KAISER PERMANENTE®

Kaiser Permanente Insurance Company

# District of Columbia

# Out-of-Area PPO

# Large Group

# (*Non-Grandfathered Coverage)*

## *Certificate of Insurance*



Notice:

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

**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.**

# TABLE OF CONTENTS

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

***Schedule of Coverage****

**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 (Certificate) for a more complete description of your coverage.

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.

**Introduction to Your Plan**

Plan types(s) described in this Certificate are the Participating Provider Organization plan (PPO) and the Out-of-Area plan (OOA). It is important that You reference the Schedule of Coverage to determine the plan type under which You are covered.

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

**Access to Care**

Your coverage under the Group Policy includes coverage for Covered Services received from Participating Providers as well as Non-participating Providers. (See Your Schedule of Coverage to determine if Your coverage includes Participating Providers.) In order for benefits to be payable at the Participating Provider level, the Covered Person must receive care from a Participating Provider. KPIC's Participating Provider network consists of the PHCS network within MD, CA, DC, GA, HI, CO, OR, VA, and WA (hereafter referred to as KP states) and the Cigna Healthcare[sm] PPO Network in all other states.

NOTE: Cigna Healthcare PPO Network providers will obtain any necessary Precertification on Your behalf. Please refer to the **PRECERTIFICATION** section for Precertification processes including a list of Covered Benefits subject to Precertification.

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, You may call the phone number listed on Your ID card, or You may visit KPIC's Participating Provider's network's web site at: www.kp.org/flexiblechoice/mas. To request a printed copy at no cost, call the phone number on the back of Your card. 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 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 that KPIC will pay for a Covered Service.

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

This Certificate forms 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: | 1-888-225-7202 (TTY 711) |
| For name and address changes: | 1-888-225-7202 (TTY 711) |

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.

**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.

**Air Ambulance Service** means medical transport of a patient by rotary wing air ambulance (as defined in 42 CFR 414.605) or fixed wing air ambulance (as defined in 42 CFR 414.605).

**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.

**Ancillary Service** means Services that are:

- Items and Services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner;
- Items and Services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic Services, including radiology and laboratory Services; and
- Items and Services provided by a Non-Participating Provider if there is no Participating Provider who can furnish such item or Service at such facility.

Items or Services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or Service is furnished, regardless of whether the non-Plan Provider satisfies the notice and consent requirements under federal law.

**Authorized representative** means an individual authorized under State law to provide consent on behalf of a patient, provided that the individual is not a provider affiliated with the facility or employee of the facility, unless such provider or employee is a family enrollee of the patient.

**Benefit Maximum** means a total amount of benefits that will be paid by KPIC for a specified type of Covered Charges incurred during a plan year. 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.

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

**Civil Union** means a same-sex relationship similar to marriage that is recognized by the District of Columbia.

**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.

**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.

**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 seven (7) days following its occurrence. The 7-day requirement shall be extended to one hundred eighty (180) days in the case of an act of rape or incest of a female under thirteen (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.

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

**Continuing Care Patient** means a member who, with respect to a provider or facility:

- Is in active course of treatment with the terminated provider prior to the notice of termination.
- Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
- Is undergoing a course of institutional or inpatient care from the provider or facility;
- Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
- Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
- Is in active course of treatment with the terminated provider prior to the notice of termination except for when the provider is terminated for cause; or
- Is or was determined to be terminally ill, as determined under section 1861(dd)(3)(A) of the Social Security Act, and is receiving treatment for such illness from such provider or facility.

**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 Participating 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 (Individual or Family) Deductible(s) and the Out-of-Pocket Maximum or 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.

# GENERAL DEFINITIONS

**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 Group Policy.

**Covered Services** means services and items as defined and listed under the section of this Certificate entitled **GENERAL BENEFITS** subject to the exclusions and limitations set forth in this Certificate.

**Creditable Coverage means**

1. Any individual or group policy, contract, or program that is written or administered by an insurer, health service plan or HMO, 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 Calendar Year. The Deductible will apply to each Covered Person separately and must be met within each Calendar Year. When Covered Charges equal to the Deductible are incurred during that Calendar Year, and are submitted to Us, the Deductible will have been met for that Covered Person except if there is an additional or separate Deductible that is applicable. 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 Deductible.

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;
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 Admission Services** means all Inpatient Covered Services which are related to the Emergency Services treatment of a Covered Person provided at a Hospital for up to the first five (5) consecutive days of Hospital Confinement when a Covered Person is admitted as an inpatient to the Hospital directly and immediately from the Hospital emergency facility. For the purposes of this definition, the first day of Hospital Confinement begins at the time of admission and ends at 11:59pm on the same day. Each additional consecutive day begins at 12:00am and ends at 11:59pm. The first and last days of Hospital Confinement may be for periods of less than twenty-four (24) hours.

**Emergency facility** means an emergency department of a hospital, or an Independent Freestanding Emergency Department where emergency services are provided. emergency facility includes a hospital, regardless of the department of the hospital, in which items or services with respect to emergency services are provided by a Non-Participating Provider or Non-Participating Emergency Facility: after the individual is stabilized; and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which other emergency services are furnished.

**Emergency Medical Condition** means a medical condition, including a mental health condition or substance use disorder, 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 Room Services** means Covered Services which are Emergency Services provided in a Hospital emergency facility. Emergency Room Services do not include services provided after admission to a Hospital or other care facility.

**Emergency Services (Emergency Care)** means all of the following with respect to an Emergency Medical Condition:

1. An appropriate medical screening examination, as required under the Emergency Medical Treatment and Active Labor Act (EMTALA), that is within the capability of the emergency department of a Hospital, including Ancillary Services routinely available to the emergency department, to evaluate the Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the Hospital, or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department, to Stabilize the patient regardless of the department of the Hospital in which such examination or treatment is furnished; and.
3. Except as further described in this paragraph 3, covered Services, also referred to as Post-Stabilization Care, that are furnished by a Non-Plan Provider after You are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which the Emergency Services are furnished:
    a. When, under applicable federal law, the covered Services described in item #3 are not included as Emergency Services if all of the following conditions are met:
        i. The attending emergency physician or Treating Provider determines that the member is able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Hospital or Plan Facility located within a reasonable travel distance, taking into account the member's medical condition;
        ii. The provider or facility furnishing such additional covered Services satisfies the notice and consent requirements set forth in federal regulation 45 C.F.R § 149.420(c) through (g) with respect to such covered Services, provided that the written notice additionally (1) identifies Plan Providers to whom you can be referred when a non-Plan Provider proposes to furnish covered Services at a Plan Hospital or Plan Facility when a non-Plan Provider proposes to provide such covered Services and (2) includes a good faith estimate of the charges for covered Services to be furnished at a non-Plan Hospital or non-Plan Facility by non-Plan Providers during the Visit; and
        iii. The member, or an Authorized Representative of such member, is in a condition to receive the information in the consent as described in item #3, as determined by the attending emergency physician or Treating Provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; or
    b. When the covered Services are rendered by a Health Care Provider who is subject to state law prohibiting balance billing.

**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 of the item that is a Covered Service.

**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 include:

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.

**Iatrogenic Infertility** means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment affecting the reproductive organs or processes.

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

**Independent Freestanding Emergency Department** means a health care facility that is geographically separate and distinct and licensed separately from a Hospital under applicable State law and provides any Emergency Services.

**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 Vocational Nurse (LPN) (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 six (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 Covered Services that, in the judgment of the Medical Review Program, are:

1. Essential and medically appropriate for the diagnosis or treatment of a Covered Person's Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the Covered Person, the Covered Person's family, and/or the 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 Covered Services rendered or due to the Covered Person's condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

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

**Medically necessary food** means food, including a low-protein modified food product or an amino acid preparation product, a modified fat preparation product, or a nutritional formula that is specially formulated and processed for the partial or exclusive feeding of an individual by means of oral intake or enteral feeding by tube, and intended for dietary management of an individual who, because of therapeutic or chronic medical needs, has limited or impaired capacity to ingest, digest, absorb, or metabolize ordinary foodstuffs or certain nutrients or who has other specially medically determined nutrient requirements, the dietary management of which cannot be achieved by modification of the normal diet alone.

