPIC's Administrator receives the request.

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.

Rights of a Custodial Parent
If the parents of a covered Dependent child are:
1. divorced or legally separated; and
2. subject to the same Order,

The custodial parent will have the rights stated below without the approval of the non-custodial parent. However, for this provision to apply the non-custodial parent must be a Covered Person approved for family health coverage under the Policy, and KPIC must receive:
1. a request from the custodial parent who is not a Covered Person under the policy; and
2. a copy of the Order.

If all of these conditions have been met, KPIC will:
1. provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Policy;
2. accept claim forms and requests for claim payment from the custodial parent; and
3. make claim payments directly to the custodial parent for claims submitted by the custodial parent, subject to all the provisions stated in the Policy. Payment of claims to the custodial parent, which are made in good faith under this provision, will fully discharge KPIC's obligations under the Policy to the extent of the payment.

KPIC will continue to comply with the terms of the Order until We determine that:
1. the Order is no longer valid;
2. the Dependent child has become covered under other health insurance or health coverage;
3. in the case of employer-provided coverage, the employer has stopped providing family coverage for all employees; or
4. the Dependent child is no longer a Covered Person under the Policy.

"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.

Time Limitations
If any time limitation provided in the plan for giving notice of claims, or for bringing any action at law or in equity, is less than that permitted by the applicable law, the time limitation provided in the plan is extended to agree with the minimum permitted by the applicable law.

Overpayment
KPIC will not withhold any portion of a claim payment on the basis that the sum withheld is an adjustment or correction for an overpayment made on a prior claim unless:
1. KPIC's files contain clear, documented evidence of an overpayment and written authorization from the claimant or assignee, if applicable, permitting such withholding procedure; or
2. KPIC's files contain clear, documented evidence of all of the following:
   a. The overpayment was erroneous under the provisions of the Policy;
   b. The error which resulted in the payment is not a mistake of the law;
   c. KPIC notifies the claimant within 6 months of the date of the error, except that in instances of errors prompted by representations or nondisclosure of claimants or third parties, KPIC notifies the claimant within 15 calendar days after the date of discovery of such error. For the purpose of this provision, the date of the error is the day on which the draft for benefits is issued; and
   d. such notice states clearly the cause of the error and the amount of the overpayment; however,
   e. the procedure set forth above will not be used if the overpayment is the subject of a reasonable dispute as to facts.

With each payment, KPIC will provide to the claimant and assignee, if any, an explanation of benefits which shall include, if applicable, the Provider's name or service covered, dates of service, and a clear explanation of the computation of benefits.

Assignment
Payment of benefits under the Group Policy for treatment or services that are not provided, prescribes or directed by a Health Plan Physician:
a. Are not assignable and thereby not binding on KPIC, unless previously approved by KPIC in writing;
b. Shall be made by KPIC, in its sole discretion, directly to the Provider or to the Insured Person on Insured Dependent or, in the case of the Insured Person's death, to his or her executor, administrator, Provider, spouse or relative.

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

Incontestability
Any statement made by the Policyholder or a Covered Person in applying for insurance under This Plan will be considered a representation and not a warranty. After This Plan has been in force for two years, its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement as determined by a court of competent jurisdiction. After a Covered Person's insurance has been in force for two years during his or her lifetime,

its validity cannot be contested due to misstatement other than a fraudulent misstatement. 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 Plan has been misstated: 1) premiums shall be adjusted to correspond to his or her true age; and 2) if benefits are affected by a change in age, benefits will be corrected accordingly (in which case the premium adjustment will take the correction into account).

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.

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

Continuation of Coverage during Layoff or Leave of Absence
If Your Active Service ends because of a disability, an approved leave of absence or layoff, You may be eligible to continue insurance for Yourself and Your Dependents up to a maximum of three months if Active Service ends because of disability or two months if it 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 Policyholder's written eligibility requirements, and this Group Policy 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.

