KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Mid-Atlantic

Flexible Choice

Notice:

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

KAISER PERMANENTE INSURANCE COMPANY

SCHEDULE OF COVERAGE

SMALL GROUP POINT OF SERVICE
GOLD 1650 Ded/HSA/Vision

Payments under the Group Policy are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service. (Refer to the definition of Maximum Allowable Charge shown in the **GENERAL DEFINITIONS** section of the Certificate of Insurance) All inpatient admissions and select outpatient procedures are subject to Pre-certification. (Refer to the section entitled **PRECERTIFICATION, MEDICAL REVIEW AND GRIEVANCE AND APPEALS** for complete details.) All Covered Services are subject to the Maximum Benefit While Insured, Deductible and Out-of Pocket Maximum unless otherwise noted below.

COVERED PERSONS: Employee and Dependents (if elected)

Dependent Child Age Limit: 26

MAXIMUM BENEFIT WHILE INSURED UNDER THE GROUP POLICY: Unlimited

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
DEDUCTIBLES (Policy Year):		
Individual/Self-Only Deductible:	$3,300	$4,500
Family Deductible:	$5,500	$9,000
OUT-OF-POCKET MAXIMUMS (Policy Year):		
Individual/Self-Only Out-of-Pocket Maximum:	$4,650	$8,050
Family Out-of-Pocket Maximum:	$9,300	$16,100

IMPORTANT NOTICE:

Covered charges applied to satisfy the Medical Deductible or Out-of-Pocket Maximums at the Participating Provider level will also be applied towards satisfaction of the Medical Deductible or the Out-of-Pocket Maximums at the Non-Participating Provider level. Likewise, Covered Charges applied to satisfy the Medical Deductible or the Out-of-Pocket Maximums at the Non-Participating Provider level will also be applied towards satisfaction of the Medical Deductible or Out-of-Pocket Maximums at the Participating Provider level

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Physician Office Visits:		
Primary Care Physicians:	$10 Co-payment per visit, after deductible	80%
Specialist Care Visits:	$30 Co-payment per visit, after deductible	80%
Telemedicine Service:	Covered, subject to Co-payment shown above based on whether the provider is a Primary Care Physician or a specialist. Deductible does not apply to Telemedicine Services that are considered preventive by the Affordable Care Act	80%
Outpatient Surgery: (Ambulatory/Free Standing Surgery Center)		
Outpatient surgery facility fee:	$250 Co-payment per visit, after deductible	80%
Outpatient surgery Physician fee:	$40 Co-payment per visit, after deductible	80%
Inpatient Hospital Services:		
Hospital admission:	$250 Co-payment per admission, after deductible	80%
Inpatient Physician and Surgical Fees:	$40 Co-payment per admission, after deductible	80%
Accidental Dental: Dental Services for Accidental Injury and Other Related Medical Services	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center	80%
Acupuncture (Covered when medically necessary):	$30 Co-payment per visit, after deductible	80%
Allergy/Injections:		
Allergy Treatment (evaluation & diagnosis):	$30 Co-payment per visit, after deductible	80%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Allergy Serum Injections (without a provider visit):	$10 Co-payment per visit, after deductible	80%
Ambulance Services:		
Emergency Transportation/Ambulance:	Covered In-Plan	Covered In-Plan
Non -Emergent Transport: Ambulette:	Not Covered	Not Covered
Blood, Blood Products and Derivatives:	80%	60%
Bone Mass Measurements:		
Preventive Screening:	$0 Co-payment per visit (Deductible waived)	80%
Diagnostic:	$30 Co-payment per visit, after deductible	80%
Chiropractic Services:	$30 Co-payment per visit, after deductible Limited to a combined Benefit Maximum of 20 visits per condition per Policy Year	80%
Cleft lip, Cleft Palate or both:	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center	80%
Clinical Trials:	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center	80%
Dental Anesthesia and Facility Fees:	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center	80%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Diabetic Equipment, Supplies & Self-Management Training:		
Diabetic Equipment and Supplies:	80%	60%
Glucometers including lancets and control solution (preventive):	80% (Deductible waived)	60%
	Glucometers are treated as preventive care only when prescribed to treat an individual diagnosed with diabetes. Otherwise the supply will be considered non-preventive and provided under the Diabetic Equipment and Supplies benefit and subject to the applicable deductible and coinsurance.	
Diabetic Test Strips:	100% (Deductible is waived for diabetic test strips used in conjunction with glucometers prescribed to treat an individual with diabetes.)	100% after deductible
Self-Management Training:	$30 co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center	80%
Dialysis:		
Renal Dialysis/Hemodialysis/Peritoneal in a renal dialysis center, including diagnostic, supplies, equipment & drugs:	$30 Co-payment per visit, after deductible	80%
Home Dialysis (including equipment and supplies):	100% after deductible	80%
Durable Medical Equipment:	80%	60%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Peak Flow Meters (preventive):	80% (Deductible waived) Peak flow meters are treated as preventive care only when prescribed to treat an individual diagnosed with asthma. Otherwise the supply will be considered non-preventive and provided under the Durable Medical Equipment benefit and subject to the applicable deductible and coinsurance.	60%
Home Ultraviolet (UV) Light Box:	80%	60%
Emergency Room Services:	Covered In-Plan	Covered In-Plan
Habilitative Services (Adults & Children)		
Physical Therapy – Outpatient: (No Visit limit)	$30 Co-payment per visit, after deductible	80%
Speech Therapy – Outpatient: (No Visit limit)	$30 Co-payment per visit, after deductible	80%
Occupational Therapy – Outpatient: (No Visit limit)	$30 Co-payment per visit, after deductible	80%
Applied Behavioral Analysis (ABA) – Outpatient: (No Visit limit)	$10 Co-payment per visit, after deductible	80%
Assistive Devices:	80%	60%
Hearing Services:		
Hearing Tests: Note: Hearing screening tests for newborns covered under Preventive Care	$30 Co-payment after deductible in provider office	80%
Hearing Aid Exam Visit:	$30 Co-payment per visit, after deductible	80%
Hearing Aids (adults and children):	80% Limited to a combined Benefit Maximum of one hearing aid for each hearing-impaired ear every 36 months	60%
Home Health Care:	$100 Co-payment after deductible per Policy year	80%
Hospice Care Services:	$100 Co-payment after deductible per Policy year	80%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Immunization Related to Foreign Travel:	Not Covered	Not Covered
Maternity Services:		
Inpatient and Birthing Center Delivery:	$250 Co-payment per admission, after deductible	80%
Inpatient and Birthing Center Physician and Surgical fees:	$40 Co-payment per admission, after deductible	80%
Routine prenatal care and postnatal visit including telemedicine services:	$0 Co-payment per visit (Deductible waived)	80%
Postpartum Home Visits:	$0 Co-payment per visit, after deductible	100%, after deductible
Medical Foods: (Including Amino Acid-based Elemental Formula)	80%	60%
Medical Nutrition Therapy & Counseling:	$10 Co-payment per visit, after deductible	80%
Mental Health and Substance Abuse Services:		
Inpatient treatment in a hospital or residential treatment center, including detoxification:	$250 Co-payment per admission, after deductible	80%
Inpatient Physician and Surgical fees:	$40 Co-payment per admission, after deductible	80%
Diagnostic Evaluation:	$10 Co-payment per visit, after deductible	80%
Outpatient Individual Therapy:	$10 Co-payment per visit, after deductible	80%
Outpatient Group Therapy:	$5 Co-payment per visit, after deductible	80%
Outpatient Intensive Therapy:	$10 Co-payment per visit, after deductible	80%
Medication evaluation and management visits:	$10 Co-payment per visit, after deductible	80%
All Other Outpatient Services (when not performed as part of an office visit):	$10 Co-payment per visit, after deductible	80%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Partial hospitalization Treatment:	$10 Co-payment per visit, after deductible	80%
Psychological and Neuropsychological Testing:	$10 Co-payment per visit, after deductible	80%
Electroconvulsive Therapy (ECT):	$10 Co-payment per visit, after deductible	80%
Crisis Intervention and Stabilization:	$10 Co-payment per visit, after deductible	80%
Morbid Obesity Services, including bariatric surgery:	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center $250 Co-payment per inpatient hospital admission, after deductible	80%
Oral Surgery:		
Medically necessary coverage of diseases and injury to jaw:	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center $250 Co-payment per inpatient hospital admission, after deductible	80%
TMJ:	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center $250 Co-payment per inpatient hospital admission, after deductible	80%
TMJ Appliances (removable appliances for TMJ repositioning):	80%	60%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Prosthetics and Orthotics:		
Internal Prosthetics: (Covers medically necessary internally implanted devices during surgery, i.e. pacemakers, ocular lens implants, artificial hips & joints, breast implants and cochlear implants approved by FDA.)	80%	60%
External Prosthetics & Orthotics: (Includes all medically necessary, including artificial limbs/eyes, breast prosthesis following a medically necessary mastectomy; Ostomy and Urological Supplies, Hair Prosthesis)	80%	60%
	Limited to a combined Benefit Maximum of 4 mastectomy bras per Policy Year and one (1) hair prosthesis for hair loss when prescribed by a provider	
Radiation Therapy/Chemotherapy and Infusion Therapy:		
Radiation Therapy:	$30 Co-payment per visit, after deductible	80%
Chemotherapy Visit:	$30 Co-payment per visit, after deductible	80%
Infusion Therapy:	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center	80%
Reconstructive Surgery:	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center $250 Co-payment per inpatient hospital admission, after deductible	80%
Routine Foot Care:	$30 Co-payment per visit, after deductible	80%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Skilled Nursing Care Services in a Skilled Nursing Facility:	$250 Co-payment per admission, after deductible	80%
	Limited to a combined Benefit Maximum of 100 days per Policy Year	
Therapy, Rehabilitation:		
Physical Therapy – Outpatient:	$30 Co-payment per visit, after deductible	80%
	Limited to a combined Benefit Maximum of 30 visits per condition per Policy Year	
Speech Therapy – Outpatient:	$30 Co-payment per visit, after deductible	80%
	Limited to a combined Benefit Maximum of 30 visits per condition per Policy Year	
Occupational Therapy – Outpatient:	$30 Co-payment per visit, after deductible	80%
	Limited to a combined Benefit Maximum of 30 visits per condition per Policy Year	
Cardiac Rehabilitation Therapy – Outpatient:	$30 Co-payment per visit, after deductible	80%
	Limited to a combined Benefit Maximum of 90 visits per therapy per Policy Year	
Pulmonary Rehabilitation:	$30 Co-payment per visit, after deductible	80%
X-Ray; Laboratory and Special Procedures – Outpatient:		
X-Rays, Imaging:	$30 Co-payment per visit, after deductible	80%
Lab Tests – Diagnostic:	$10 Co-payment per visit, after deductible	80%
Sleep Lab:	$150 Co-payment per visit, after deductible	80%
Sleep Studies:	$30 Co-payment per visit, after deductible	80%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

COVERED SERVICES	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Interventional Radiology:	$150 Co-payment per visit, after deductible	80%
Specialty Imaging (per test, not per visit) MRI, CT Scan, PET Scan, Nuclear Medicine:	$150 Co-payment after deductible	80%
Transplants:	Covered In-Plan Only	Covered In-Plan Only
Urgent Care Service:		
Urgent Care Office Visits:	$10 Co-payment per visit, after deductible (Primary) $30 Co-payment per visit, after deductible (Specialist)	80%
Urgent Care Centers or Facilities:	$30 Co-payment per visit, after deductible	80%
Vision Services:		
Routine Eye Exams (Optometrist):	$ Co-payment per visit, after deductible	80%
Routine Eye Exams (Ophthalmologist)	$30 Co-payment per visit, after deductible	80%
Pediatric Frames/Lenses:	Not Available	60%, up to a benefit maximum of one non-designer frame
Pediatric Contact Lenses (in lieu of eyeglasses):	Not Available	60%, up to a benefit maximum of the first purchase per year
Pediatric Medically Necessary Contact Lenses:	Not Available	60%, up to a benefit maximum of 2 pair per eye per year
Low Vision Aids:	Not Available	Not Available
Adult Frames:	Not Available	Not Available
Adult Lenses:	Not Covered	Not Covered
Adult Contact Lenses:	Not Covered	Not Covered