**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 or Psychologist may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group or Individual 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.

**Mental Health 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.

**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 Emergency Facility** means an emergency facility that has not contracted directly with Us or indirectly, such as through an entity contracting on behalf of us to provide health care services to our members.

**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. Please consult with Your group administrator for a list of Participating Pharmacies or visit MedImpact's web site at www.medimpact.com.

**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.

**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.

**Other health care provider** means any person who is licensed or certified under applicable State law to provide health care services and is acting within the scope of practice of that provider's license or certification, but does not include a provider of air ambulance services.

**Out-of-network rate** means with respect to an item or service furnished by a Non-Participating Provider, Non-Participating Emergency Facility, or Non-Participating Provider of air ambulance services:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, Non-Participating Provider/Non-Participating Emergency Facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service.
2. If there is no such All-Payer Model Agreement applicable to the item or service, but a specified State law is in effect and applicable, the amount for the item or service determined in accordance with such specified State law.
3. If there is no such All-Payer Model Agreement or specified State law applicable to the item or service, an amount agreed upon by us and the Non-Participating Provider or Non-Participating Emergency Facility.
4. If none of the three conditions above apply, an amount determined by a certified independent dispute resolution (IDR) entity under the IDR process described in section 2799A–1(c) or 2799A–2(b) of the federal Public Health Service Act, as applicable.

**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 Calendar 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 twenty-four (24) hours and not less than four (4) hours for mental illness, emotional disorders, drug or alcohol abuse in a licensed or certified facility or program.

**Participating Emergency Facility** means any emergency facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our members. A single case agreement between an emergency facility and us that is used to address unique situations in which a Covered Person requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement.

**Participating facility** means a health care facility that has contracted directly with us or an entity contracting on behalf of us to provide health care services to our members. A single case agreement between a health care facility and us that is used to address unique situations in which a Covered Person requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement. Additionally, for purposes of this definition and in the context of non-emergency services, “health care facility” is limited to a hospital (as defined in section 1861(e) of the Social Security Act); a hospital outpatient department; a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

**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 MultiPlan to provide Covered Services at Negotiated Rates. A current copy of KPIC’s Participating Providers is available from Your employer or call the phone number listed on your ID card or visit the company's web site at: www.multiplan/kpmas.

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

**Percentage Payable** means that percentage of Covered Charges 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.

**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.

**Preventive Services** means measures taken medical services rendered to prevent diseases rather than curing them or treating their symptoms. 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, general internal medicine, general 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, except for the treatment of children with congenital or genetic birth defects;
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. Replacement of lost prosthetic devices;

10. Repair, adjustments or replacements necessitated by misuse;
11. Spare or alternate use equipment; and
12. 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.

**Qualifying Payment Amount** means the amount calculated using the methodology described in 45 C.F.R. § 149.140(c), which is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or service that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

**Recognized Amount** means with respect to an item or service furnished by a Non-Participating Provider or Non-Participating Emergency Facility, an amount that is determined as follows*:*

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan/carrier, Non-Participating Provider/Non-Participating Emergency Facility, and item/service, the amount that the State approves under the All-Payer Model Agreement for the item or service.
2. If there is no such All-Payer Model Agreement applicable to the item or service, in a State that has in effect a specified State law, the amount for the item or service determined in accordance with such specified State law.
3. If neither an All-Payer Model Agreement or a specified State law apply to the item or service, the lesser of: the amount billed by the Non-Participating Provider or Non-Participating Emergency Facility, or the Qualifying Payment Amount.

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

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

**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 90 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.

**Serious or Complex Condition** means in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

**Service** means a Health care item or service that is covered under this Agreement and Medically Necessary to prevent, diagnose, or treat a medical condition.

**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 to provide the medical treatment for an Emergency Medical Condition that is necessary to assure, within reasonable medical probability, which no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility to a Plan Provider. 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.

**Treating Provider** means a Physician or other health care Provider who has evaluated the member’s Emergency Medical Condition.

**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.

# GENERAL DEFINITIONS

**Visit** means the instance of going to or staying at a health care facility, and, with respect to Services furnished to a member at a health care facility, includes, in addition to Services furnished by a provider at the health care facility, equipment and devices, telemedicine Services, imaging Services, laboratory Services, and preoperative and postoperative Services, regardless of whether the provider furnishing such Services is at the health care facility.

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

# ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

**Eligibility for Insurance**

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

**Eligible Employee**

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

Note: The term Eligible Employee does not include the following:

1. A person who is eligible for Medicare Part A or Medicare Part B, except that this does not apply to those entitled to Medicare benefits who under federal law elect, or are required, to have the Policyholder's health coverage as their primary health care coverage;
2. Employees who work on a temporary, seasonal or substitute basis; or
3. Employees who have been employed by the Policyholder for fewer than 90 days, unless allowed to by the Policyholder.

**Full-Time (Permanent Employee)**

The terms "full-time," "working full-time," "work on a full-time basis," and all other references to full-time work mean that the Insured Employee is actively engaged in the business of the Policyholder for at least 30 hours per week.

**Contributions**

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

**Eligibility Date**

Your Eligibility Date is the effective date of the Group Policy if You are an Eligible Employee on that date, or the Policyholder's application for the Group Policy indicates that the eligibility waiting period does not apply to those employees who are employed by the Policyholder on the effective date of the Group Policy. Otherwise, Your Eligibility Date is the first day of the calendar month coinciding with or next following the date You complete the eligibility waiting period, if any, is the date elected by the Policyholder. Any delay in an Eligible Employee's effective date will not be due to a health status-related factor, as defined under the Health Insurance Portability and Accountability Act of 1996, or as later amended.

**Enrollment Rules**

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

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

**Effective Date of Your Insurance**

# ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

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

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

**Active Service**

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

**Eligibility of an Eligible Employee's Dependent**

For an eligible Dependent to become a Covered Person, You the Insured Employee must:

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

Your Group determines which persons are eligible to be enrolled as your Dependents. Please contact your Group's benefits administrator for questions regarding Dependent eligibility.

**Age Limits for Dependent Children**

The age limit for Dependent children is 26 years.

**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.

**Exceptions**

The age limits shown above and the requirement in item b) of the Dependent definition do not apply to a Dependent child who is continuously incapable of self-sustaining employment due to a physical handicap or mental retardation that occurred prior to the age limit. Such child will continue to qualify as a Dependent until the earlier of the following dates: a) the date the child recovers from the physical handicap or mental retardation; or b) the date the child no longer chiefly depends on You for support and maintenance.

Proof of such incapacity and dependency must be furnished to KPIC within 31 days of the child's attainment of the limiting age and subsequently as may be required by KPIC, but not more frequently than annually after the two-year period immediately following the child's attainment of the limiting age.

**Eligibility Date**

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

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

**Effective Date of Dependent Coverage**

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

**IMPORTANT:**

KPIC will not deny enrollment of a child under the health insurance coverage of a child's parent because:

1. the child was born out of wedlock;
2. the child is not claimed as a Dependent on the parent's federal income tax return; or
3. the child does not reside with the parent or in an applicable service area.

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

**Enrollment Rules**

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

**Special Enrollment Rules**

**I. Court or Administrative Ordered Coverage for a Dependent Child**

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

If the Covered Person fails to apply for coverage for the Dependent child pursuant to the Order, the custodial parent, the state medical assistance agency, or the state child support enforcement agency or a delegate child support enforcement unit may submit the application for insurance for the eligible child. The coverage for any child enrolled under this provision will continue pursuant to the terms of this plan unless KPIC is provided written evidence that:

1. The Order is no longer in effect;
2. The child is or will be enrolled in comparable health coverage through another insurer which will take effect on or before the requested termination date of the child's coverage under the Policy;
3. The employee is no longer an Insured Employee under the Group Policy;
4. All family coverage is eliminated for members of the employer group; or
5. Non-payment of premium.

**II. Special Enrollment due to Newly Acquired Dependents**

If You have a new Dependent as a result of marriage, birth, Domestic Partnership or Legal Partnership, adoption or Placement for Adoption, You may be able to enroll yourself or yourself and any or all of Your Dependents, or, (if You are already enrolled, You may be able to enroll any or all or Your Dependents) provided that You request enrollment within 31 days after the marriage, birth, Domestic Partnership or Legal Partnership, adoption, or Placement for Adoption.