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, deliver, or postpartum care in connection with that arrangement ("Surrogacy Health Services").

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 payment are characterized as being for medical services. To secure Our rights, We will also have a lien on those payments and on any escrow account, trust, or other account that holds those payments. 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 associated with the arrangement
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Surrogacy Health Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Surrogacy Health Services that the baby (or babies) receive
- A signed copy of any contacts and other documents explain the arrangement

- Any other information We request to satisfy Our rights

You must send this information to:

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

You must complete and send Us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Us to determine the existence of any right We may have under this Surrogacy Arrangement 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 shall be subject to Our liens and Our rights to the same extent as if You had asserted the claim against the third part. We may assign Our rights to enforce Our liens and other rights.

If You have questions about Your obligation under this provision, please contact Our Administrator at 1-800-392-8694.

ERISA CLAIMS AND APPEALS PROCEDURES

This section explains provisions for filing Claims and Appeals arising from decisions made regarding benefit Claims under Tier Two and Tier Three of your Kaiser Permanente Point of Service health coverage plan. For Claims and Appeals decisions regarding benefit claims under Tier One of Your Kaiser Permanente Point of Service health coverage plan, please refer to Your Evidence of Coverage.

This section contains the following:

- Definitions of Terms unique to this section
- General 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
  - 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, including but not limited to, reduction of benefits or a failure or refusal to cover an item or service resulting from a determination that an expense is:
   a) experimental or investigational;
   b) not Medically Necessary or appropriate.
2. terminate Your coverage retroactively except as the result of non-payment of premiums (also known as rescission), or
3. uphold Our previous Adverse Benefit Determination when You Appeal.

Appeal means a request for Us to review Our initial 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.

Language and Translation Assistance
If We send You an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then Your notice of Adverse Benefit Determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request language assistance with Your Claim and/or Appeal by calling 1 800-392-8649.

SPANISH (Español): Para obtener asistencia en Español, llame al. 1- 800-788-2949.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-2949

CHINESE (中文): 如果需要中文的帮助,请拨打这个号码 1-800-788-2949.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-2949.

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 Department address listed in the adverse determination notice you received. 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 any diagnosis and treatment codes and their meanings that are the subject of Your Claim. To make a request, You should contact the Department address listed in the adverse determination notice you received.

B. The Claims Process

There are several types of Claims, and each has a different procedure described below for sending Your Claim to Us as described in this section.

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

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

In addition, there are separate Appeals procedures for Adverse Benefit Determinations due to a retroactive termination of coverage (rescission). Please refer to the subsection **6) 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 contact the number listed on the back of your -ID Card, or You may write to the address to the Department address listed in the adverse determination notice you received.

1) Post-service Claims

Post-service Claims mean a Claim involving the payment or reimbursement of costs for medical care that has already been received.

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

NTT DATA Services, LLC
KPIC Grievance and Appeals
P.O. Box 261155
Plano, TX 75026
Telephone number 1-800-392-8694

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

- **Post-service Claim**
  - In accordance with the **Notice of Claim** subsection of this **CLAIMS AND APPEALS PROCEDURES** section, within 20 days after the date You received or paid for the Covered Services, or as soon as reasonably possible, You must mail Us a Notice of Claim for the Covered Services for which You are requesting payment. The Notice should contain the following: (1) the date You received the Covered Services, (2) where You received them, (3) who provided them, and (4) why You think We should pay for the Covered Services. You must include a copy of the bill and any supporting documents. Your letter and the related documents constitute Your Claim. You must mail the Notice to Our Administrator at:

    NTT DATA Services, LLC
    Kaiser Permanente Insurance Company (KPIC) – Claims Administrator
    P.O. Box 261155
    Plano, TX 75026

  - In accordance with the **Proof of Loss** subsection of this **CLAIMS AND APPEALS PROCEDURES** section, We will not accept or pay for claims received from you more than one year from the time proof is otherwise required, except in the absence of legal capacity.