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

	PERCENTAGE PAYABLE*	
COVERED SERVICES	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**
Wellness Benefit:	$0 Co-payment per visit (Deductible waived)	80%
Other Covered Services:	80%	60%
Preventive Care:		
Exams:	$0 Co-payment per visit (Deductible waived)	80%
Screenings:	$0 Co-payment per visit (Deductible waived)	80%
Health Promotion:	$0 Co-payment per visit (Deductible waived)	80%
Disease Prevention:	$0 Co-payment per visit (Deductible waived)	80%
Breast Cancer Screening: (Diagnostic and supplemental examinations including MRI, ultrasound and image-guided biopsy)	No Charge after deductible	No Charge after deductible
Lung Cancer Screening: (Diagnostic examination including MRT, CT scan, ultrasound and image-guided biopsy	No Charge after deductible	No Charge after deductible
Other Preventive Care (Non-ACA):		
Routine Adult Physical Exams:	$0 Co-payment per visit (Deductible waived)	80%
Other Identified Labs and Screenings:	$0 Co-payment per visit (Deductible waived)	80%
Family Planning Non-Preventive:		
Male sterilization (vasectomy):	100%, after deductible	100%, after deductible
Abortion Care Services:	100% after deductible	100% after deductible
Fertility Services:		
Standard fertility preservation visit and procedure for iatrogenic infertility:	$30 Co-payment per visit after deductible	80%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

	PERCENTAGE PAYABLE*	
COVERED SERVICES	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER**
All Other Covered Services: (Including sperm and oocyte collection and cryopreservation; evaluations, laboratory assessments, medications and treatments associated with sperm and oocyte collection and cryopreservation.):	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center	80%
Infertility Services:		
Infertility Drugs (self-administered drugs obtained through Pharmacy):	See Rx Cost Shares	See Rx Cost Shares
Infertility Diagnosis and Treatment (excludes In vitro fertilization):	$30 Co-payment after deductible in provider office $150 Co-payment after deductible in outpatient hospital/surgery center	80%

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

OPTIONAL BENEFITS:	PERCENTAGE PAYABLE* PARTICIPATING PROVIDER	PERCENTAGE PAYABLE* NON-PARTICIPATING PROVIDER**
Outpatient Prescription Drug Benefit		
After satisfaction of the Self-Only Deductible (shown below), each Covered Person shall pay the lesser of the cost of the Prescription Drug or the applicable co-payment or coinsurance (Co-payments/coinsurance shown are based on a 30-day supply.)		
Self Only Deductible (per Policy Year):	Policy Year Deductible	Policy Year Deductible
Tier 1 Drugs (Includes commonly prescribed Generic Drugs):	$20 Co-payment per prescription, after satisfaction of deductible	20%, after satisfaction of deductible
Tier 2 Drugs (Includes commonly prescribed Brand Name Drugs and commonly prescribed higher-cost Generic Drugs:	$45 Co-payment per prescription, after satisfaction of deductible	20%, after satisfaction of deductible
Tier 3 Drugs (Includes all other Brand Name Drugs and a limited number of Generic Drugs that are on the Formulary list and not included in Tier 1 Drugs or Tier 2 Drugs. Drugs on this tier also include Biosimilar Drugs):	$65 Co-payment per prescription, after satisfaction of deductible	20%, after satisfaction of deductible
Tier 4 Drugs (Includes Specialty Drugs as defined in the **GENERAL DEFINITIONS** section):	50% up to $150, after satisfaction of the deductible	50% up to $150, after satisfaction of deductible
Outpatient prescription drugs are listed in the Formulary by drug tier, please refer to the Formulary located at: https://healthy.kaiserpermanente.org/static/health/pdfs/formulary/mid/mid_flexchoice.pdf		
Infertility Drugs:	See Drug Tier for applicable Rx cost share	See Drug Tier for applicable Rx cost share
Insulin:	See Drug Tier for applicable Rx cost share; not to exceed $30 per 30-day supply/$90 per 30-day supply	See Drug Tier for applicable Rx cost share; not to exceed $30 per 30-day supply/ $90 per 30-day supply
Diabetes, Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Drugs:	See Drug Tier for applicable Rx cost share; not to exceed $150 per 30-day supply/$450 per 90-day supply	See Drug Tier for applicable Rx cost share; not to exceed $150 per 30-day supply/$450 per 90-day supply

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

SCHEDULE OF COVERAGE

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits otherwise payable will be reduced by 30%, limited to a maximum of $5,000 per Policy Year if you fail to obtain Precertification.

	PERCENTAGE PAYABLE*	
OPTIONAL BENEFITS:	**PARTICIPATING PROVIDER**	**NON-PARTICIPATING PROVIDER****
Smoking Cessation Drugs:	$0 Co-payment per prescription	20%, after satisfaction of deductible
Contraceptive Drugs:	$0 Co-payment per prescription	100%, after satisfaction of deductible
Preventive Care Drugs (Includes OTC Drugs required under ACA Rules with prescription):	$0 Co-payment per prescription	20%, after satisfaction of deductible
Oral Chemotherapy Drugs:	$0 Co-payment per prescription, after satisfaction of deductible	100%, after satisfaction of deductible
Self-Injectable: (Limited to a 30-day supply)	See Drug Tier for applicable Rx cost share	See Drug Tier for applicable Rx cost share
Maximum Daily supply:	Limited to the lesser of a 30-day supply or the standard amount prescribed for a prescription drug or supply. Maintenance Drugs will be limited to a 90-day supply subject to 2 Co-payments. For contraceptive drugs, up to a 12-month supply may be obtained at one time.	

**A Pharmacy claim form is required for prescriptions filled at non-participating pharmacies. Reimbursement of claims for prescriptions filled at non-participating pharmacies are based on the Percentage Payable of the Maximum Allowable Charge.

Members may obtain a partial supply of a prescription drug and will be charged a prorated daily copayment or coinsurance from a participating pharmacy if the following conditions are met:

1. the prescriber or the pharmacist determines dispensing a partial supply of a prescription drug to be in the best interest of the member;
2. the prescription drug is anticipated to be required for more than 3 months;
3. the member requests or agrees to a partial supply for the purpose of synchronizing the dispensing of the member's prescription drugs;
4. the prescription drug is not a schedule II controlled dangerous substance; and
5. the supply and dispensing of the prescription drug meets all prior authorization and utilization management requirements specific to the prescription drug at the time of the synchronized dispensing.

IMPORTANT: For a complete understanding of the benefits, exclusions and limitations applicable to Your coverage, this Schedule of Coverage must be read in conjunction with the Certificate of Insurance.

*Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for a Covered Service to calculate the benefit payable under the Group Policy after satisfaction of any deductibles, Co-payments or Coinsurance amounts.

†After satisfaction of the Co-payment, KPIC will then pay 100 percent of Covered Charges incurred for such visits up to the Benefit Maximum.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. KPIC does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-225-7202** (TTY: **7**[illegible])

If you believe that Kaiser Permanente Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: KPIC Civil Rights Coordinator, Grievance 1557, 8954 Rio San Diego Dr, 4th Floor, Ste 406 San Diego, CA 92108, telephone number 1-8[illegible]8-567-6847.

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

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-225-7202** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-225-7202** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-225-7202** (TTY: **711**).

Băsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ ǹià ɛ̀kɛ dyéɖé gbo: Ɔ jŭ ké m̀Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jŭ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ bɛ́ǹ m̀gbo kpáa. Đá **1-800-225-7202** (TTY: **711**)

বাংলা (Bengali) লক্ষ্য করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিম্নখরচায় ভাষা সহায়তা পিরেষবা উপলব্ধ আছে। ফোন করুন **1-800-225-7202** (TTY: **711**)।

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-225-7202**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-225-7202** (**711**:TTY) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-225-7202** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-225-7202** (TTY: **711**).

ગુજરાતી (Gujarati) સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-800-225-7202** (TTY: **711**).

Kreyòl Ayisyen (Haitian Creole) ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-225-7202** (TTY: **711**).

हिन्दी (Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपकेलिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-225-7202** (TTY: **711**) पर कॉल करें।

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-225-7202** (TTY: **711**).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-800-225-7202** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-225-7202**（TTY: **711**）までお電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용하실 수 있습니다. **1-800-225-7202** (TTY: **711**)번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí na'ólnih koj j' hódíílnih **1-800-225-7202** (TTY: **711**).

Português (Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-225-7202** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-225-7202** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-225-7202** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-225-7202** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-225-7202** (TTY: **711**).

اُردو (Urdu) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-800-225-7202** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-225-7202** (TTY: **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-225-7202** (TTY: **711**).

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

HSA AMENDMENT RIDER

This Rider is issued and made part of the Group Policy/Certificate to which it is attached. This Rider shall be effective on the earlier of: (1) the Group Policy's Effective Date occurring on or after January 1, 2018, or (2) the first Group Policy Anniversary occurring on or after January 1, 2018.

By attachment of this Rider, the Group Policy/Certificate to which it is attached is amended as follows:

I. The **"INTRODUCTION**" section is amended by the addition of the following provision:

If You are Enrolled in a Health Savings Account Qualified Plan

The health insurance coverage described in this Certificate has been designed to be a High Deductible Health Plan (HDHP) qualified for use with a Health Savings Account (HSA) in accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (as then constituted or later amended). An HSA is a tax-exempt trust or custodial account for the exclusive purpose of paying current and future qualified medical expenses of the account beneficiary. Contributions to such an account may be tax deductible, but in order to qualify for and make contributions to an HSA, You must be enrolled in a qualified HDHP. Enrollment in an HSA qualified HDHP is only one of the eligibility requirements for establishing and contributing to an HSA. Please consult with Your employer regarding other HSA eligibility requirements.

Kaiser Permanente Insurance Company does not provide tax advice. Consult with Your financial or tax advisor for tax advice or more information about Your eligibility for an HSA.

II. The following definitions are added to the **"GENERAL DEFINITIONS"** section:

1. **Health Savings Account (HSA)** means a tax-exempt trust or custodial account established in accordance with the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (as then constituted or later amended) exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to an HSA by an eligible individual may be tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to an HSA, You must be covered under a qualified High Deductible Health Plan (HDHP) and meet other tax law requirements. Kaiser Permanente Insurance Company does not provide tax advice. Consult with Your financial or tax advisor for tax advice or more information about Your eligibility for an HSA.

2. **High Deductible Health Plan (HDHP)** means a health benefit plan that meets the requirements of the Internal Revenue Code. The health insurance coverage under the Group Policy has been designed to be a HDHP qualified for use with a Health Savings Account.

III. The "**DEDUCTIBLES AND MAXIMUMS"** section is amended by the addition of the following provision:

Keep Your Receipts

When You pay out-of-pocket for qualified medical expenses associated with your Deductible, You will receive a receipt. Keep Your receipts. If You have an HSA account, You may need to prove to the IRS that distributions from Your HSA were for qualified medical expenses. Also, if You have met Your Deductible, and we have not received and processed all of Your claims, You can use Your receipts to

prove that You have met Your Deductible. You can also obtain a statement of the amounts that have been applied toward Your Deductible from KPIC

IV. The "**Coordination of Benefits (COB)"** section is amended to include the following provision:

Members with a Health Savings Account (HSA)

Please note that if You have other health care coverage in addition to the health insurance coverage under the Group Policy, in most instances You will not be eligible to establish or contribute to an HSA unless both plans qualify as High Deductible Health Plans. Consult with Your financial or tax advisor for tax advice or more information about Your eligibility for an HSA.