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

If the cost of Your Dependent coverage would increase when You add a Dependent, You must enroll the Dependent for insurance and agree to pay any additional cost in accordance with the Enrollment Rules. The effective date of insurance for that Dependent will be the date determined from the Enrollment Rules. The Dependent must be enrolled within 31 days of their eligibility date or they will be considered a Late Enrollee.

**A. Newborns**

A newborn Dependent child is insured from birth. If the Eligible Employee is enrolled, the newly eligible Dependent Child will be covered automatically, but only for the first thirty-one (31) days following the child's date of birth. The Member must enroll such a Dependent Child and furnish premium for the subsequent month within thirty-one (31) days of the child's First Eligibility Date to continue coverage. This Coordination of Benefits provisions under the Group Policy do not apply when a Member has enrolled a newly born Dependent Child in accordance with the Group Policy. If the Member has made no attempt to enroll a newly born Dependent Child in accordance with the Group Policy, then this Group Policy will provide coverage for the newborn for (31) days. If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next Open Enrollment Period to enroll the child for coverage.

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

**B. Adopted Children**

An adopted child is insured from the earlier of the date of adoption or the date of Placement for Adoption. If the cost of Your Dependent coverage would increase because of the addition of an adopted child, You must enroll the adopted child for insurance and agree to pay the additional cost within 31 days of his eligibility date in order for insurance to extend beyond the 31-day period.

If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next Open Enrollment Period to enroll the child for coverage. If the cost of Your coverage would not increase as a result of the child being enrolled under the coverage, You should still notify Us, in writing, of the child's adoption or placement within 31 days of the event. This will allow Us to add the child to Our records and help avoid delays on any claim You might file on behalf the child.

**C. Guardianship**

A child as a result of guardianship granted by court or testamentary appointment is insured from the date of court or testamentary appointment. If the cost of Your Dependent coverage would increase because of the addition of a child as a result of guardianship, You must enroll the child as a result of

guardianship for insurance and agree to pay the additional cost within 31 days of his eligibility date in order for insurance to extend beyond the 31-day period. If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next Open Enrollment Period to enroll the child for coverage.

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

**III. Special Enrollment due to Loss of Medicaid or Child Health Insurance Program (CHIP) Coverage.**

If you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program coverage you must request special enrollment within 60 days of the loss of coverage.

**IV. Special Enrollment due to Eligibility for Premium Subsidy under Medicaid or a State CHIP.**

If You declined enrollment for yourself and/or your Dependents because you or they were enrolled in Medicaid or your state's CHIP, You may be able to enroll yourself along with any Dependents and existing Covered Persons may add Dependents under this Group Policy when You or your Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP, providing you request special enrollment within 60 days of when eligibility is determined.

**V. Special Enrollment due to a Section 125 qualifying event.**

If your Policyholder's plan is a Section 125 cafeteria plan, you may enroll as a Covered Person (along with any eligible Dependents), and existing Covered Persons may add eligible Dependents, if you experience an event that your Policyholder designates as a special enrollment qualifying event. Please ask your Policyholder whether your Policyholder's plan is a Section 125 cafeteria plan and, if it is, which events your Policyholder designates as special enrollment qualifying events. To request enrollment, the Covered Person must submit a Health Plan approved enrollment or change of enrollment application to your Policyholder within the timeframes specified by your Policyholder for making elections due to a section 125 qualifying event.

**VI. 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.

**VII. Late Enrollees:**

The following rules revise the late enrollment provisions. All other eligibility, participation, and enrollment rules of the Plan remain in effect and must be met.

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

1. The person meets all of the following requirements:
   a. At the time of initial enrollment, the person was covered under another employer's medical plan and certified, at the time of initial enrollment, that coverage under the other employer medical plan was the reason for declining coverage; and

b. The person has lost or will lose coverage under the other employer plan because of:
   i. termination or change in status of employment of the Eligible Employee or of the person through whom the individual was covered as a Dependent;
   ii. termination of the other employer's medical plan;
   iii. cessation of an employer's contributions toward an employee's or Dependents' medical coverage;
   iv. death of the Eligible Employee or person through whom the individual was covered as a Dependent;
   v. legal separation or divorce; or

2. The person is enrolled for the employee's medical coverage within 30 days after termination of the other medical coverage or cessation of the other employer's contributions toward the other medical coverage.
3. The employee is employed by an employer who offers multiple health benefit plans and the individual elects coverage under a different plan during an Annual Open Enrollment Period.
4. A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.
5. No written statement can be provided proving that prior to declining the medical coverage, the Eligible Employee was provided with, and signed acknowledgment of, written notice specifying that failure to elect coverage during the 30-day period following the person's eligibility date could result in the person being subject to Late Enrollment rules.
6. The person meets the criteria described in paragraph "1" of this provision and was under a COBRA continuation provision and the coverage under that provision has been exhausted.

If, at the time of initial enrollment, You declined enrollment for yourself or Your Dependents (including Your spouse) because of other health insurance coverage, You may, in the future be able to enroll yourself along with any Dependents and existing Covered Persons may add Dependents under this Group Policy, provided that You request enrollment within 30 days after the other coverage ends.

**Termination of an Insured Employee's Insurance**

Your insurance will automatically terminate on the earlier of:

1. The latter of, the date of your written notice of voluntarily terminating Your or Your Dependent's coverage under the Group Policy to Your employer, or the date KPIC receives the termination notice from Your employer;
2. The date You cease to be covered by KPIC;
3. The date the Group Policy is terminated;
4. The date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
5. The end of the grace period after the employer fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion;
6. The last day of the month You cease to qualify as an Eligible Employee; or
7. The date You relocate to a place outside of the geographic service area of a provider network, if applicable.

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

**Termination of Insured Dependent's Coverage**

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

1. The date You cease to be covered by KPIC;
2. The last day of the of the calendar month in which the person ceases to qualify as a Dependent;
3. The date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. The date Your insurance ends, unless continuation of coverage is available to the Dependent under the provisions of the Group Policy;

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

**Reinstatement**

If any renewal premium be not paid within the time granted the Insured Employee for payment, a subsequent acceptance of premium by Us, without requiring in connection therewith an application for reinstatement, shall reinstate Your coverage under this Group Policy; provided, however, that if We require an application for reinstatement and issue a conditional receipt for the premium tendered, Your coverage under this Group Policy will be reinstated upon approval of such application by Us, or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless We have previously notified You in writing of its disapproval of such application.

The reinstated coverage under this Group Policy shall cover only loss resulting from the (accidental loss) benefits listed in the Group Policy as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects You and We shall have the same rights thereunder as they had under this Group Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

**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 of coverage 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 Your coverage became effective.

For purposes of this section, a rescission is a cancellation or discontinuation of coverage that has retroactive effect and does not include a cancellation or discontinuation that (a) has only a prospective effect; (b) is effective retroactively based upon a failure to timely pay required premiums or contributions (including COBRA premiums) towards the cost of coverage; or, (c) is initiated by You or Your representative and neither KPIC nor the Group takes action, directly or indirectly, to influence Your decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate or threaten You.

If You or Your Dependent's policy is rescinded , You have the right to appeal the rescission . Please refer to the **ERISA CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the claims and appeals process.

# PRECERTIFICATION

**Precertification through the Medical Review Program**
This section describes:
1. The Medical Review Program and Precertification procedures for Covered Services;
2. How failure to obtain Precertification affects coverage;
3. Precertification administrative procedures;
4. Which clinical procedures require Precertification;

**You are responsible for ensuring Pre-certification is obtained when you choose to receive Covered Services from a licensed Provider.** A Covered Person must obtain Precertification of all Hospital stays and certain other services and procedures. Request for Precertification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment or within forty-eight (48) hours of an admission after an emergency room visit or as soon as reasonable possible. If Precertification is required, it must be obtained to avoid a reduction in benefits. If you received Covered Services from a licensed Provider, and Pre-certification is not obtained, benefits payable by KPIC will be reduced even if the Covered Service is deemed Medically Necessary.