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

  - If We deny Your Claim (if We do not agree to provide or pay for extending the ongoing course of treatment), please refer to subsection **C. The Internal Appeals Process** provision under this section for a detailed provision regarding the mandatory appeal rights. Likewise, Our Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding the mandatory appeal rights, including external review, that may be available to You.

Participating Provider Claims

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

ERISA CLAIMS AND APPEALS PROCEDURES

Notice of Claims
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.

NTT DATA Services, LLC
KPIC Grievance and Appeals
P.O. Box 261155
Plano, TX 75026

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

Proof of Loss
Written Proof of Loss must be sent to Us or to Our Administrator at the address shown above 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 time proof is otherwise required, 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.

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

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

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

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

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

Please refer to **C. 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.

Overpayment

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

1. KPIC's files contain clear, documented evidence of an overpayment and written authorization from the claimant or assignee, if applicable, permitting such withholding procedure; or
2. KPIC's files contain clear, documented evidence of all of the following:
   a) the overpayment was erroneous under the provisions of the Policy;
   b) the error which resulted in the payment is not a mistake of law;
   c) KPIC notifies the claimant within 6 months of the date of the error, except that in instances of errors prompted by representations or nondisclosure of claimants or third parties, KPIC notifies the claimant within 15 calendar days after the date of discovery of such error. For the purpose of this provision, the date of the error is the day on which the draft for benefits is issued; and
   d) such notice states clearly the cause of the error and the amount of the overpayment; however, the procedure set forth above will not be used if the overpayment is the subject of a reasonable dispute as to facts.

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

2) Pre-Service Claims

Pre-Service Claims means requests for approval of benefit(s) or treatment(s) where under the terms of the Group Policy, condition the receipt or provision of the benefit(s) or treatment(s), in whole or in part, on approval of the benefit(s) in advance of obtaining medical care. Pre-service claims can be either Urgent Care Claims or non-Urgent Care Claims. Failure to receive authorization before receiving a Covered Service that is subject to Pre-certification in order to be a covered benefit may be the basis of reduction of Your benefits or Our denial of Your Pre-service Claim or a Post-Service Claim for payment. If You receive any of the Covered Services You are requesting before We make Our decision, Your pre-service Claim or Appeal will become a post-service Claim or Appeal with respect to those Services. If You have any general questions about pre-service Claims or Appeals, please call our administrator at 1-888-567-6847.

Please refer to the **PRE-CERTIFICATION** section of this Certificate for a more detailed provision of the Pre-certification process.

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 pre-certify a benefit or treatment You have not yet received. Your request and any related documents You give Us constitute Your Claim. You must either mail Your Claim to Us or, fax Your Claim to Us at

Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

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

- We will review Your Claim and, if We have all the information We need, We will make a decision within a reasonable period of time but not later than 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 cover or pay for all the Covered Services You requested), please refer to subsection **C. The Internal Appeals Process** provision under this section for a detailed provision regarding the mandatory appeal rights. Likewise, Our Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding the mandatory appeal rights, including external review, that may be available to You

3) Concurrent Care Claims

Concurrent Care Claims means requests for authorization that We continue to cover or pay for an ongoing course of treatment for a Covered Service to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. Failure to receive authorization before continuing to receive treatment beyond the number of days or number of treatments initially authorized may be the basis of reduction of Your benefits. 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 Services. If You have any general questions about Concurrent Care Claims, please call 1-888-567-6847. Concurrent claims can be either Urgent Care Claims or Non-Urgent Care Claims.

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 **PRE-CERTIFICATION** section of this Certificate for a more detailed provision of the Pre-certification process.

Here are the procedures for filing a Concurrent Care Claim.