This does not change, waive or extend any part of the Group Policy/Certificate other than as set forth herein. This Rider is subject to all the provisions of the Group Policy/Certificate that are not in conflict with this Rider. In the event this Rider creates a duplication of benefits, duplicate benefits will not be paid, but the higher of the applicable benefits will apply. This Rider terminates on the same date as the Group Policy, unless otherwise terminated by KPIC upon renewal of the Group Policy.

Charles P. Bavilacqua
President

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Maryland

Point-of-Service (POS) Small Group (*Non-grandfathered Coverage)*

Certificate of Insurance

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverages funded through a Group Insurance Policy (Group Policy) issued to Your group by Kaiser Permanente Insurance Company (KPIC). It becomes Your Certificate of Insurance (Certificate) when You have met certain eligibility requirements and are enrolled in the Plan.

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 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". Refer to the **GENERAL DEFINITIONS** section for the meaning of capitalized terms.

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

Language Assistance

SPANISH (Español): Para obtener asistencia en Español, llame al 1-(800)-686-7100.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-(800)-686-7100.

CHINESE (中文): 如果需要中文的帮助，请拔打这个号码1-(800)-686-7100.

NAVAJO (Dine): Dinek'ehgo shika at'onwol ninisingo, kwiijigo holne' 1-(800)-686-7100.

Please refer to the General Limitations and Exclusions section of this Certificate for a description of this health insurance 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 Non-Participating Providers. The Provider you select can affect the dollar amount you must pay.

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.

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

INTRODUCTION

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

Introduction To Your Plan

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

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

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

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

Access to Care

For the Participating Providers and Non-participating Provider options, KPIC is responsible for paying for the medical and hospital services described in this Certificate/Group Policy. Your coverage under the Group Policy includes coverage for certain Covered Services received from Participating Providers in Option 2. 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 Pre-certification on Your behalf. Please refer to the **PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS** section for Pre-certification processes including a list of Covered Benefits subject to Pre-certification.

To verify the current participating status of a provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Providers is available from Your employer, or You may call the phone number listed on Your ID card, or You may visit KPIC's Participating Provider network's website 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 level at the Out-of-Network option level. Your financial responsibility is different for Covered Services rendered by Non-Participating Providers, and You should consult the Schedule of Coverage to determine the amount which KPIC will pay for a Covered Service.

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

Neither Health Plan nor KPIC is responsible for any Covered Person's/Member's decision to receive treatment, services or supplies at any option level. Neither Health Plan nor KPIC is liable for the qualifications of providers or treatment, services or supplies rendered under the other payor's coverage. This Certificate and the Group Policy set forth the terms of the coverage underwritten by KPIC.

IMPORTANT: If a Covered Person is diagnosed with a condition or disease that requires specialized medical care and: (1) KPIC's Participating Provider network does not have a specialist or non-physician specialist with the professional training and expertise to treat the condition or disease, or (2) KPIC cannot provide reasonable access to a specialist or non-physician specialist with the professional training and expertise to treat the condition or disease without unreasonable delay or travel, then the Covered Person may obtain Covered Services from a specialist or non-physician specialist who is not part of KPIC's Participating Provider network and such Covered Services will be payable at the Participating Provider benefit level. Services received for mental health or substance use disorders from a Non-Participating Provider are provided at no greater cost to the Covered Person than if the Covered Services were provided by a Participating Provider on KPIC's provider panel.

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

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

Who Can Answer Your Questions?

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

For coverage, benefits, and current eligibility: 1-888-225-7202 (TTY 711)

For name and address changes: 1-888-225-7202 (TTY 711)

Or You may write to the Administrator:

Kaiser Permanente Claims Administration
PO Box 371860

Denver CO, 80237-9998]

For information or verification of enrollment and/or 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 please call the number listed on Your ID card or 1-888-567-6847.

GENERAL DEFINITIONS

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

Accumulation Period means the time period of not less than twelve (12) months.

Administrator means Kaiser Permanente Claims Administration, PO Box 371860, Denver CO, 80237-9998 and refers to the administrator of the Group Policy only. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior notice. Neither KPIC nor Health Plan is the administrator of Your employee benefit plan as that term is defined under Title I of the federal Employee Retirement Income Security Act of 1974 (ERISA), as then constituted or later amended.

Air Ambulance Service means medical transport by a 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 a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical; legal; financial; or psycho-social.

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

Amino Acid-Based Elemental Formula(s) medical formulas that are made from individual (single) non-allergenic amino acids unlike regular dairy (milk or soy based) formulas as well as foods that contain many complete proteins. Amino acid-based elemental formulas are made of proteins broken down to their "elemental level" so that they can be easily absorbed and digested.

Ancillary services means:

1. Items and services furnished by a non-participating provider in a participating facility related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;
2. Items and services provided by assistant surgeons, hospitalists, and intensivists.
3. Diagnostic services, including radiology and laboratory services; and
4. Items and services provided by a non-participating provider if there is no Participating provider who can furnish such item or service at such facility.

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 member of the patient.

Benefit Maximum means a total amount of benefits that will be covered and/or paid by KPIC for a specified type of Covered Charges incurred during a given period of time. Applicable Benefit Maximums are contained within the text of this Certificate and/or are shown in the Schedule of Coverage. When a Benefit Maximum is reached, additional Expenses Incurred for the specific benefit, or class of benefits, do not qualify as Covered Charges and will not count toward satisfaction of any Deductible or Out of Pocket Maximum.

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

Birth Center means a free-standing health care 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.

Body Mass Index means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

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 listed by Us as a drug preferred or favored to be dispensed.

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

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

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

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

Coinsurance means that percentage of Covered Charges to be paid by the Covered Person. The percentage of Covered Charges to be paid by the Covered Person is the difference between the Percentage Payable by KPIC and the Maximum Allowable Charge. 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.

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 24-hour-a-day basis as a registered inpatient upon the order of a Physician.

Continuing care patient means an individual who, with respect to a provider or facility:
1. Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. Is undergoing a course of institutional or inpatient care from the provider or facility;
3. 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:
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. 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.

Contract Year means a consecutive 12-month 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 day before the same date of the next calendar year unless otherwise 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.

Co-payment means the predetermined dollar amount, as shown in the Schedule of Coverage, which is to be paid by the Covered Person directly to a Participating Provider for a Covered Service, usually at the time the health care is rendered for the Covered Service. Co-payments do not count toward satisfaction of the Individual or Family Deductibles. All Co-payments applicable to the Covered Services are shown in the Schedule of Coverage. Co-payments are applied on a per visit or per service basis. Co-payments paid for Covered Services and those paid for prescription drugs under the Prescription Drug benefit do count toward satisfaction of the Out-of-Pocket Maximum.

Cosmetic Surgery means surgery that: a) is performed to alter or reshape normal structures of the body in order to change the patient's appearance; and b) will not result in significant improvement in physical function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.

Cost Share means a Covered Person's share of Covered Charges. Cost Share includes and is limited only to the following: 1) Coinsurance; 2) Copayment; and 3) Deductible; and 4) any benefit specific deductible.

Covered Charge means the Maximum Allowable Charge for a Covered Service.

Covered Person means a person covered under the terms of the Group Policy and who is duly enrolled as an Insured Employee or Insured Dependent under the Group Policy. No person may be covered as both an Insured Employee and a Dependent at the same time.

Covered Services means those services and items which a Covered Person is entitled to receive pursuant to the Group Policy and are defined and listed under the section 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 a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit,

disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

2. The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3. The Medicaid program pursuant to Title XIX of the Social Security Act.
4. Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
5. A health plan offered under 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
9. A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(l) 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 Contract Year. The Deductible will apply to each Covered Person separately, and must be met within each Contract Year. When Covered Charges equal to the Deductible are incurred during that Contract 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, nor will such Covered Charges 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 are not subject to, nor do they contribute towards satisfaction of, the Individual or Family Deductibles nor the Out-of-Pocket Maximum.

Dependent means:

1. Your lawful spouse:
2. Your or Your covered spouse's dependent child under the limiting age of twenty-six (26) who is:
    a. A biological child, stepchild, grandchild, or foster child;
    b. A lawfully adopted child from the date of placement or a child in the process of being adopted;our or Your covered spouse's grandchild under testamentary or court-appointed guardianship;
    c. A child for whom You or Your covered spouse have been granted legal custody (other than custody as a result of aguardianship); or
    d. A child for whom You or Your covered spouse have a legal obligation to provide coverage pursuant to a child support order or other court order or court-approved agreement or testamentary appointment.

An unmarried child who is covered as a Dependent when they reach the limiting age of twenty-six (26) may be eligible for coverage as a disabled Dependent if the child meets all of the following requirements:

1. They are incapable of self-sustaining employment because of a mental or physical incapacity that occurred prior to reaching the age limit for Dependents;

2. They must be chiefly financially dependent for their support and maintenance from You or Your spouse, or other Covered Person and
3. You provide Us proof of the child's incapacity and dependency upon attainment of the limiting age and no more frequently than annually during the duration of the incapacity during the duration of the dependency.

Covered Persons must notify Health Plan of any change in eligibility of a Dependent for any reason other than when a child reaches age twenty-six (26).

As used in this definition, the term "spouse" will include Your Domestic Partner if such eligibility is elected by the Policyholder.

Domestic Partner means an individual in a relationship with an Insured Employee of the same or opposite sex, provided both individuals:

1. Are at least eighteen (18) years old;
2. Are not related to each other by blood or marriage within four degrees of consanguinity under civil law rule;
3. Are not married or in a civil union or domestic partnership with another individual;
4. Have been financially interdependent for at least six (6) consecutive months prior to application in which each individual contributes to some extent to the other individual's maintenance and support with the intention of remaining in the relationship indefinitely; and
5. Share a common primary residence.

Drug Abuse means a disease which is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life; medical, legal, financial, or psycho-social.

Durable Medical Equipment means medical equipment which is:

1. designed for repeated use;
2. mainly and customarily used for medical purposes;
3. not generally of use to a person in the absence of a Sickness or Injury;
4. approved for coverage under Medicare approved, except for apnea monitors and breast pumps;
5. not primarily and customarily for the convenience of the Covered Person;
6. Provides direct aid or relief of the Covered Person's medical condition;
7. appropriate for use in the home, and
8. Serves a specific therapeutic purpose in the treatment of an illness or injury.

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 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:

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 medical conditions are covered by the Health Plan as an In-Plan benefit. For details of coverage see the Health Plan's Evidence of Coverage.

Emergency Services (Emergency Care) means, with respect to an emergency medical condition:

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd), or as would be required under such section if such section applied to an independent freestanding emergency department) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate the emergency medical condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and
3. Except as provided in item 4. below, Covered Services that are furnished by a nonparticipating provider or nonparticipating 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 the services described in item 1. above are furnished.
4. The Covered Services described in item 3. above are not included as emergency services if all of the following conditions are met:
    a. The attending emergency physician or treating provider determines that the individual is able to travel using nonmedical transportation or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition;

b. The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 C.F.R § 149.420(c) through (g) with respect to such items and services, provided that the written notice additionally satisfies items 4.b.i. and ii. below, as applicable;
    i. In the case of a participating emergency facility and a non-participating provider, the written notice must also include a list of any Participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or member may be referred, at their option, to such a Participating provider.
    ii. In the case of a non-participating - Facility, the written notice must include the good faith estimated amount that the individual may be charged for items or services furnished by the non-participating emergency facility or by non-participating providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the non-participating emergency facility or non participating providers in conjunction with such items or services);
c. The individual (or an authorized representative of such individual) is in a condition to receive the information described in item b. above, 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; and
d. The covered services are not rendered by a health care provider who is subject to §19-710(p) of the Health-General Article.