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

If Precertification is not obtained when required and unless Pre-certification is not permitted under applicable law, or obtained but not followed, benefits otherwise payable by KPIC for all Covered Charges incurred in connection with the Covered Service will be reduced by 30% (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. If the Covered Service is deemed not to be Medically Necessary, the Covered Service, item or service will not be covered.

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

**Medical Review Program** means the organization or program that evaluates proposed services and/or items to determine that they are Covered Services and Medically Necessary to the Covered Person's health care needs. If the Medical Review Program determines that such services and/or items are not Covered Services and/or is not Medically Necessary, Precertification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven (7) days per week [1-888-567-6847] or visit [https://healthy.kaiserpermanente.org/maryland-virginia-washington-dc/community-providers/permanente-advantage] for more information regarding Covered Services that require precertification.

Medical Review Program for providers accessed via the Cigna Healthcare PPO Network outside KP states will be performed by Cigna Healthcare Medical Review. Cigna Healthcare PPO Network providers will obtain any necessary Precertification on Your behalf. Providers may contact them at 888-831-0761.

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

The following Covered Services must be pre-certified by the Medical Review Program subject to all exclusions and limitations as set forth in this Certificate:
1. Inpatient admissions including:
    a. Inpatient Rehabilitation Therapy admissions
    b. Inpatient Skilled Nursing Facility, long term care, and sub-acute admissions and services
    c. Inpatient mental health and chemical dependency admissions
    d. Inpatient Residential Treatment

2. Non-Emergent (Scheduled) Air or Ground Ambulance
3. Pediatric Medically Necessary contact lenses
4. Amino Acid-Based Elemental Formulas
5. Low Protein Modified Foods
6. Clinical Trial Services
7. Medical Foods
8. Bariatric Surgery
9. Dental & Endoscopic Anesthesia
10. Durable Medical Equipment
11. Genetic Testing
12. Home Health & Home Infusion Services
13. Hospice (home, inpatient)
14. Infertility Procedures
15. Imaging Service (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)
16. Outpatient Injectable Drugs
17. Outpatient Surgery (performed at hospital, ambulatory surgery center of licensed facility)
18. Orthotics/Prosthetics
19. Implantable prosthetics (includes breast, bone conduction, cochlear)
20. Pain Management services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)
21. Radiation Therapy Services
22. Reconstruction Surgery
23. TMJ/Orthognathic Surgery
24. Transplant Services (Including Pre & Post)
25. Transgender Surgery & Services (sexual re-assignment)
26. 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 Precertification is not obtained, benefits will be reduced even if the treatment or service is deemed Medically Necessary. If the Covered Service is deemed not to be Medically Necessary, the Covered Service, item, 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 Precertification (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 Precertification:** When a Covered Person is admitted to a Hospital for delivery of a child, the Covered Person is automatically Pre-certified 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 Pre-certification for an extended confinement through the Medical Review Program. Treatment for Complications of Pregnancy is subject to the same Pre-certification requirements as any other Sickness.

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 Precertification requirements as any other Sickness.

**Precertification Procedures**

The Covered Person, or attending 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 the scheduled (planned) Hospital Confinement, but at least three (3) days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Pre-certified.
3. Other Covered Services requiring Precertification - As soon as reasonably possible after the Covered Person learns of the need for any outpatient Covered Service requiring Precertification but at least three (3) days prior to performance of any outpatient Covered Service requiring Precertification.

A Covered Person, or attending 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 Provider selected from a panel of three (3) or more Providers designated by the Medical Review Program. If the Covered Person is required to obtain a second opinion, it will be provided at no charge (including but not limited to Cost Share) 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 Provider information required by the Medical Review Program relating to the Covered Person’s medical condition and the requested service or item. If the Covered Person or the Covered Person’s Provider, does not provide the necessary information or will not release necessary information, Precertification will be denied.

# 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 Calendar 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 Calendar Year and are submitted to Us, the Deductible will have been met for that Covered Person for that Calendar Year. Benefits will not be payable for Covered Charges applied to the 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 Calendar Year Deductible.

**Family Deductible Maximum**

The Deductible for a family has been satisfied for a Calendar 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 Calendar Year by Covered Persons in a family enrollment unit, then the Individual Deductible for any Covered Person in the family enrollment unit will not be further applied to any other Covered Charges incurred during the remainder of that Calendar Year.

**Benefit-Specific Deductibles**

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

**NOTE:** Please refer to the Schedule of Coverage section for the actual amount of Your Individual/Self-Only and Family Deductible(s) and any other additional or separate Deductible(s).

**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 Calendar Year in which the accident occurs; or (2) in the next Calendar 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. Amounts 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 satisfying the Deductible or the Out-of-Pocket Maximum.

# DEDUCTIBLES AND MAXIMUMS

Individual Out-of-Pocket Maximum*:* When a Covered Person's Cost Share amounts equal or exceed the individual Out-of-Pocket Maximum (shown in the Schedule of Coverage) during a Calendar Year, then the Percentage Payable will be 100% of Covered Charges for that same Covered Person during the remainder of the Calendar 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 Calendar Year, the Percentage Payable will increase to 100% of further Covered Charges incurred by all family members during the remainder of that Calendar Year.

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

**Maximum Allowable Charge**

Payments for Expenses Incurred 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. In addition to the applicable Cost Sharing, Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service from a Provider. Such difference will not apply towards satisfaction of the Out-of-Pocket Maximum nor any Deductible under the Group Policy. (Refer to the definition of Maximum Allowable Charge shown in the 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 Covered Services are subject to benefit-specific limits or maximums. These additional limits or maximums 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**

## DEDUCTIBLES AND MAXIMUMS

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**

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

1. The Covered Person is insured under the Group Policy on the date when the Covered Service is received;
2. The claim is for a Covered Service and the Covered Service is Medically Necessary;
3. The claim is for a Covered Service provided or rendered by a Provider in accordance with all terms and conditions of this Certificate;
4. Prior to payment on the claim, any Deductible applicable to the Covered Service has been satisfied; and
5. The Covered Person has not exceeded limits related to the Covered Service including but not limited to the Maximum Benefit While Insured or any other maximum shown in the Schedule of Coverage.

**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 Hospital, the Covered Person, or someone acting on behalf of the Covered Person, must notify the Medical Review Program within forty-eight (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 that 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 (1) Medically Necessary hair prosthesis for hair loss when prescribed by a provider, not to exceed a Benefit Maximum of $350 per prosthesis per Calendar 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 was 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 forty-eight (48) hours of inpatient hospitalization following a mastectomy or removal of a testicle on an outpatient basis:
        i. One home visit scheduled to occur twenty-four (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.

    Covered Durable Medical Equipment includes, but is not limited to:
    a. Apnea Monitors;
    b. Asthma Equipment for pediatric and adult asthmatics limited to the following:
        i. Spacers;
        ii. Peak-flow meters; or
        iii. Nebulizers

c. Bilirubin Lights;
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 thirty (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 thirty (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; non-insulin using diabetes; 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 sixty (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 sixty (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 sixty (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 sixty (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 sixty (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 (2) days of partial hospitalization may be substituted for one (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 twenty-four (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. Transplant services limited to autologous and non-autologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants. Charges incurred or in connection with non-human and artificial organs and their implantation are not covered under the transplant benefit. Services for, or related to, the removal of an organ from a Covered Person for purposes of transplantation into another person will not be covered unless: a). Transplant recipient is covered under the plan and is undergoing a covered transplant, and b). Services are not payable by another carrier.
36. Allergy testing and treatment, services, material, and serums.

37. Musculoskeletal Therapy.
38. Cardiac Rehabilitation.
39. Pulmonary Rehabilitation.
40. Dialysis.
41. Urgent Care.
42. Sleep Studies.
43. Sleep Lab.
44. 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.
45. Vision services, including routine exams from an optometrists or ophthalmologist, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses. Coverage for Medically Necessary treatment for diseases of or injuries to the eye. Such treatment shall be covered to the same extent as for other Medically Necessary treatments for illness or injury.
46. Special contact lenses for aniridia for adults ages nineteen (19) and over. Coverage is limited to up to two (2) Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris)
47. 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.
48. 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.
49. Covered Services rendered as part of an approved Clinical Trial.
50. Other services or treatment approved through the Medical Review Program.
51. 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.
52. 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.