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

    Permanente Advantage
    Appeals Department
    5855 Copley Drive, Suite 250
    San Diego, CA 92111
    Telephone number: 1-888-567-6847
    Fax number: 1-866-338-0266

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

  - We will review Your Claim, and if We have all the information We need We will make a decision within a reasonable period of time. If You submitted Your Claim 24 hours or more before Your care is ending, We will make Our decision before Your authorized care actually ends. If Your authorized care ended before You submitted Your Claim, We will make Our decision but no later than 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 it all when We make Our decision. If We do not receive any of the requested information (including documents) within the stated timeframe after We send Our request, We will make a decision based on the information We have within the appropriate timeframe, not to exceed 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 Claim on an urgent basis, We will notify You of Our decision orally or in writing as soon as Your clinical condition requires, but not later than 24 hours after We received Your Appeal. If We notify You of Our decision orally, We will send You written confirmation within 3 days after receiving Your Claim.

  - If We deny Your Claim (if We do not agree to provide or pay for extending the ongoing course of treatment), please refer to subsection **C. The Internal Appeals Process** provision under this section for a detailed provision regarding the mandatory appeal rights. Likewise, Our Adverse Benefit Determination notice will

tell You why We denied Your claim and will include information regarding the mandatory appeal rights, including external review, that may be available to You.

C. 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. Such appeals will be subject to the following:

1. You may appeal a Denial any time, up to 180 days following the date You receive a notification of Denial;
2. Our review of Your appeal will not afford deference to the initial Denial. This review will be conducted by a committee comprised of individuals who are neither the person who made the initial Denial that is the subject of the appeal, nor the subordinate of such person;
3. In deciding an appeal of any Denial that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, We will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. In the case of a claim involving Urgent Care, We will provide for an expedited review process. You may request an expedited appeal of a Denial orally or in writing. All necessary information, including Our approval or Denial of the appeal, will be transmitted by telephone, facsimile, or other available and similarly expeditious method.

As a member of a group with health coverage insured by KPIC, Your internal appeals process includes a single mandatory level of appeal for Denials.

If We deny Your Claim (Post Service, Pre-Service or Concurrent Claims), in whole or in part, You have the right to request an Appeal of such decision. Our Denial notice will tell You why We denied Your claim and will include information regarding the mandatory appeal rights, including external review, that may be available to You.

We must receive Your Appeal within 180 days of Your receiving this notice of Our initial Denial. 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.

Our decision wil exhaust Your internal appeal rights with respect to that Denial. If You disagree with Our decision, You may have the right to request for an external review. For detailed information regarding Your right to an external review process, please refer to **L. External Review** under this section. To begin the internal appeal process, You must either mail Your Appeal to Us, or fax Your Appeal to Us at:

Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

Providing Additional Information Regarding Your Claim

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

Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111

Telephone number: 1-888-567-6847When You Appeal, You may give testimony in writing or by telephone. Please send Your written testimony to:

Kaiser Permanente Insurance Company
Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Telephone number: 1-888-567-6847

To arrange to give testimony by telephone, You should contact Kaiser Permanente Appeals Department at 1-877-847-7572.

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. Your must mail Your Appeal to:

  For Medical Claims:

  Kaiser Permanente Insurance Company (KPIC)
  Appeals Department
  PO Box 939001
  San Diego, CA 92193-9001
  Phone: 1-800-788-0710
  Fax: 1-855-414-2318

For Optional Prescription Drug:

Kaiser Permanente Insurance Company (KPIC)
ATTN: KPIC Operations
Grievance and Appeals Coordinator
1800 Harrison Street, 20th Floor
Oakland, CA 94612

- We will review your appeal as follows:
  - For Appeals involving medical claims- We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 15 days from the date that we receive your request for our review at that level unless we inform you otherwise in advance.
  - For Appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision 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) Non-Urgent Pre-Service Appeal

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

Permanente Advantage
Appeals Department
5855 Copley Drive, Suite 250
San Diego, CA 92111
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

- We will review your appeal as follows:
  - For Appeals involving medical claims - Because you have not yet received the services or equipment that You requested, we will review Your Appeal and send you a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 15 days from the date that we receive your request for our review at that level unless we inform you otherwise in advance.
  - For appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision 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) Urgent Pre-Service Appeal

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

  Permanente Advantage
  Appeals Department
  5855 Copley Drive, Suite 250
  San Diego, CA 92111
  Telephone number: 1-888-567-6847
  Fax number: 1-866-338-0266

- 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), 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 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 **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.