Emergency services are covered by the Health Plan as an In-Plan benefit. For details of coverage see the Health Plan's Evidence of Coverage.

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 Services means services that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered.

Experimental Services do not include controlled clinical trials as defined in the **General Benefit** section.

External Prosthetics and Orthotics means:

1. An External Prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Examples of external prosthetics includes artificial limbs, parental and enteral nutrition, urinary collection and retention systems, colostomy bags and other items and supplies directly related to ostomy care and eye wear after cataract surgery or eyewear to correct aphakia. Supplies necessary for the effective use of prosthetic device are also considered prosthetics.
2. Orthotics that are rigid or semi rigid external devices. They must: a) support or correct a defective form or function of an inoperative or malfunctioning body part; or b) restrict motion in a diseased or injured part of the body. Orthotics do not include casts.

External Prosthetics and Orthotics must be approved for coverage under Medicare to be covered under this plan.

Filing Date means the earlier of**:**
1. Five (5) days after the date of mailing; or
2. The date of receipt.

Formulary means a list of prescription drugs and which will be dispensed through Participating and Non-participating Pharmacies to Covered Persons. Unless specifically excluded under the plan, all FDA-approved drugs are part of this Plan's Formulary. A copy of the formulary may be obtained by visiting https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/flexible-choice-and-out-of-area-ppo-formulary-mas-en.pdf.

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 means a prescription drug that does not bear the trademark of a specific manufacturer. It is chemically the same as 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 Care Facility means a medical facility as defined in Health-General Article, §19-114, Annotated Code of Maryland.

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

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 means the continued care and treatment of a Covered Person in the home if:
1. The institutionalization of the covered person in a hospital or related institution or skilled nursing facility would otherwise have been required if home health care were not provided; and
2. The plan of treatment covering the home health care service is established and approved in writing by the health care practitioner.

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; and
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, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the Illness and bereavement to: (a) Covered Persons who have no reasonable prospect of cure as estimated by a Physician; and (b) the immediate families or family caregivers of those individuals. As used in this definition: (1) "bereavement counseling" means counseling provided to the immediate family or family caregiver of the Covered Person after the Covered Person's death to help the immediate family or family caregiver cope with the death of the Covered Person; (2) "family caregiver" means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of the terminally ill Covered Person; (3) "family counseling" means counseling given to the immediate family or family caregiver of the terminally ill Covered Person for the purpose of learning to care for the Covered Person and to adjust to the death of the Covered Person; (4) "immediate family" means the spouse, parents, siblings, grandparents, and children of the terminally ill Covered Person; (5)"respite care" means temporary care provided to the terminally ill Covered Person to relieve the family caregiver from the daily care of the Covered Person; (6) "terminally ill" means a medical prognosis given by a Physician that the Covered Person's life expectancy is six (6) months or less.

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-based physician means:

1. a physician licensed in the State who is under contract to provide health care services to patients at a hospital; or
2. a group physician practice that includes physicians licensed in the State that is under contract to provide health care services to patients at a hospital.

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

Human Papillomavirus Screening means the use of any laboratory test that specifically detects for infection by one or more agents of the human papillomavirus; and is approved for this purpose by the Federal Food and Drug Administration.

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.

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.

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

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry.

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

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

Insured Employee means a Covered Person who is an employee of the Policyholder or who is entitled to coverage under the Group Policy through a welfare trust agreement and is enrolled in this Plan.

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.

Late Enrollee means, as determined by Health Plan, an otherwise eligible employee or dependent who requests enrollment under the Group Policy other than during: (1) the first period in which the individual is eligible to enroll; or (2) a special enrollment period.

Licensed Vocational Nurse (LVN) means an individual who has: 1) received specialized nursing training; 2) acquired vocational nursing experience; and 3) is duly licensed to perform nursing service by the state in which he or she performs such service. An LVN will include a licensed practical nurse and a certified nurse practitioner.

Limited Distribution Drug (LDD) means a prescription drug that is limited in distribution by the manufacturer or FDA.

Low Protein Modified Food Product means a food product that is: (1) specially formulated to have less than 1 gram of protein per serving; and (2) intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. Low Protein Modified Food Product does not include a natural food that is naturally low in protein.

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

Mastectomy means the surgical removal of all or part of a breast.

Maternity Services means 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 any applicable Deductible, Copayment, and Coinsurance by the Covered Person.

5. 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. In no instance, however, shall the UCR be less than the Maximum Allowable Charge paid applicable to the same service rendered by a similarly licensed provider who is a Participating Provider in the same geographic region. With regard to Non-participating on-call Physicians and Non-participating Hospital-based Physicians, the UCR shall be calculated in accordance with the requirements of Maryland Insurance Article 14-225.2.

      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.

      Except as provided below, 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 or 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.

An on-call physician or a hospital-based physician who has accepted an assignment of benefits, will accept the payment as payment in full for Covered Services, subject to payment of any applicable Deductible, Copayment, and Coinsurance by the Covered Person.

KPIC’s Maximum Allowable Charge for a health care service provided by Non-Participating Providers will not be less than the Maximum Allowable Charge paid to a similarly licensed provider who is a Participating Provider for the same health care service in the same geographic area.

An ambulance service provider that obtains an assignment of benefits and receives direct reimbursement may only collect from the insured any copayment, deductible or coinsurance owed by the insured or the charge for services that are not covered services.

Balance billing will not apply to the following: (i) services received from a referral to a non-panel specialist and non-Physician specialist as result of referral as described in §15-830(d) for mental health or substance use disorders as described in the **INTRODUCTION** section of this Certificate; (ii) items and services furnished by a Non-Participating Provider with respect to a covered visit at a Participating Facility, except when the Non-Participating Provider has satisfied the notice and consent criteria of 45 C.F.R. § 149.420 (c) through (i); (iii) Emergency Services furnished by Non-Participating Providers or Non-Participating Emergency Facilities and Air Ambulance Services as described in the **GENERAL BENEFITS** section of this Certificate; (iv) services received from a Provider who is incorrectly listed as an in-network Provider as described in the **GENERAL BENEFITS** section of this Certificate; and (v) when an on-call Physician or a hospital-based Physician has accepted an assignment of benefits, the Member will not be responsible for any charges that exceed this amount.

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

Notwithstanding the above, KPIC will base payment of hospital services rendered at Maryland Hospitals on the rate approved by the Health Services Cost Review Commission.

Medical Food means a food that is: (1) intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and (2) formulated to be consumed or administered enterally under the direction of a Physician.

Medically Necessary means Covered Services that, in the judgment of the Medical Review Program (when applicable by law), 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 health care provider or facility; and
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility. When applied to Confinement in a Hospital or other facility, this test means that the Covered Person needs to be confined as an inpatient due to the nature of the 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.

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 (7) days per week.

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

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

Mental Health Illness means mental or nervous condition, including an emotional disorder that is of sufficient severity to result in substantial interference with the activities of daily living.

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 a Body Mass Index (BMI) greater than forty (40) kilograms per meter squared; or equal to or greater than thirty-five (35) kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

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 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 fees KPIC has negotiated with Participating Provider (or Participating Provider Organization) to accept as payment in full for Covered Services rendered to Covered Persons.

Nicotine Replacement Therapy means a product that: 1) Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and 2) Is obtained under a prescription written by an authorized prescriber. Nicotine Replacement Therapy does not include any over-the-counter products that may be obtained without a prescription.

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

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

Non-Participating Provider means a Physician or other health care that has not contracted directly with KPIC or an entity contracting on behalf of KPIC to provide health care services to KPIC's members. In most instances, You will be

responsible for a larger portion of Your bill when You visit a Non-Participating Provider. Please consult Your group administrator for a list of participating providers or visit PHCS' website at www.phcs.com.

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.

On-call physician means a physician who:

1. Has privileges at a hospital;
2. Is required to respond within an agreed upon time period to provide health care services for unassigned patients at the request of a hospital or a hospital emergency department; and
3. Is not a hospital-based physician.

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 ruling that:

1. Is issued by a Maryland court or a court or administrative agency of another state; and
2. Creates or recognizes the right of a child to receive benefits under a parent's health insurance or establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

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. For certain items or services billed by Maryland hospitals this is the amount for the item or service approved by the Health Services Cost Review Commission (HSCRC).
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. Under specified Maryland law this is the amount required by §19-710.1 of the Health-General Article.
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-Plan means those benefits underwritten by KPIC and set forth in the Group Policy. Unless specifically stated otherwise in the Group Policy, KPIC will not pay for services arranged, provided or reimbursed under Health Plan's In-Plan coverage.

Out-of-Pocket Costs means a Covered Person's share of Covered Charges. For purposes of the Out–of-Pocket Maximum, a Covered Person's Out-of-Pocket costs means the difference between the amount payable by KPIC for

Covered Charges and the Maximum Allowable Charge. Out-of-Pocket does not include Covered Charges applied towards satisfying deductibles, Co-payment amounts or 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 paying during a Contract Year.

Partial Hospitalization means medically directed intensive or intermediate short-term treatment of not more than twenty-four (24) hours and not less than four (4) hours for mental illness, emotional disorders, Substance 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 website at: www.MedImpact.com.

Participating Provider means health care provider including Primary Care Physicians, Specialty Care, Hospital, Participating Pharmacy, laboratory, or other similar entities operating under a written contract with a Participating Provider Organization (PPO), KPIC or its Administrator to deliver medical services to Covered Persons or an entity contracting on behalf of KPIC to provide health care services to KPIC's members. Please consult Your group administrator for a list of Participating Providers or visit MultiPlan/PHCS' website at www.multiplan.com/kpmas. You may also contact Member Services at the number shown on Your ID card.

Participating Provider Organization (PPO) means an organization under a written contract with KPIC in which Covered Persons have access to a network of Participating Providers. In most instances, Your Out-of-Pocket costs are lower when you receive Covered Services from Participating Providers.

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

Percentage Payable means that percentage of Covered Charges 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.

Pharmacy means a place licensed by state law where You can get prescription drugs and other medicines from a licensed pharmacist when You have a prescription from Your Provider..

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 may be defined elsewhere in this **GENERAL DEFINITIONS** section or elsewhere in the Group Policy/Certificate.

Policyholder means the employer(s) or trust or other entity defined in the Group Policy as the entity(ies) which perform certain the administrative activities and other obligations established under the Group Policy.

Pre-certification/Pre-certified means the required assessment of the coverage and/or Medical Necessity of specified health care services or items other than outpatient prescription drugsmade by the Medical Review Program. Request for Precertification must be made by the Covered Person or the Covered Person's attending Physician prior to the commencement of any service or treatment. If Precertification is required, it must be obtained to avoid a reduction in benefits.

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

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

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

Prosthetic Device means an artificial device to replace, in whole or in part, a leg, an arm, or an eye.

Prosthetics means internally implanted devices and/or external 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; breast prosthesis, including a mastectomy bra, needed following a mastectomy, including custom-made prosthetics. This definition does not include "Prosthetic Devices" which are defined separately above.

Prosthetics will not include:

1. Internally implanted breast prosthetics for cosmetic purposes;
2. Dental prosthetics, devices, implants and appliances. This exclusion does not include treatment of children with congenital and genetic birth defects to enhance the child's ability to function, such as cleft lip, cleft palate, or both;
3. Hearing aids;
4. Corrective lenses and eyeglasses, except as provided under the "Vision Care" benefit;
5. Repair or replacement of prosthetics due to misuse or loss;
6. More than one prosthetic for the same part of the body, except for replacements, spare devices or alternative use device;
7. Non-rigid supplies, such as clastic stockings, and wigs;
8. Electronic voice producing machines;
9. Hair prosthesis.
10. "Prosthetic Devices" which are separately defined;

Provider means any individual or entity that, pursuant to the law of the jurisdiction where Covered Services are to be rendered, is licensed and is acting within the scope of such license in providing the Covered Services.