53. 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.

54. Medically Necessary 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.
55. 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.
56. 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 (3), 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 effecting a cure. Benefits payable are limited to $5,000 per Dependent per Calendar Year. These Services are provided in addition to the Physical, Occupational, Speech Therapy and Multidisciplinary Rehabilitation Services described in this Certificate of Insurance.
57. 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.
58. 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.
59. Accidental Dental Injury Services. Dental services for accidental injury and other related medical services. 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 sixty (60) days of the injury;
    d. The Covered Services are provided during the twelve (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 by a Non-Participating Provider;
    b. Services provided after twelve (12) months from the date the injury occurred; and

c. 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.

60. Infertility and Standard Fertility Preservation Services. Coverage for the diagnosis and treatment of infertility including artificial insemination and in vitro fertilization (IVF) services. IVF coverage includes:
    a. At least three-(3) complete oocyte retrievals with unlimited embryo transfers from those oocyte retrievals or from any oocyte retrieval procedure performed in accordance with the American Society for Reproductive Medicine, using single embryo transfer when recommended and medically appropriate; and
    b. Medical costs related to an embryo transfer to be made from a Covered Person to a third-party except that the Covered Person's coverage shall not extend to any medical costs of the surrogate or gestational carrier after the embryo transfer procedure.

    Coverage for standard fertility preservation services for Iatrogenic Infertility. Standard Fertility Preservation Services means procedures that are consistent with established medical practices or professional guidelines published by the American Society for Reproductive Medicine or the American Society of Clinical Oncology for a Covered Person who has a medical condition or is expected to undergo medication therapy, surgery, radiation, chemotherapy, or other medical treatment that is recognized by medical professionals to cause a risk of impairment to fertility.
61. 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.
62. 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).
63. Routine foot care limited to Medically Necessary treatment of patients.
64. 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.
65. 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 visits to obtain the recommended preventive services, including preconception counseling and Routine Prenatal Care and postpartum 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. Behavioral/Social/Emotional Screening for children newborn to age twenty-one (21)
5. Breast cancer 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).
6. Cervical cancer and dysplasia screening including Human Papillomavirus (HPV) screening,

7. 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.
8. Depression screening for children and adults including suicide risk as an element of universal depression screening for children ages twelve to twenty-one (12-21).
9. Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus
10. Gestational and postpartum diabetes screening
11. Hepatitis B and Hepatitis C virus infection screening
12. Hematocrit or Hemoglobin screening in children
13. Hypertension (High blood pressure) screening
14. Lead Screening
15. Lipid disorders screening
16. Lung cancer screening with low-dose computed tomography in adults who have a 20 pack-year smoking history and currently smoke or have quit within the past fifteen (15) years. One pack year is equal to smoking one pack per day for one (1) year, or two (2) packs per day for half a year.
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 (Body Mass Index) and management and counseling for obesity
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. Sudden cardiac arrest and sudden cardiac death risk assessment in children ages twelve to twenty-one (12-21)
28. Type 2 diabetes mellitus screening
29. Tuberculin (TB) Testing
30. Urinary incontinence screening in women
31. Visual impairment in children screening
32. Emergency Department HIV screening test
33. High-risk human papillomavirus (HPV) DNA testing every three years for women ages thirty (30) years or older with normal cytology results.

**Health Promotion**

1. Screening by asking questions about unhealthy drug use in adults ages eighteen (18) years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
2. Unhealthy alcohol and drug use assessment and behavioral counseling interventions in a primary care setting to reduce alcohol use.
3. Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease
4. Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children
5. Counseling for midlife women with normal or overweight body mass index to maintain weight or limit weight gain to prevent obesity.

6. Offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
7. Tobacco use screening and tobacco-caused disease counseling and interventions, FDA-approved tobacco cessation prescription or over-the-counter medications prescribed by a licensed health care professional authorized to prescribe drugs for women who are not pregnant and men.
8. Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and BRCA mutation testing
9. Sexually transmitted infections counseling
10. Discuss use of the risk-reducing medications such as aromatase inhibitors, tamoxifen and raloxifene, with women who are at increased risk for breast cancer and at a low risk for adverse medication effects.
11. When prescribed by a licensed health care professional authorized to prescribe drugs:
    a) Aspirin in the prevention of preeclampsia in pregnant women.
    b) Oral fluoride supplementation at currently recommended doses to preschool children older than six (6) months of age whose primary water source is deficient in fluoride.
    c) 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
    d) Folic acid supplementation for women planning or capable of pregnancy for the prevention of neural tube defects.
12. Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and counseling by a Provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the post-partum period; breast milk storage supplies; any equipment and supplies as clinically indicated to support women and babies with breast feeding difficulties; and the purchase of a manual 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.
13. All prescribed FDA-approved contraceptive methods for women with reproductive capacity, including but not limited to drugs, cervical caps, vaginal rings, continuous extended oral contraceptives and patches. This includes all FDA-approved cleared or granted contraceptive products that are determined by an individual's medical Provider to be medically appropriate. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, female sterilization procedures, follow-up and management of side effects; counseling for continued adherence, device removal and patient education and counseling. Items and services that are integral to the furnishing of a recommended preventive service such as a pregnancy test needed before provision of certain contraceptives is included in contraceptive coverage. Over-the-counter FDA-approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs.
14. Screening, counseling, and other interventions such as education, harm reduction strategies, and referral to appropriate supportive services for interpersonal and domestic violence.
15. Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions.
16. Low-to-moderate dose statins for adults without a history of cardiovascular disease (CVD) who meet the USPSTF criteria.
17. Counseling young adults, adolescents, children and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged six (6) months to twenty-four (24) years with fair skin types to reduce their risk for skin cancer.
18. 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 forty to seventy-five (40-75) years; 2) they have one (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 as well as the following baseline and monitoring services:
    - Pre-exposure prophylaxis (PrEP) with at least one drug providing effective antiretroviral therapy to persons who are at high risk of HIV acquisition as well as the following baseline and monitoring services:
        - HIV testing – to confirm the absence of HIV infection before PrEP is started and testing for HIV every three (3) months while PrEP is being taken
        - Hepatitis B testing before PrEP is started.
        - Hepatitis C testing before PrEP is started and periodically during treatment according to CDC guidelines.
        - Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) is covered as follows:
            - eCrCl or eGFR testing before starting PrEP to assess kidney function.
            - Creatinine and eCrCL or eGFR testing periodically consistent with CDC guidelines during treatment.
        - Pregnancy testing for persons of childbearing potential before PrEP is started and periodically during treatment consistent with CDC guidelines.
        - Sexually transmitted infection screening and counseling before PrEP is started and periodically during treatment consistent with CDC guidelines.
        - Adherence counseling for assessment of behavior consistent with CDC guidelines.

**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 unless clinically indicated.

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

For a complete list of current preventive services required under the Patient Protection Affordable Care Act for which cost share does not apply, please call: 1-888-225-7202 (TTY 711). You may also visit: https://www.healthcare.gov/coverage/preventive-care-benefits/. Please note, however, for recommendations that have been in effect for less than one (1) year, KPIC will have one (1) year from the effective date to comply.

**Note**: The following services are not Covered Services under this 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**

# GENERAL BENEFITS

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 Coverage.
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. Iron supplementation for children from 6 months to 12 months of age
5. Family planning limited to:
   a) Family planning counseling, including pre-abortion and post-abortion counseling;
   b) Male Sterilization (vasectomies);
   ;
   c) Voluntary termination of pregnancy , elective and therapeutic termination of pregnancy as permitted under state law.

   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, gamete intrafallopian tube transfer; ovum transplants; zygote intrafallopian transfer, and prescription drugs related to such services.
6. Iron deficiency anemia screening for pregnant women
7. Prostate cancer screening in accordance with the latest screening guidelines issued by the National Comprehensive Cancer Network, to include no less than one prostate-specific antigen test and digital rectal exam per year.:

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

8. Venipuncture for ACA preventive lab screenings. If a venipuncture is for the purpose of drawing blood for both ACA preventive and Non-ACA preventive labs, a cost share may apply.
9. Behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease (CVD) prevention in adults with CVD risk factors and type 2 diabetes mellitus.