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 send Your Appeal to:

  Permanente Advantage
  Appeals Department
  5855 Copley Drive, Suite 250
  San Diego, CA 92111
  Telephone number: 1-888-567-6847
  Fax number: 1-866-338-0266

We will review your appeal as follows:

- For Appeals involving medical claims - We will review Your Appeal and send you a written decision of each level of your two level appeal process within a reasonable period of time appropriate to the circumstances, but in no event later than 15 days from the date that we receive your request for our review at that level unless we inform you otherwise in advance.

- For appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision 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.

  The notification will include the following information:
  1. The specific reason or reasons for the Denial;
  2. Reference to the specific provisions in the Group Policy on which the Denial was based;
  3. Your right to obtain reasonable access to, and copies of, all documents, records and other information relevant to Your Claim for Benefits;
  4. An explanation of any procedures for You to follow to request a voluntary level of appeal, if applicable;
  5. A statement of Your rights under section 502(a) of ERISA following a Denial on Your appeal;
  6. If any internal rule, guideline, protocol or other similar criterion was relied upon in making the Denial, an offer to provide the rule, guideline, protocol or similar criterion;
  7. If the Denial was based upon Medical Necessity, experimental treatment or similar exclusions or limitations, an offer to provide the specific basis for the Denial.

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 send your Appeal to:

  Permanente Advantage
  Appeals Department
  5855 Copley Drive, Suite 250
  San Diego, CA 92111
  Telephone number: 1-888-567-6847
  Fax number: 1-866-338-0266

- 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 **D. 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 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 write to:

Kaiser Permanente Insurance Company
Grievance and Appeals (level 2)
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

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 either mail or fax Your Appeal to:

Kaiser Permanente Insurance Company
Grievance and Appeals
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

- 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 **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.

Help With Your Appeal

You may contact the state ombudsman:

Office of Health Care Ombudsman and Bill of Rights
Department of Health Care Finance
One Judiciary Square
441 4th St. N.W., 900 South

Washington, D.C. 20001
Phone number: (202) 724-7491
Toll Free: 1-877-685-6391
Fax number: (202) 442-6724

D. External Review

After We have rendered Our final Adverse Benefit Determination at the level of the formal appeals process, as described above, You or Your designated representative have a right, under applicable law of the District of Columbia, to request an independent external review of Our final adverse determination through the Director of the District of Columbia Department of Insurance. You or Your representative must file a written request with the Director within four (4) months of the final Adverse Benefit Determination, together with a signed form allowing Us to release Your medical records that are pertinent to the external appeal.

If you have a complaint involving an issue of medical necessity, you may call or write to:

Office of Health Care Ombudsman and Bill of Rights
District of Columbia
Department of Health Care Finance
One Judiciary Square
441 4th St. N.W., 900 South
Washington, D.C. 20001
Phone number: (202) [illegible]4-7491
Toll Free: 1-877-685-639[illegible]
Fax number: (202) 44[illegible]-6724

If you have a complaint that does not involve an issue of medical necessity, you may call or write to:

Commissioner of Insurance
Department of Insurance, Securities and Banking
Government of the District of Columbia
810 First Street, N. E., Suite 701
Washington, D.C. 20002
(202) 727-8000

Note: A Member shall also have the option to contact the District of Columbia Department of Insurance, Securities and Banking to request an investigation or file a complaint with the Department at any time during the internal claims and appeal process.

If the external reviewer overturns Our decision with respect to any Covered Service, We will provide coverage or payment for that Covered Service as directed.

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

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court. The state ombudsman listed above should be able to help you understand any further review rights available to you.

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.*

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, California 94612
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