Pulmonary Rehabilitation Program means pulmonary rehabilitation program sessions limited to a maximum of two 1-hour sessions per day for up to thirty-six (36) sessions, with the option for an additional thirty-six (36) sessions if Medically Necessary. The care must be rendered according to an individualized treatment plan.
As used in this definition, individualized treatment plan means a written plan established, reviewed, and signed by a Physician every thirty (30) days, that describes all of the following:

1. The individual's diagnosis.
2. The type, amount, frequency, and duration of the items and services under the plan.
3. The goals set for the individual under the plan.

The pulmonary rehabilitation team may include doctors, nurses, and specialists. Examples of specialists include respiratory therapists, physical and occupational therapists, dietitians or nutritionists, and psychologists or social workers.

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. For certain items or services billed by Maryland hospitals, this is the amount for the item or service approved by the HSCRC.
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. Under specified Maryland law this is the amount required by §19-710.1 of the Health-General Article.
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 registered graduate professional 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 a reasonable period of time.

Residential Crisis Services mean intensive health and support services that are:

1. Provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual's ability to function in the community;
2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
3. Provided out of the individual's residence on a short-term basis in a community-based residential setting; and

4. Provided by entities that are licensed by the Maryland Department of Health and Mental Hygiene to provide Residential Crisis Services.

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.

Sickness means illness or a disease of a Covered Person. Sickness will include 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, licensed by the Maryland Department of Health, which is:
1. Primarily engaged in providing:
   a. Skilled nursing care, and related services, for residents who require medical or nursing care, or
   b. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; and
2. Certified by the Medicare Program as a skilled nursing facility.

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 Drugs means a prescription drug that: (1) is prescribed for an individual with a Complex or Chronic Medical Condition, or a Rare Medical Condition; (2) costs $600 or more for up to a 30-day supply; (3) is not typically stocked at retail pharmacies; and (4) requires a difficult or unusual process of delivery to the Member in the preparation, handling, storage, inventory, or distribution of the drug; or requires enhanced patient education, management, or support, beyond those required for traditional dispensing, before or after administration of the drug. Prescription drugs prescribed to treat diabetes, human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS) are not considered Specialty Drugs.

Complex or chronic medical condition means a physical, behavioral, or developmental condition that: (1) may have no known cure; (2) is progressive; or (3) can be debilitating or fatal if left untreated or undertreated.

Rare medical condition means a disease or condition that affects fewer than: (1) 200,000 individuals in the United States; or (2) approximately 1 in 1,500 individuals worldwide.

Stabilize with respect to an emergency medical condition, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Standard Fertility Preservation Procedures means procedures to preserve fertility that are consistent with established medical practices and professional guidelines published by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.

Standard Fertility Preservation Procedures includes sperm and oocyte cryopreservation and evaluations, laboratory assessments, medications, and treatments associated with sperm and oocyte cryopreservation.

Standard Fertility Preservation Procedures does not include the storage of sperm or oocytes.

Substance Abuse means: (a) Alcohol Abuse and (b) Drug Abuse.

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.

Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a location other than the location of the patient. "Telemedicine" includes from July 1, 2021, to June 30, 2025, both inclusive, an audio-only telephone conversation between a health care provider and a patient that results in the delivery of a billable, covered health care service.

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

Treating provider means a physician or other health care provider who has evaluated the individual.

Urgent Care means non-life threatening medical and health services for the treatment of a covered Sickness or Injury. Urgent care received outside of the Health Plan Service Area is covered under Health Plan's In-Plan coverage.

Urgent Care Center means a facility legally operated to provide health care services in emergencies or after hours. It is not part of a Hospital. Urgent Care center means a facility that meets all of the tests that follow:

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

Visit means the instance of going to or staying at a health care facility, and, with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider

at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

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

To be eligible to enroll, You must meet the following requirements:

A. You must meet the Policyholder's eligibility requirements that We have approved (the Policyholder is required to inform Insured Employees of the Policyholder's eligibility requirements) and meet the Insured Employee or Dependent eligibility requirements below.

B. You must live or work in the Health Plan Service Area (the Service Area is described in the "Definitions" section of the Heath Plan Evidence of Coverage). You or Your spouse's or Domestic Partner's eligible children who live outside of the Service Area may be eligible to enroll if You are required to cover them pursuant to any court order, court-approved agreement, or testamentary appointment. In addition, Your Dependent children who attend school outside the Health Plan Service Area and meet the eligibility requirements as provided under the "Enrollment and Effective Date of Coverage" provisions below are also eligible for enrollment.

C. Neither You nor any member of Your family may enroll under the Group Policy if:
(1) You or any Dependent has ever had entitlement to coverage and/or services through KPIC and/or Health Plan terminated due to cause.
(2) You were ever an Insured Employee and/or Health Plan subscriber in this or any other plan, who had entitlement to receive Services through KPIC and/or Health Plan terminated for: (a) failure of You or Your Dependent to pay any amounts owed to KPIC; or (b) failure to pay any amounts due under this Certificate. If so, You may not enroll under the Group Policy until you pay all amounts owed by You and Your Dependents.

D. If You are an Insured Employee, Your eligible Dependents may enroll under the Group Policy.

E. You, and any eligible Dependents to be covered, must be eligible for enrollment and enrolled in Health Plan as Members.

Addition of Insured Employees/Members

Eligible new Insured Employees, Members, or Dependents may be added periodically to the Group originally insured in accordance with the terms of the Group Policy.

Insured Employee

You and Your eligible Dependents may be eligible to enroll as a Covered Person if You are an eligible employee of the Policyholder or You are entitled to coverage under the Group Policy through a welfare trust agreement.

Extension of Dependent Eligibility

Your or Your Spouse's or Domestic Partner's currently enrolled Dependents may continue coverage beyond the age limit for Dependents, as shown in the Schedule of Coverage, if all of the following requirements are met:

A. he or she is incapable of self-sustaining employment because of mental or physical incapacity that occurred prior to reaching the age limit for Dependents; and

B. he or she is chiefly financially dependent upon You or Your spouse or Domestic Partner, Member, or other Covered Person for their financial support and maintenance; and

C. You provide us with proof of their incapacity and dependency within 31 days after We request proof.

Enrollment and Effective Date of Coverage

When the Health Plan provides its annual Open Enrollment Period, it will begin at least thirty (30) days prior to the 1st day of the Contract Year. The Open Enrollment Period will extend for a minimum of thirty (30) days. During the annual Open Enrollment Period an eligible employee may enroll or discontinue enrollment in this health benefit

plan; or change their enrollment from this health benefit plan to a different health benefit plan offered by the Small Employer.

Your Policyholder will let You know when the Open Enrollment Period begins and ends. The Effective Date of an eligible employee's or Dependent's insurance will be the date the person becomes covered by Health Plan as a Point-of-Service Member. Health Plan membership begins at 12 a.m. Eastern Time (the time at the location of the administrative office of Health Plan at 2101 East Jefferson Street, Rockville, Maryland, 20852 on the 1st day of the Contract Year. Eligible individuals may enroll as follows:

New Employees and their Dependents:
Employees who become eligible outside of the annual Open Enrollment Period may enroll themselves and eligible Dependents within thirty (30) days from the date that the employee first becomes eligible.

The Policyholder shall notify its employees and their enrolled Dependents of their effective date of coverage if such date is different than the effective date of the Group Policy, or is different than the dates specified under the provision entitled "Special Enrollment Due to Newly Acquired Dependents" set forth below.

You can only enroll during the annual Open Enrollment described above, unless one of the following is true. You:
1. Become eligible for a special enrollment period, as described in this section, or
2. Did not enroll in any coverage through Your Employer when You were first eligible and Your Employer does not give us a written statement that verifies You signed a document that explained restrictions about enrolling at a later time. The effective date of an enrollment resulting from this provision is no later than the 1st day of the month following the date Your Employer receives a KPIC approved enrollment or change of enrollment application from the Member.

Special Enrollment Due to Newly Acquired Dependents: You may enroll as an Insured Employee (along with any eligible Dependents) and existing Insured Employees may add any and all eligible Dependents including Spouses of eligible Insured Employees, within 31 days after marriage, birth, adoption, placement for foster care or placement for adoption or through a child support order or other court order by submitting a KPIC-approved enrollment form to the Policyholder. An otherwise eligible employee who is not enrolled for coverage under the Group Policy at the time he/she acquires a new Dependent, may also enroll at the same time as the newly acquired Dependent.

The effective date for an eligible employee and/or Spouse or Domestic Partner that enrolls at the time of birth of a Dependent is the moment of birth. The effective date for an eligible employee and/or Spouse or Domestic Partner that enrolls at the time of adoption or placement for adoption of a Dependent is the date of adoption. The effective date for a Spouse or Domestic Partner who enrolls at the time of placement of a child for foster care, or through a child support order or other court order is the date of the placement, child support order, or other court order.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION DATE

The membership effective date for newly acquired Dependents will be:

A. For a new Spouse or Domestic Partner, no later than the first day of the month following the date Your Group receives an enrollment application from the Insured Employee.

B. For newborn children, the moment of birth. If payment of additional premium is required to provide coverage for the newborn child, then, in order for coverage to continue beyond the 31 days from the date of birth, notification of birth and payment of additional premium must be provided within 31 days of the date of birth. Otherwise, coverage under the Group Policy will terminate 31 days from the date of birth.

C. For newly adopted children (including children newly placed for adoption), the "date of adoption." The date of adoption" means the earlier of: (1) a judicial decree of adoption, or (2) the assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent. If payment of additional premium is required to provide coverage for the child, then, in order for coverage to continue beyond the 31 days from the date of adoption, notification of adoption and payment of the additional premium must be provided within 31 days of the date of adoption. Otherwise, coverage for the newly adopted child will terminate 31 days from the date of adoption.

D. For a newly eligible grandchild, the date the grandchild is placed in Your or Your Spouse's custody. If payment of additional premium is required to provide coverage for the child, then, in order for the coverage to continue, notification of the court ordered custody and payment of the additional premium must be provided within 31 days of the date of the court ordered custody. Otherwise, coverage terminates 31 days from the date of the court ordered custody.

E. For children who are newly eligible for coverage as a result of a court or administrative order received by You or Your Spouse or Domestic Partner, the date of the court or administrative order. If payment of additional premium is required to provide coverage for the child, notification of the court or administrative order may be provided at any time, but payment of additional premium must be provided within 31 days of enrollment of the child. Otherwise, enrollment of the child will be void. Enrollment for such child will be allowed in accordance with the requirements and time frames established by Section 15-405(c) of the Maryland Insurance Article, which provides for the following:

(1) An insuring parent is allowed to enroll in family member's coverage and include the child in that coverage regardless of enrollment period restrictions;

(2) A non-insuring parent, child support agency, or Maryland Department of Health is allowed to apply for health insurance coverage on behalf of the child and include the child in the coverage regardless of enrollment period restrictions; and

(3) Health Plan may not terminate health insurance coverage for a child eligible under this subsection unless written evidence is provided that:
   (i) the court or administrative order is no longer in effect;
   (ii) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
   (iii) the employer has eliminated family member's coverage for all of its employees; or
   (iv) the employer no longer employs the insuring parent, except the parent elects to enroll in COBRA, coverage shall be provided for the child consistent with the employer's plan for post-employment health insurance coverage for Dependents.

If a child's parent, subject to the court or administrative order, is an otherwise eligible employee, but has not enrolled for coverage under the Group Policy, We will enroll both the employee and child without regard to enrollment period restrictions, pursuant to the requirements and time periods specified by Sections 15-405(f) and (g) of the Maryland Insurance Articles. Children enrolled subject to a court or administrative order may not have their coverage terminated unless written evidence is provided to Us that: (i) the order is no longer in effect; (ii) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination; (iii) the employer has eliminated family members' coverage for all its employees; or (iv) the employer no longer employs the insuring parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for post-employment health insurance coverage for Dependents.