10. Aspirin when prescribed by a licensed health care professional authorized to prescribe for the prevention of cardiovascular disease and colorectal cancer screening.

**Extension of Benefits**

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

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

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

1. The date on which the Total Disability ends;
2. The last day of the 12-month period that follows the date the Total Disability starts; or
3. The date on which the Covered Person becomes covered under any plan that: a) replaces this insurance; and b) covers the disabling condition so that benefits are not limited due to the Total Disability having started before that plan was in effect.
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 twelve (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 twelve (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 forty-eight (48) hours following normal vaginal delivery and not less than ninety-six (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 forty-eight (48) hours following normal vaginal delivery and ninety-six (96) hours following a Caesarean section, one home visit within twenty-four (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 four (4) days.

**Emergency Services**

Emergency Services are covered twenty-four (24) hours per day, seven (7) days per week, anywhere in the world. If You have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department or Independent Freestanding Emergency Department. When You have an Emergency Medical Condition, We cover Emergency Services that You receive from Participating Providers or Non-Participating Providers anywhere in the world, as long as the Services would be covered under the **GENERAL BENEFITS** section of this Certificate (subject to the **GENERAL LIMITATIONS AND EXCLUSIONS** of this Certificate) if You had received them from Participating Providers. Emergency Services are covered:

1. Without the need for any prior authorization determination, even if the Emergency Services are provided on an out-of-network basis;
2. Without regard to whether the health care provider furnishing the Emergency Services is a Participating Provider or a Participating Emergency Facility, as applicable, with respect to the Services;
3. If the Emergency Services are provided by a Non-Participating Provider or Non-Participating Emergency Facility, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to Emergency Services received from Participating Providers;
4. Without limiting what constitutes an Emergency Medical Condition solely on the basis of diagnosis codes; and
5. Without regard to any other term or condition of the coverage, other than:
   a. Applicable Cost-sharing; and
   b. For Emergency Services provided for a condition that is not an Emergency Medical Condition, the exclusion or coordination of benefits.

**Cost-sharing Requirements, Payment, and Balance Billing Protections for Emergency Services**

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed under the Group Policy for Emergency Services provided by a Participating Provider or Participating Emergency Facility;
2. Any Cost-sharing payments made with respect to Emergency Services provided by a Non-Participating Provider or a Non-Participating Emergency Facility will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum;
3. If Emergency Services are provided by a Non-Participating Provider or Non-participating Emergency Facility, any Cost-sharing requirement will be calculated based on the Recognized Amount;
4. If Emergency Services are provided by a Non-Participating Provider or Non-Participating Emergency Facility, We will make payment for the covered Emergency Services directly to the Non-Participating Provider or Non-Participating Emergency Facility. The payment amount will be equal to the amount by which the out-of-network rate exceeds the Cost-sharing amount for the services; and
5. For Emergency Services furnished by Non-Participating Providers or Non-Participating Emergency Facilities, the member will not be liable for an amount that exceeds the member's Cost-sharing requirement.

**Cost-sharing Requirements, Payment, and Balance Billing Protections for Non-Emergency Services Performed by Non-Participating Providers at Participating Facilities, Including Ancillary Services for Unforeseen Urgent Medical Needs**

The Group Policy covers items and services furnished by a Non-Participating Provider with respect to a covered visit at a Participating Facility in the following manner, except when the Non-Participating Provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i):

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for such items and services furnished by a Non-Participating Provider with respect to a visit in a Participating Facility is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed in the Group Policy for the items and services when provided by a Participating Provider;

2. Any Cost-sharing requirement for the items and services will be calculated based on the Recognized Amount;
3. Any Cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum;
4. We will make payment for the items and services directly to the Non-Participating Provider. The payment amount will be equal to the amount by which the out-of-network rate exceeds the Cost-sharing amount for the items and services; and
5. For charges for such items or services that exceed Our payment, the member will not be liable for an amount that exceeds the member's Cost-sharing requirement.

   Provisions 1 – 5 above are not applicable when the Non-Participating Provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i), including providing notice to the member of the estimated charges for the items and services and that the provider is a Non-Participating Provider, and obtaining consent from the member to be treated and balance billed by the Non-Participating Provider. The notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i) do not apply to Non-Participating Providers with respect to:

   - Covered Services rendered by an on-call Physician or a Hospital-based Physician who has obtained an assignment of benefits from the Member.
   - Ancillary Services; and
   - Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Participating Provider satisfied the notice and consent criteria;

   and such items and services furnished by Non-Participating Providers will always be subject to the above five provisions.

**Cost-sharing Requirements, Payment, and Balance Billing Protections for Non-Participating Providers Air Ambulance Services**

When services are received from a Non-Participating Provider of air ambulance services:

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for the air ambulance service is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed in the Group Policy for air ambulance services when provided by a Participating Provider of ambulance services;
2. Any Cost-sharing requirement will be calculated based on the lesser of the Qualifying Payment Amount or the billed amount for the Services;
3. Any Cost-sharing payments made with respect to the air ambulance service will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum;
4. We will make payment for the air ambulance services directly to the Non-Participating Provider of ambulance services. The payment amount will be equal to the amount by which the out-of-network rate exceeds the Cost-sharing amount for air ambulance services; and
5. The member will not be liable for an amount that exceeds the member's Cost-sharing requirement.

**Cost-sharing and Balance Billing Protections for Services Provided Based on Reliance on Incorrect Provider Network Information**

If a Covered Person is furnished, by a Non-Participating Provider, an item or service that would otherwise be covered if provided by a Participating Provider, and the Covered Person relied on a database, provider directory, or information regarding the provider's network status provided by Us through a telephone call or electronic, web-based, or Internet-based means which incorrectly indicated that the provider was a Participating Provider for the furnishing of such item or service, then the following apply:

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for such item or service furnished by a Non-Participating Provider is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed in the Group Policy for the item or service when

provided by a Participating Provider; and
2. Any Cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum.
3. The member will not be liable for an amount that exceeds the Cost-sharing that would have applied to the member if the provider was a Participating Provider.

For more information about Your rights and protections against surprise medical bills, visit https://choiceproducts-midatlantic.kaiserpermanente.org/wp content/uploads/2022/10/DC_NSA-Disclosure.pdf.

**Continuity of Care**

A Continuing Care Patient receiving care from a Participating Provider may elect to continue to receive transitional care from such provider if the provider's Participating Provider Group Policy is terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud or if the Group Policy terminates resulting in a loss of benefits with respect to such provider or facility. We will notify each member who is a Continuing Care Patient at the time of termination or non-renewal on a timely basis of such termination and the member's right to elect transitional care.

When elected, benefits will be provided under the same terms and conditions as would have applied with respect to items and services that would have been covered had termination not occurred, with respect to the course of treatment provided by such provider or facility relating to the member's status as a Continuing Care Patient. Benefits will be provided during the period beginning on the date we will notify the Continuing Care Patient of the termination and ending on the earlier of: (i) ninety (90) days after the date of such notice; or (ii) the date on which such member is no longer a Continuing Care Patient with respect to such provider or facility.

The member will not be liable for an amount that exceeds the Cost-sharing that would have applied to the Member had the termination not occurred.

# 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 Services in an Emergency Department or Independent Freestanding Emergency Department 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. Except for Emergency Services, weekend admission charges for Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
5. Covered Services including but not limited to confinement, treatment, services, or supplies not Medically Necessary. This exclusion does not apply to preventive or other Covered 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. Covered Services other than Emergency Services outside the United States.
8. 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.
9. Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third-party coverage.
10. Injury or Sickness arising out of, or in the course of, past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.
11. Services for military service-related conditions regardless of service in any country or international organization.
12. 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.
13. Covered Services including but not limited to confinement, treatment, services, or supplies received where care is provided at government expense. This exclusion does not apply if: a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or b) payment is required by law
14. Dental care and treatment, dental x-rays; dental appliances; orthodontia; and dental surgery. This exclusion will not apply to the extent that diagnostic and surgical treatment is required because of a medical condition or Injury that prevents normal function of the joint or bone of the head, face or jaw to attain functional capacity of the affected part. 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.
15. 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.
16. Non-prescription drugs or medicines; vitamins, nutrients, and food supplements, even if prescribed or administered by a Physician.
17. 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.

18. 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.
19. Confinement, treatment, services or supplies that are required: a) only by a court of law except when Medically Necessary and otherwise covered under the plan; or b) only for insurance, travel, employment, school, camp, government licensing, or similar purposes.
20. Personal comfort items such as telephone, radio, television, or grooming services.
21. Custodial care. Custodial care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
22. 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.
23. Routine foot care except as set forth under the Covered Services in the **GENERAL BENEFITS** section of this Certificate.
24. Confinement or services that are not Medically Necessary or treatment that is not completed in accordance with the attending Physician's orders.
25. Services of a private duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility, or in the Covered Person's home;
26. 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.
27. Living expenses or transportation, except as provided under Covered Services.
28. Reversal of sterilization.
29. Services provided in the home other than Covered Services provided through a Home Health Care Agency.
30. Maintenance therapy for rehabilitation.
31. The following Home Health Care Services:
    a. treatment of Mental Illness and substance abuse disorders,
    b. meals,
    c. personal comfort items,
    d. housekeeping services.
32. 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.
33. Services in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Covered Person who is a surrogate.
34. 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.
35. Biofeedback or hypnotherapy.

36. 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.
37. 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.
38. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
39. Services for which no charge is normally made in the absence of insurance.
40. 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.
41. Rehabilitation services while confined in a Hospital or any other licensed medical facility.
42. Acupuncture.
43. Chiropractic Services.
44. Treatment of infertility including, but not limited to:
    a. Any Services or supplies, after an embryo transfer, provided to a person not covered under your Health Plan in connection with a surrogate/gestational carrier pregnancy (including, but not limited to, the bearing of a child by another person for an infertile couple).
    b. Fallopian scar revision surgery.
    c. Services to reverse voluntary and surgically induced infertility.
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. Artificial insemination shall not include (a) the cost of donor semen and donor eggs including retrieval of eggs, and (b) storage and freezing of eggs and/or sperm.
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.
52. Drugs used for weight loss – All prescription drugs to treat obesity or weight loss, including drugs prescribed for off label use relating to weight loss.

# OPTIONAL OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

**Outpatient Prescription Drug Benefits**

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 LIMITATIONS AND EXCLUSIONS** 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 one hundred fifty (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: https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/markeplace-formulary-effective-upon-renewal-mas-en-2023.pdf.

**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. Ophthalmic, otic, and topical medications. The standard prescription amount for ophthalmic, otic, 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.

**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 of this Certificate:

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 of this Certificate.)
4. Drugs not approved by the United States Food and 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 LIMITATIONS AND EXCLUSIONS** section of this Certificate, 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 from Us subject to the applicable Cost Share.

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.

# FEDERAL CONTINUATION OF COVERAGE PROVISIONS

**This section only applies to Participating Employers who are subject to Public Law 99-271 (COBRA)**
You may be able to continue Your coverage under this policy for a limited time after You would otherwise lose eligibility, if required by the federal COBRA law. Please contact Your Employer Group if You want to know how to elect COBRA coverage or how much You will have to pay Your Employer Group for it.

**Continued Health Coverage under Uniformed Services Employment and Reemployment Rights Act (USERRA)**

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

Please contact Your Employer to find out how to elect USERRA coverage and how much You must pay Your Employer.

# 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. Plan is defined below. 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 (100%)of the Allowable Expenses during any Calendar Year; and
3. will not exceed the benefits payable in the absence of other coverage.

**Order of Benefit Determination Rules**

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

1. General: A Plan that does not coordinate with other Plans is always the primary Plan.
2. Non-dependent\Dependent: The benefits of the Plan which covers the person as a Covered Person, or subscriber (other than a Dependent) is the primary Plan; the Plan which covers the person as a Dependent is the secondary Plan.
3. Dependent Child: Parents Not Separated or Divorced: When This Plan and another Plan cover the same child as a Dependent of different parents, benefits for the child are determined as follows:
   a) the primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The secondary Plan is the Plan of the parent whose birthday falls later in the year.
   b) if both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the primary Plan; the Plan, which covered the parent the shorter time, is the secondary Plan.
4. Dependent Child: Separated or Divorced Parents or not living together, whether or not married: 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; and
   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 Calendar Year during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the Provider, if the custodial parent so requests.

5. Active/Inactive Service: The primary Plan is the Plan, which covers the person as a Covered Person who is neither laid off 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.

**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**

**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-Plan 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:

Kaiser Permanente Claims Administration
PO Box 371860
Denver CO, 80237-9998

**Questions about claims:** For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when You call 1-888-225-7202 (TTY 711) 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.

**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 twenty (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 Claims Administration
PO Box 371860
Denver CO, 80237-9998

**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 fifteen (15) days after receipt of Your notice of claim, You shall be deemed to have complied with the Proof of Loss requirements by submitting written proof covering the occurrence, character and extent of the loss, within the time limit stated in the Proof of Loss section.

**Proof of Loss**
Written Proof of Loss may be sent to Us by fax or at the address shown above or Our Administrator within ninety (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 (1) 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 thirty (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 sixty (60) days after the notice of denial is received. A written decision on reconsideration will be issued within sixty (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 one hundred twenty (120) days from the time KPIC's Administrator receives the request.

**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 six (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 fifteen (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, prescribed, or directed by a Health Plan Provider:

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.

**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 (2) 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 sixty (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.

**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 (3) months if Active Service ends because of disability or two (2) months if it ends because of layoff or leave of absence other than family care leave of absence. These provisions apply so 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.

**Conformity with State Statutes**

Any provision in this Policy that is in conflict with the requirements of any state and/or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such 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 thirty (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 explaining the arrangement; and
- 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 1-888-225-7202 (TTY 711).

**Extra Services**

In addition to the Services that we describe in this EOC, we may make available a variety of extra services. Extra services are not covered by your Plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your Plan;
2. Certain health education publications; and
3. Discounts for fitness club memberships.

Some of these extra services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card;
2. Pay the fee, if any; and/or
3. Participate in any required activity.

Because these services are not covered by your Plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

We do not endorse or make any representations regarding the quality or medical efficacy of any extra service or the financial integrity of the companies offering them. We expressly disclaim any liability for the administration of any extra services provided by these companies. If you have a dispute regarding extra services, you must resolve it with the company providing it. Although we have no obligation to assist with this resolution, you may call Member Services, [Monday through Friday between 7:30 a.m. and 9 p.m. Eastern Standard Time (EST)] at [1-800-777-7902] or [711 (TTY)], and a representative may try to assist in getting the issue resolved.

**Wellness Programs**

You may also participate in a wellness program to incentivize healthy activities (“Wellness Program”), which enables you to earn rewards for participating in health and wellness related activities that are designed to benefit you directly either by promoting physical, mental, or emotional wellness, healthy activity, or your general wellbeing.

The Wellness Program is free to participate in and does not require you to make any payment or exchange any item of value in order to participate and earn any available rewards. However, rewards are subject to a maximum cap on the number of rewards you can receive in a calendar year. Once you reach the maximum number of total rewards for the year, completing an activity will not earn a reward, however, to encourage you to continue to engage in healthy behaviors, you will continue to receive the same number of points as the activity would have earned as a

reward. Points automatically are entered as entries in promotional contests of chance, also called drawings or promotions, for each additional activity you complete.

The Wellness Program may be available only to Members enrolled through certain groups or plans. Health Plan may engage a third party to act as the administrator of the drawings under applicable laws. This third party will ensure all details, such as drawing dates, are disclosed in official rules documents that are published on our website. This third party, and not the Health Plan, will be responsible for all aspects of these promotions. Additional conditions may apply to promotions, as explained by the administrator, including how to participate without internet access, including free alternate methods of entry, eligible activity periods, contact information, and winners lists. Participation in any promotion is always free and you are never required to make any purchase or provide any consideration, or exchange any item or thing of value, if you choose to voluntarily participate.
To learn about the Wellness Program, related rewards, and which ones are available to you, please check our website [kp.org/rewards].