F. For children who are newly eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment. If payment of additional premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time, but payment of the premium must be provided within 31 days of the enrollment of the child, otherwise, enrollment of the child terminates 31 days from the date of court or testamentary appointment.

G. For children, stepchildren, grandchildren, or adopted children who are newly eligible for coverage as the result of the Insured Employee's new Domestic Partner arrangement, the date of the signed Affidavit of Domestic Partnership. If payment of additional premium is required to provide coverage for the child, in order for coverage to continue beyond the 31 days from the date of eligibility, notification of eligibility and payment of additional premium must be provided within 31 days of the date of eligibility. Otherwise, coverage for the newly eligible child will terminate 31 days from the date of eligibility.

H. For children, stepchildren, grandchildren, or adopted children who are newly eligible for coverage as the result of the Insured Employee's marriage, the first day of the first month beginning after the date the completed request is received. If payment of additional premium is required to provide coverage for the child, in order for coverage to continue beyond the 31 days from the date of eligibility, notification of eligibility and payment of additional premium must be provided within 31 days of the date of eligibility. Otherwise, coverage for the newly eligible child will terminate 31 days from the date of eligibility.

I. For a Dependent placed in foster care, the effective date is the date of placement.

Special Enrollment due to Loss of other Coverage*:* You may enroll as an Insured Employee (along with any of Your eligible Dependents), and an existing Insured Employee may add eligible Dependents by submitting a KPIC-approved enrollment form to the Policyholder within 30 days after the enrolling persons lose other coverage if:

A. The Employee or at least one of the Dependents had other coverage when he or she previously declined KPIC's coverage (some groups require you to have stated in writing when declining KPIC coverage that other coverage was the reason), and

B. The loss of the other coverage is due to (1) exhaustion of COBRA coverage or Continuation of Coverage under Maryland law; (2) in the case of non-COBRA coverage, loss of eligibility or termination of employer contributions. If the loss of eligibility for a Dependent child is due to the death of a spouse or Domestic Partner, the child may be added at any time; however the timeframe for submitting the application for enrollment is within 6 months after the death of the spouse or Domestic Partner.

Note: If You are enrolling Yourself as an Insured Employee along with at least one eligible Dependent, only one of You need lose other coverage, and only one of You must have had other coverage when You previously declined

KPIC coverage. The Policyholder will let You know the membership effective date as applicable to the loss of coverage described in §15–1208.1.(b) of the Maryland Insurance Article.

Special Enrollment Due to a Triggering Event: A Special Enrollment Period of 30 days, unless otherwise specified, will be provided from the date an individual experiences a triggering event, during which the individual may enroll in this plan or change from one plan to another plan offered.

A "triggering" event occurs when:

1. An eligible employee or Dependent either:
   a. Loses Minimum Essential Coverage. The date of the loss of coverage is the last day the eligible employee or Dependent would have coverage under his or her previous plan or coverage;
   b. Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) or loses access to health care services through coverage provided to a pregnant women's unborn child of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day the eligible employee or dependent would have pregnancy-related coverage access to health care services through the unborn child coverage;
   c. Loses medically needy coverage as described under section 19[illegible]Va)(1[illegible])(C) of the Social Security Act only once per calendar year. The date of the loss of coverage is the last d[illegible] the e[illegible]gible employee or Dependent would have medically needy coverage;
   d. Loses non-calendar year group health plan or indi[illegible]al h[illegible]alth pl[illegible]n coverage. The date of the loss of coverage is the last day of the expiring non-cale[illegible]dar ye[illegible] plan [illegible] policy year. Loss of coverage described above in items a) does not include voluntary term[illegible]at[illegible]n of coverage, failure to pay premiums on a timely basis, including COBRA premiums prior to exp[illegible]a[illegible]on o[illegible] COBRA coverage, except for circumstances in which an employer completely ceases its [illegible]ontribu[illegible]ion[illegible] to COBRA continuation coverage, or government subsidies of COBRA continuation cov[illegible]age [illegible]mpletely cease; or loss due to rescission of coverage authorized under 45 C.F.R. §14[illegible]38.

2. An eligible employee or a D[illegible]pe[illegible]dent [illegible]ho is enrolled in a QHP adequately demonstrates to the Exchange that the QHP in which the eligible em[illegible]ee [illegible]r a Dependent is enrolled substantially violated a material provision of the QHP's contract in relation to t[illegible]e eligible employee or a Dependent;

3. An eligible Insured Employee or a Dependent gains access to new QHP plans as a result of a permanent move; and either
   (i) Had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 days preceding the date of the permanent move, or
   (ii) Was living in a foreign country or in a United States territory for 1 or more days during the 60 days preceding the date of the permanent move; or
   (iii) For 1 or more days during the 60 days preceding the move or during the most recent preceding Open Enrollment Period or Special Enrollment Period, lived in a service area where no QHP was available through the SHOP Exchange; or
   (iv) Had pregnancy related coverage or access to healthcare services through unborn child coverage described in 45 CFR § 155.420(d)(1)(iii) for 1 or more days during the 60 days preceding the move; or
   (v) Had medically needy coverage described in 45 CFR § 155.420(d) (1)(iv) for 1 or more days during the 60 days preceding the move.
   (vi) Gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act

4. An eligible employee or Dependent of an eligible employee who loses eligibility for coverage under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Plan under Title XXI of the Social Security Act.
5. An eligible employee who becomes pregnant, as confirmed by a Physician; and an eligible employee's spouse or Dependent who becomes pregnant as confirmed by a Physician, provided the spouse or Dependent is otherwise eligible for coverage.

   The Special Enrollment Period shall be open for a period of 90 days and begin on the date a Physician confirms the pregnancy. If enrolled, the coverage will become effective on the first day of the month in which the individual receives confirmation of pregnancy.

7. An eligible employee or Dependent adequately demonstrate to KPIC or Your Group that a material error related to plan benefits, service area, or premium influenced the eligible employee's or Dependent's decision to purchase a plan through KPIC;

8. An eligible employee or Dependent:
   1. Is a victim of domestic abuse or spousal abandonment, as defined by 26 C.F.R. § 1.36B–2T; 23;
   2. Is enrolled in minimum essential coverage
   3. Seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment;
   4. Victim's Dependents may enroll in separate coverage at the same time as the victim.

9. An eligible employee or Dependent:
   1. Applies for coverage through the individual exchange during the annual Open Enrollment Period or a Special Enrollment Period;
   2. Is assessed by the individual exchange as potentially eligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program; and
   3. Is determined ineligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program by the by the Maryland Department of Health either:
      A. after Open Enrollment has ended; or
      B. more than 60 days after the qualifying event.
   4. Applies for coverage through the Maryland Medical Assistance Program or the Maryland's Health Program during the annual Open Enrollment Period; and
   5. Is determined ineligible for the Maryland Medical Assistance Program or the Maryland Children's Health Program after Open Enrollment has ended

An eligible employee or a Dependent who meets the requirements for a triggering event under item 4 above shall have 60 days from the triggering event to select a Qualified Health Plan.

Effective Date of Coverage Due to a Triggering Event

If an eligible employee or dependent enrolls as the result of a triggering event, the effective date of coverage shall be:

1. In the case a triggering event under item 1 or item 3, the 1st day of the month the date of the triggering event; and if plan selection is made after the loss, coverage will be effective in accordance with item 2, below.

2. For all other triggering events, coverage will be effective the 1st day of the month after the individual selects a plan when a selection is received by the Health Plan between the 1st and the 15th day of any month; and the

1st day of the 2nd following month when a selection is received by the Health Plan between the 16th and the last day of any month.

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.

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.

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 in enrollment application to Your Policyholder within the timeframes specified by Your Policyholder for making elections due to a section 125 qualifying event.

Open Enrollment

You may enroll as an Insured Employee (along with any of Your eligible Dependents), and an existing Insured Employee may add eligible Dependents, by submitting a KPHP approved enrollment form to the Policyholder during the Open Enrollment Period. The Policyholder will let You know when the open enrollment period begins and ends and Your membership effective date.

Member Contribution

Insured Employees are entitled to coverage under the Group Policy only for the period for which we have received the appropriate premiums from the Policyholder with the exception of the grace period, at which time coverage will continue during the grace period. You are responsible for any contribution to the premiums and the Policyholder will tell You the amount and how You are to pay Your contribution (through payroll deduction, for example).

Open Enrollment due to Termination of Spouse's Employment

A continuous Open Enrollment Period will exist for the purpose of allowing an Insured Employee to add his/her spouse or Domestic Partner and/or Dependent children if the Insured Employee's spouse or Domestic Partner loses coverage under another group health insurance contract or policy because of the involuntary termination of the spouse's or Domestic Partner's employment other than for cause. Coverage provided in accordance with this provision will not be subject to evidence of insurability. To be eligible for coverage, the Insured Employee must notify the Policyholder within 6 months after the date on which his/her spouse's or Domestic Partner's coverage under another group health insurance contract or policy terminates.

Termination of a Covered Person's Insurance

A Covered Person's insurance will automatically terminate on the earlier of:

1. The date the Covered Person ceases to be covered by Health Plan as a Member, except as described under "Extension of Benefits" in the **GENERAL BENEFITS** section of this Certificate;
2. The date the Group Policy terminates, except as described under "Extension of Benefits" in the **GENERAL BENEFITS** section of this Certificate;

3. The end of the grace period after the employer group fails to pay any required premium to KPIC, Health Plan or its Administrator when due or KPIC does not receive the premium payment in a timely fashion;
4. The date the Insured Employee and/or his/her Dependents cease to be eligible for coverage under the Group Policy or Health Plan's Evidence of Coverage;
5. The date You no longer live or work in Health Plan's Service Area (as that term is defined in the Evidence of Coverage and is hereby incorporated by reference); or
6. The date the Group Agreement between Your group and Health Plan terminates.

Rescission for Fraud or Intentional Misrepresentation

Subject to 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 no less than 30 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 **PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS** section of this Certificate for a description of the Appeals process and Your right to an Independent External Review.

In no event will Your insurance continue beyond the earlier of the date Your employer is no longer a Policyholder or the date the Group Policy terminates, except as described under "Extension of Benefits" in the **GENERAL BENEFITS** section of this Certificate.

PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS

Pre-certification Through the Medical Review Program
This section describes:

1. The Medical Review Program and Pre-certification procedures for Covered Services;
2. How failure to obtain Pre-certification affects coverage;
3. Pre-certification administrative procedures;
4. Which clinical procedures require Pre-certification;
5. How to appeal an adverse determination by the Medical Review Program; and
6. The Independent External Review program.

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 Pre-certification of all non-emergency Hospital stays and certain other non-emergency services and procedures. Request for Pre-certification must be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment. If Pre-certification is required, it must be obtained to avoid a reduction in benefits. 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.

If Pre-certification 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 thirty percent (30%). However, the reduction will be limited to $5,000 per occurrence. Any such reduction in benefits will not count toward satisfaction of any Deductible, Co-payment, 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, Pre-certification is not required when Your Primary Plan has made payment on the Covered Services requiring Pre-certification.

Continuity of Care When Transitioning Carriers Pre-certification
At the request of the Covered Person, Covered Person's parent or guardian, the Covered Person's authorized representative, or the Covered Person's Health Care Provider; a preauthorization for behavioral health and dental benefits if covered, to the extent they are authorized by a third-party administrator, shall be accepted by KPIC for Covered Persons who may be transitioning from the Maryland Medical Assistance Program to KPIC, for the time periods described in item 2, below.

At the request of the Covered Person, Covered Person's parent or guardian, the Covered Person's authorized representative, or the Covered Person's Health Care Provider; a preauthorization from a relinquishing carrier, managed care organization, or third-party administrator shall be accepted by KPIC for:

1. The procedures, treatment, medications, or services covered by the benefits offered by the Group Policy; and
2. For the following time periods:
   a. The lesser of the course of treatment or ninety (90) days; and
   b. The duration of the three trimesters of a pregnancy and the initial postpartum visit.

A copy of the preauthorization from the relinquishing carrier shall be provided within ten (10) days after receipt of the request from KPIC.

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. If the Medical Review Program determines that such services and/or items are not Covered Services and/or not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven (7) days per week.

PRECERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS

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 Pre-certification on Your behalf. Providers may contact them at 888-831-0761.

If Pre-certification 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
2. Inpatient Rehabilitation Therapy admissions
3. Inpatient Skilled Nursing Facility, long term care, and sub-acute admissions
4. Inpatient mental health and chemical dependency admissions
5. Inpatient Residential Treatment
6. Non-Emergent (Scheduled) Air or Ground Ambulance
7. Pediatric Medically Necessary contact lenses
8. Amino Acid-Based Elemental Formulas
9. Low Protein Modified Foods
10. Clinical Trial Services
11. Medical Foods
12. Bariatric Surgery
13. Dental & Endoscopic Anesthesia
14. Durable Medical Equipment
15. Genetic Testing
16. Home Health & Home Infusion Services
17. Hospice (home, inpatient)
18. Infertility Procedures
19. Imaging Service (Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography Angiography(CTA), Positron Emission Tomography (PET), Electronic Beam Computed Tomography (EBCT), SPECT, not including x-ray or ultrasound)
20. Outpatient Injectable Drugs
21. Outpatient Surgery (performed at a hospital, ambulatory surgery center of licensed facility)
22. Orthotics/Prosthetics
23. Implantable prosthetics (includes breast, bone conduction, cochlear)
24. Pain Management services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)
25. Radiation Therapy Services
26. Reconstruction Surgery
27. TMJ/Orthagnathic Surgery
28. The following outpatient procedure:
    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

An Adverse Decision regarding an admission of a Covered Person may not be rendered during the first twenty-four (24) hours after the admission when: 1) the admission is based on a determination that the Covered Person is in imminent danger to self or others; 2) the determination has been made by the Covered Person's Physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and 3) the hospital immediately notifies the Medical Review Program of the admission of the Covered Person, and the reason for the admission.

If We fail to make a determination within the time limits described below, the request will be deemed approved. Except as provided in the first and third paragraphs of page 3 and the last paragraph of page 6 of this section, We will make initial determinations on whether to authorize or certify an emergency course of treatment or Health Care Service for a member within twenty-four (24) hours after the initial request after receipt of the information necessary to make the determination. If We determine that additional information is needed after confirming through a complete review of the information already submitted by the Health Care Provider, We will: (1) Promptly request the specific information needed, including any lab or diagnostic test or other medical information; and (2) Promptly, but not later than two (2) hours after receipt of the information, notify the Health Care Provider of an authorization or certification determination when made by Us. We will initiate the expedited procedure for an Emergency Case if the patient or the patient's representative requests or if the Health Care Provider attests that the services are necessary to treat a condition or illness that, without immediate medical attention, would: (1) Seriously jeopardize the life or health of the member or the member's ability to regain maximum functions; (2) Cause the member to be in danger to self or others; or (3) Cause the member to continue using intoxicating substances in an imminently dangerous manner.

An Adverse Decision regarding a Hospital admission of a Covered Person may not be rendered for up to seventy-two (72) hours when: 1) the Hospital admission is determined to be Medically Necessary by the Covered Person's treating Physician; 2) the admission is an involuntary admission (as defined in the Maryland Health General Article); and 3) the hospital immediately notifies the Medical Review Program of the admission of the Covered Person, and the reason for the admission.

If Our review for a nonemergency case results in an Adverse Decision, We will provide oral communication of the decision to the Covered Person, Authorized Representative, or Health Care Provider and send a written notice to the Covered Person or Authorized Representative, and Health Care Provide within five (5) working days after making the Adverse Decision. This notification will:

1. State in detail in clear, understandable language the specific factual bases for Our decision and the reasoning used to determine that the Health Care Service is not Medically Necessary and did not meet Our criteria and standards used in conducting utilization review;
2. Provide the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines used by Us, on which the Grievance Decision was based including, but not limited to, interpretive guidelines used by Us and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary" or language directing You to review additional coverage criteria in the Your Group Policy or plan documents;
3. The name, business address and business telephone number of the designated employee or Our representative who has the responsibility for Our internal grievance process and the Physician who is required to make all Adverse Decisions. The business telephone number included in the notice is a dedicated number for Grievance Decisions and not Our general customer call number;
4. Give written details of Our internal grievance process and procedures and includes a description of Your, Your Authorized Representative, or Health Care Provider's right to file a Complaint with the Commissioner within four (4) months following receipt of Our Grievance Decision;
5. You, Your Authorized Representative, or Health Care Provider acting on your behalf may file a Complaint with

the Commissioner, without first filing a Grievance with KPIC and receiving a final decision on the Grievance, if:

i. KPIC waives the requirement that our internal grievance process must be exhausted before filing a Complaint with the Commissioner;
ii. KPIC has failed to comply with any of the requirements of the internal grievance process as described below in our internal grievance process; or
iii. You, Your Authorized Representative or a Health Care Provider acting on your behalf provides sufficient information and supporting documentation in the Complaint that demonstrates a compelling reason to do so.

6. The Commissioner's address, telephone number and facsimile number;
7. A detailed description of Our internal grievance process including a statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in both mediating and filing a Grievance under Our internal grievance process; and
8. The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

IMPORTANT: If Pre-certification 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 inpatient care is extended beyond the number of days first Pre-certified without further Pre-certification (concurrent review), benefits for the extra days: (1) will similarly be reduced; or (2) will not be covered if deemed not to be Medically Necessary.

Pregnancy 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 an uncomplicated vaginal delivery, and
2. Ninety-six (96) hours for an uncomplicated 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.

The following benefits will not be subject to a deductible (except for high deductible health plans), Co-payment or Coinsurance amount:

1. For a mother and newborn child who have a shorter hospital stay than that allowed above, KPIC will cover on the same basis as normal pregnancy, the cost of: (i) one home visit scheduled to occur within twenty-four (24) hours after Hospital discharge, and (ii) an additional home visit if prescribed by the attending Physician.
   For a mother and newborn child who remain in the Hospital for at least the minimum authorized stay allowed above, KPIC will cover on the same basis as normal pregnancy the cost of a home visit if prescribed by the attending Physician.

As used above, "home visit" means a visit by a Registered Nurse in the Covered Person's home for care of a mother and newborn child and includes any services required by the attending provider. To be eligible for coverage, the visit must: (i) be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child; and (ii) be provided by a Registered Nurse with at least one (1) year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health.

In addition, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, KPIC will treat on the same basis as normal pregnancy the cost of additional hospitalization for the newborn for up to four (4) days.

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

Pre-certification 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 Pre-certification - As soon as reasonably possible after the Covered Person learns of the need for any outpatient Covered Service requiring Pre-certification but at least three (3) days prior to performance of any outpatient Covered Service requiring Pre-certification.

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, pre-certification will be denied.

If a course of treatment has been Pre-certified or approved for a Covered Person, the Medical Review Program may not retrospectively render an Adverse Decision regarding the Pre-certified or approved services delivered to that Covered Person except as outlined below.

Regarding prior authorization requirements for prescription drugs, We will approve a request for the prior authorization of a course of treatment, including for chronic conditions, rehabilitative services, substance use disorders, and mental health conditions that is: (1) for a period of time that is as long as necessary to avoid disruptions in care; and (2) determined in accordance with applicable coverage criteria, the Covered Person's medical history, and the Health Care Provider's recommendation. For new enrollees, We will not disrupt or require reauthorization for an active course of treatment for Covered Services for at least ninety (90) days after the date of enrollment.

The Medical Review Program may retrospectively render an Adverse Decision regarding Pre-certified or approved services delivered to a Covered Person if:

1. The information submitted to the Medical Review Program regarding the services to be delivered to the Covered Person was fraudulent or intentionally misrepresentative;
2. Critical information requested by the Medical Review Program regarding services to be delivered to the Covered Person was omitted such that the Medical Review Program determination would have been different had the Medical Review Program known the critical information; or
3. The planned course of treatment for the Covered Person that was approved by the Medical Review Program was not substantially followed by the Provider.

I. The Medical Review Program

Pre-Service Reviews: If We fail to make a determination within the time limits described below, the request will be deemed approved. If You do not have an Emergency Case and You have not received the nonemergency course of treatment or Covered Service which You are requesting, including pharmaceutical services not submitted electronically, then within two (2) working days of receiving all necessary information the Medical Review Program will make its determination. We will promptly notify the Health Care Provider of the

determination. We will provide notice that additional information is needed after receipt of the initial request for Health Care Services and confirming through a complete review of information already submitted by the Health Care Provider. We will promptly notify the Covered Person, the Authorized Representative, and Health Care Provider of the need for additional information within three (3) calendar days of the initial request and explain in detail what information is required by specifying the information, including lab or diagnostic test or other medical information, that must be submitted to complete the request and the criteria and standards to support the need for additional information. Necessary information includes, but is not necessarily limited to, the results of any face-to-face clinical evaluation or any second opinion that may be required. We must receive any additional necessary information requested by the notice within forty-five (45) calendar days from the receipt of the notice identifying the additional necessary information or We will make Our decision based upon the information We have available to Us at that time.

If the authorization procedures are not followed, We will notify the Covered Person, the Authorized Representative or Health Care Provider of the failure to follow the procedures within five (5) calendar days of the request for authorization. The notice will include the proper procedures to be followed to request authorization.

If an admission, procedure or service is Pre-certified, KPIC will:

1. Notify the Health Care Provider by telephone within two (2) working days of Pre-certification; and
2. Document the Pre-certification with You and the Health Care Provider in writing within five (5) working days of Our decision.

If Pre-certification is denied or an alternate treatment or service recommended, KPIC will:

1. Notify the Health Care Provider by telephone within two (2) working days of making the denial or alternate treatment or service recommendation; and
2. Document the denial decision with the Covered Person and Authorized Representative in writing within five (5) working days of making Our decision.

The Covered Person, Authorized Representative or Health Care Provider may then file an Appeal or Grievance as appropriate, as described below.

If We fail to make a determination within the time limits described below, the request will be deemed approved. If You are requesting pre-certification for admission for Residential Crisis Services or an emergency inpatient admission, the Medical Review Program will make its determination within two (2) hours after receipt of all necessary information to make the determination; and will promptly notify the health care provider of the determination. If additional information is needed, We will promptly request the specific information needed, including any lab or diagnostic test or other medical information.

If You have an Emergency Case and You have not received the Covered Service for which You are requesting review, then within seventy-two (72) hours of Your request, We will notify the Health Care Provider that additional information to make a decision We will make a decision for this type of claim within forty-eight (48) hours following the earlier of (1) receipt of the information from You; or (2) the end of the period for submitting the requested information. Decisions regarding Pre-service Review if You have an Emergency Case will be communicated to You by telephone within twenty-four (24) hours of the request. Such decisions will be confirmed in writing within one (1) day after Our decision has been orally communicated to the Covered Person, Authorized Representative, or Health Care Provider. If We fail to make a determination within the time limits in this section, the request shall be deemed approved. If an initial determination is made by the Medical Review Program not to authorize or certify a Health Care Service and the Health Care Provider believes the determination warrants an immediate reconsideration, We will provide the Health

Care Provider the opportunity to speak with the Physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed twenty-four (24) hours of the Health Care Provider seeking the reconsideration. If the Physician is unable to immediately speak with the Health Care Provider seeking the reconsideration, the Physician will provide the Health Care Provider with the following contact information for the Health Care Provider to use to contact the Physician: (1) a direct telephone number that is not the general customer call number; or (2) a monitored e–mail address that is dedicated to communication related to utilization review.