Neither the Wellness Programs nor any promotion accessible in connection with a Wellness Program is offered as an inducement to purchase a health care plan from us.

# ERISA CLAIMS AND APPEALS PROCEDURES

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

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
    - Types of Claims
        - 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 1-888-225-7202 (TTY 711).

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 Benefit 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 Benefit 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.

# ERISA CLAIMS AND APPEALS PROCEDURES

**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 Benefit 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:

Kaiser Permanente Claims Administration
PO Box 371860
Denver CO, 80237-9998
1-888-225-7202 (TTY 711)

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 twenty (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:

    Kaiser Permanente Claims Administration
    PO Box 371860
    Denver CO, 80237-9998

  - 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 thirty (30) days after We receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, if We notify You within thirty (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 forty-five (45) days to send Us the information. We will make a decision within fifteen (15) days after We receive the first piece of information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within forty-five (45) days after We send Our request, We will make a decision based on the information We have within fifteen (15) days following the end of the 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.

**Notice of Claims**

You must give Us written notice of claim within twenty (20) days , but in no event more than twelve (12) months after the occurrence or commencement of any loss covered by the Policy. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. You may give notice or may have someone do it for You. The notice should give Your name and Your policy number. The notice should be mailed to or to Our claims administrator.

Kaiser Permanente Claims Administration
PO Box 371860
Denver CO, 80237-9998

**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 fifteen (15) days after receipt of Your notice of claim, You shall be deemed to have complied with the Proof of Loss requirements by submitting written proof covering the occurrence, character and extent of the loss, within the time limit stated in the Proof of Loss section.

**Proof of Loss**

Written Proof of Loss must be sent to Us or to Our claims administrator at the address shown above within ninety (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, Expenses Incurred for Covered Services that are Medically Necessary will be paid within 30 days upon receipt of written Proof of Loss subject to all of the terms and conditions set forth in the Group Policy..

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 thirty (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 legal action may be brought to recover on this policy before sixty (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.

**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 six (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 fifteen (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 **PRECERTIFICATION** section of this Certificate for a more detailed provision of the Precertification 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
    8954 Rio San Diego Dr., 4th Floor, Ste 406
    San Diego, CA 92108
    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 fifteen (15) days after We receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, if We notify You prior to the expiration of the initial 15-day decision 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 forty-five (45) days to send the information. We will make a decision within fifteen (15) days after We receive the first piece of information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within forty-five (45) days after We send Our request, We will make a decision based on the information We have within fifteen (15) days following the end of the 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 seventy-two (72) hours after We receive Your Claim. Within twenty-four (24) hours after We receive Your Claim, We may ask You for more information. We will notify You of Our decision within forty-eight (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 forty-eight (48) hours after making Our request. If We notify You of Our decision orally, We will send You written confirmation within three (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 Care 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 twenty-four (24) hours before Your ongoing course of covered treatment will end, then during the time that We are considering Your Appeal, You may continue to receive the authorized Covered Services. If You continue to receive these Covered Services while We consider Your Appeal and Your Appeal does not result in Our approval of Your Concurrent Care Claim, then You will have to pay for the services that We decide are not covered.

Please refer to the **PRECERTIFICATION** section of this Certificate for a more detailed provision of the Precertification 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
    8954 Rio San Diego Dr., 4th Floor, Ste 406
    San Diego, CA 92108
    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 twenty-four (24) hours before Your care ends, You may request that We review Your Concurrent Care 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 twenty-four (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 fifteen (15) days after We receive Your Claim. We may extend the time for making a decision for an additional fifteen (15) days if circumstances beyond Our control delay Our decision, if We send You notice before the initial 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, forty-five (45) days to send Us the information. We will make Our decision as soon as possible, if Your care has not ended, or within fifteen (15) days after We first receive any information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within the stated timeframe after We send Our request, We will make a decision based on the information We have within the appropriate timeframe, not to exceed fifteen (15) days following the end of the timeframe We gave You for sending the additional information.

- We will send written notice of Our decision to You and, if applicable to Your provider.
- If We consider Your Concurrent Care Claim on an urgent basis, We will notify You of Our decision orally or in writing as soon as Your clinical condition requires, but not later than twenty-four (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 (Denial), 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 one hundred eighty (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;
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 and who is neither the person who made the initial Denial that is the subject of the Appeal, nor the subordinate of such person.
4. 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 Care 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 one hundred eighty (180) days of Your receiving this notice of Our initial Denial. Please note that We will count the one hundred eighty (180) days starting five (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 will 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 **D. 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:

Kaiser Foundation Health Plan
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736

**Providing Additional Information Regarding Your Claim**

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

Kaiser Foundation Health Plan
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736

When You Appeal, You may give testimony in writing or by telephone. Please send Your written testimony to

Kaiser Foundation Health Plan
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Road, NE
Atlanta, GA 30305-1736

To arrange to give testimony by telephone, You should contact Member Relations 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.

# ERISA CLAIMS AND APPEALS PROCEDURES

**Types of Claims**

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

  For Medical Claims:

  Kaiser Foundation Health Plan
  Attention: Member Relations
  Nine Piedmont Center
  3495 Piedmont Rd, NE
  Atlanta, GA 30305-1736
  Phone: 1-888-225-7202
  Fax: 404-949-5001

  For Optional Prescription Drug:

  Kaiser Foundation Health Plan
  Attention: Member Relations
  Nine Piedmont Center
  3495 Piedmont Rd, NE
  Atlanta, GA 30305-1736
  Phone: 1-855-364-3185
  Fax: 404-949-5001

- 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 fifteen (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 thirty (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 one hundred eighty (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
  8954 Rio San Diego Dr., 4th Floor, Ste 406
  San Diego, CA 92108
  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 fifteen (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 thirty (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
  8954 Rio San Diego Dr., 4th Floor, Ste 406
  San Diego, CA 92108
  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 three (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) <u>Non-Urgent Concurrent Care Appeal</u>**

- Within one hundred eighty (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
  8954 Rio San Diego Dr., 4th Floor, Ste 406
  San Diego, CA 92108
  Telephone number: 1-888-567-6847
  Fax number: 1-866-338-0266

- We will review Your Appeal as follows:
  - <u>For Appeals involving Medical Claims</u> - 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 fifteen (15) days from the date that We receive Your request for Our review at that level unless We inform You otherwise in advance.

  - <u>For Appeals involving Claims arising from the optional prescription drug benefit</u> - 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 thirty (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) <u>Urgent Concurrent Care Appeal</u>**

- Tell Us that You want to urgently Appeal Our Adverse Benefit Determination regarding Your urgent Concurrent Care 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
  8954 Rio San Diego Dr., 4th Floor, Ste 406
  San Diego, CA 92108
  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 seventy-two (72) hours after We receive Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within three (3) days after that.

- If We deny Your Appeal, 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) Appeals of Retroactive Coverage Termination (Rescission)**

- We may terminate Your coverage retroactively (see subsection: Rescission for Fraud or Intentional Misrepresentation provision under the **ELIGIBILITY, EFFECTIVE DATE, & TERMINATION DATE** section). We will send You written notice at least thirty (30) days prior to the termination. If You have general questions about retroactive coverage terminations or Appeals, please write to:

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, CA 94612

Here are the procedures for filing an Appeal of a retroactive coverage termination:

**Appeal of retroactive coverage termination**

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

Kaiser Foundation Health Plan
Attention: Member Relations
Nine Piedmont Center
3495 Piedmont Rd, NE
Atlanta, GA 30305-1736
or fax number 404-949-5001

- We will review Your Appeal and send You a written decision within sixty (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:

District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th St. N.W., 250 North
Washington, D.C. 20001
(877) 685-6391, (202) 724-7491
Fax: (202) 478-1397

**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 Benefit 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 are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
One Judiciary Square
441 4th St. N.W., 250 North
Washington, D.C. 20001
(877) 685-6391, (202) 724-7491
Fax: (202) 478-1397

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

Commissioner
District of Columbia Department of Insurance, Securities and Banking
1050 First Street, N. E., Suite 801
Washington, D.C. 20002
(T) (202) 727-8000
(F) (202) 354-1085

**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*

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