We will not render an Adverse Decision solely because the Hospital did not notify us within twenty-four (24) hours or other prescribed period of time after that admission if the patient's medical condition prevented the Hospital from determining: (1) the patient's insurance status; and (2) Our Medical Review Program's emergency admission notification requirements.

Concurrent Reviews: If We fail to make a determination within the time limits described below, the request will be deemed approved. When You make a request for additional visits or days of care submitted as part of an existing course of treatment or treatment plan, when We had previously approved a course of treatment that is about to end, the Medical Review Program will make concurrent review determinations within one (1) working day of receiving the request or within one (1) working day of obtaining all the necessary information. In the event that the Medical Review Program results in the end or limitation of Covered Services, We will make a review determination within one (1) working day after receipt of the information necessary to make the determination. We will promptly notify the Health Care Provider of the determination. We will provide notice that additional information is needed after receipt of the initial request for Health Care Services and confirming through a complete review of information already submitted by the Health Care Provider. We will promptly notify the Covered Person, the Authorized Representative, and Health Care Provider of the need for additional information within three (3) calendar days of the initial request and explain in detail what information is required by specifying the information, including lab or diagnostic test or other medical information, that must be submitted to complete the request and the criteria and standards to support the need for additional information. If You have an Emergency Case, then a request for concurrent review will be handled like any other Pre-Service request for review when an Emergency is involved except that Our decision will be made within twenty-four (24) hours of the request.

If the Medical Review Program authorizes or an extended stay or additional services under the concurrent review, KPIC will:

1. Promptly notify the Health Care Provider of the determination orally by telephone within one (1) working day after receipt of the information necessary to make the determination;
2. We will provide notice that additional information is needed after receipt of the initial request for Health Care Services and confirming through a complete review of information already submitted by the Health Care Provider. We will promptly notify the Covered Person, the Authorized Representative, and Health Care Provider of the need for additional information within three (3) calendar days of the initial request and explain in detail what information is required by specifying the information, including lab or diagnostic test or other medical information, that must be submitted to complete the request and the criteria and standards to support the need for additional information; and
3. Confirm the certification in writing with the Covered Person, Authorized Representative or Health Care Provider within five (5) working days after the adverse decision was made. The written notification will include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

If the request for extended stay or additional services is denied, KPIC will:

1. Notify the Provider and/or the Covered Person or Authorized Representative of the denial orally by telephone within one (1) working day after receipt of the information necessary to make the determination; and
2. Confirm the denial in writing with the Covered Person, Authorized Representative or Health Care Provider within five (5) working days of the denial decision. Coverage will continue for Covered Services until the Covered Person, Authorized Representative, or Health Care Provider rendering the service has been notified of the denial decision in writing.

The Covered Person, Authorized Representative or Health Care Provider may then file an Appeal or Grievance, as appropriate, as described below.

Post-service Reviews: The Medical Review Program will make its determination on Post-service Reviews within thirty (30) calendar days of receiving a claim. This time period may be extended one time by Us, for up to fifteen (15) calendar days, if We determine that an extension is necessary because (1) the legitimacy of the claim or the appropriate amount of the benefit is in dispute and additional information is necessary or (2) the claim is not clean and, therefore, We need more information to process such claim. We will notify You of the extension within the initial 30-day period. Our notice will explain the circumstances requiring the extension and the date upon which We expect to render a decision. If such an extension is necessary because We need information from You, then Our notice of extension will specifically describe the required information which You need to submit. You must respond to requests for additional information within forty-five (45) calendar days or We will make Our decision based upon the information We have available to Us at that time.

We will send an Explanation of Benefits to the Covered Person, Authorized Representative or Health Care Provider to inform the Covered Person, Authorized Representative or Health Care Provider that:

1. The claim was paid; or
2. The claim is being denied in whole or in part; or
3. Additional information is needed to determine all or part of the claim benefit and what specific information must be submitted; or
4. The claim is incomplete and/or unclean and what information is needed to make the claim complete and/or clean.

If We deny payment of the claim, in whole or in part, the Covered Person, Authorized Representative or Health Care Provider may then file an Appeal or Grievance, as appropriate, as described below.

II. Health Advocacy Unit and the Maryland Insurance Commissioner

A. The Health Advocacy Unit of the office of the Maryland Attorney General can help a Covered Person, Authorized Representative prepare a Grievance or an Appeal to file with KPIC.
   1. The Health Advocacy Unit is available to assist the Covered Person or Authorized Representative with filing a Grievance or Appeal under the internal Grievance and Appeals processes. However, the Health Advocacy Unit is not available to represent or accompany the Covered Person and/or Authorized Representative during the proceeding of the internal Grievance process;
   2. The Health Advocacy Unit can assist the Covered Person or Authorized Representative in mediating a resolution of the Adverse Decision or Coverage Decision with KPIC, but at any time during the mediation, the Covered Person, Authorized Representative, , or a Health Care Provider may file a Grievance or Appeal; and

3. The Covered Person or Authorized Representative may file a complaint with the Commissioner without first filing a Grievance or Appeal as explained in Section II, B, below.

The Health Advocacy Unit may be contacted at:

Health Education and Advocacy Unit, Consumer Protection Division
Office of the Attorney General
200 St. Paul Place
Baltimore, MD, 21202
(410) 528-1840
(877) 261-8807 (toll free out-of-area)
(410) 576-6571 (facsimile)
heau@oag.state.md.us (email address)
www.marylandattorneygeneral.gov (internet address)

B. A Covered Person or Authorized Representative or Health Care Provider must file a Grievance or Appeal with Us and exhaust Our internal Grievance and Appeals process as described in this section of the certificate prior to filing a Complaint with the Maryland Insurance Commissioner except when:

1. The Coverage Decision involves an Urgent Medical Condition for which care has not been rendered;
2. The Covered Person, Authorized Representative or Health Care Provider provides sufficient information and supporting documentation in the Complaint that supports a compelling reason to not exhaust Our internal process for resolving Grievances (protests regarding Adverse Decisions), such as, when a delay in receiving the Health Care Service could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the Covered Person remaining seriously mentally ill or using intoxicating substances with symptoms that cause the Covered Person to be in danger to self or others, or the member continues to experience severe withdrawal symptoms;
3. We failed to make a Grievance decision for a Pre-service Grievance within thirty (30) working days after the filing date or the earlier of forty-five (45) working days or sixty (60) calendar days after the filing date for a Post-service Grievance if the Covered Person, Authorized Representative, or a Health Care Provider filing a Grievance on behalf of the Covered Person agrees in writing to an extension for a period longer than 30 working days;
4. We or Our representative failed to make a Grievance Decision for an expedited Grievance for an Emergency Case within twenty-four (24) hours after the Covered Person, Authorized Representative, or a Health Care Provider filed the Grievance;
5. We fail to comply with any of the requirements of Our internal Grievance process; or
6. We waive the requirement that Our internal Grievance and Appeals process be exhausted before filing a Complaint with the Commissioner.

The Maryland Insurance Commissioner may be contacted at:

Maryland Insurance Administration
Appeal and Grievance Unit
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
(800) 492-6116 (toll free out-of-area)
(410) 468-2000
(410) 468-2260 Facsimile

III. Grievance and Appeals Processes

A. Internal Grievance Process: This process applies to a utilization review determination made by Us that a proposed or delivered Health Care Service was not Medically Necessary, appropriate, or efficient thereby resulting in noncoverage of a Health Care Service.

Pre-Service, Concurrent and Expedited Medical Review Grievance

The Covered Person, Authorized Representative or Health Care Provider acting on behalf of the Covered Person may initiate an Appeal by submitting a written request including all necessary information that relates to the Grievance to:

Permanente Advantage Appeals
8954 Rio San Diego Dr, 2nd Floor, Room 20R22
San Diego, CA 92108
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

If there is an initial determination made not to authorize or certify a Health Care Service and the Health Care Provider believes the determination warrants an immediate reconsideration, We will provide the Health Care Provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed twenty-four (24) hours of the Health Care Provider seeking the reconsideration. If the physician is unable to immediately speak with the Health Care Provider seeking the reconsideration, the physician shall provide the Health Care Provider with the following contact information for the health care provider to use to contact the physician: (1) a direct telephone number that is not the general customer call number; or (2) a monitored e-mail address that is dedicated to communication related to utilization review.

Post-service Grievance

The Covered Person, Authorized Representative or Health Care Provider acting on behalf of the Covered Person may initiate a Grievance by submitting a written request including all necessary information that relates to the Appeal to:

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

The Grievance must be filed in writing within one hundred eighty (180) days from the date of receipt of the Adverse Decision notice. If the Grievance is filed after the one hundred eighty (180) days, We will send a letter denying any further review due to lack of timely filing. We will render a final decision in writing on a Post-service Grievance within forty-five (45) working days after the date on which the Post-service Grievance is filed.

If within five (5) working days after a Covered Person, Authorized Representative or Health Care Provider files a Grievance, We need additional information to complete Our internal Grievance process, We , after confirming through a complete review of any information already submitted by the Health Care Provider will (1) notify the Covered Person, Authorized Representative or Health Care Provider that We cannot proceed with review of the Grievance unless We receive the additional information; (2) request the specific information, including any lab or diagnostic test or other medical information that must be

submitted to complete the internal grievance process; and (3) provide the specific reference, language, or requirements from the criteria and standards used by Us to support the need for the additional information. If assistance is needed and requested, We will assist the Covered Person, Authorized Representative, or Health Care Provider in gathering the necessary additional information without further delay.

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 the Grievance and Appeals Department at 1 877-847-7572.

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

We will acknowledge receipt of the Grievance within five (5) working days of the filing date of the written Grievance notice. The filing date is the earlier of five (5) days after the date of mailing (postmark) or the date of receipt.

1. Pre-service Grievance

If the Grievance is for a service that the Covered Person is requesting (that is, the service has not been rendered), an acknowledgement letter will be sent requesting any additional information which may be necessary within five (5) working days after the filing date. We will also inform You and Your Authorized Representative that a decision will be made regarding the Grievance in writing and such written notice will be sent within thirty (30) calendar days of the filing date of the Grievance.

2. Post-service Grievance

If the Grievance is asking for payment for Health Care Services already rendered, a retrospective acknowledgement letter will be sent requesting any additional information that may be necessary within five (5) working days after the filing date. We will also inform You and Your Authorized Representative that a decision will be made in writing and such written notice will be made within the earlier of forty-five (45) working days or sixty (60) calendar days of the filing date of the Grievance.

For both Pre-service and Post-service Grievances, if there will be a delay in Our concluding the Grievance in the designated period, We will send You and Your Authorized Representative a letter requesting an extension. Such extension period shall not exceed more than thirty (30) working days. If You or Your Authorized Representative do not agree to the extension, then the Grievance will be completed in the

original designated period. Any agreement to extend the period for a Grievance decision will be documented in writing.

If the Pre-service or Post-service Grievance is approved, a letter will be sent to the Covered Person and Authorized Representative stating the approval. If the Grievance was filed by Your Health Care Provider, then a letter stating the Grievance Decision will also be sent to the Covered Person.

If the Pre-service or Post-service Grievance results in a denial, We will notify You, Your Authorized Representative and a Health Care Provider of the Grievance Decision. This notification will include:

(1) The specific factual basis for the Grievance Decision in clear understandable language and reasoning used to determine that the Health Care Service is not Medically Necessary and did not meet Our criteria and standards used in conducting utilization review;
(2) The specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines used by Us on which the Grievance Decision was based;
(3) The name, business address, and business telephone number of the designated employee or Our representative who has responsibility for Our internal grievance process and the designated employee or representative's title and clinical specialty;
(4) A description of Your or Your Authorized Representative's right to file a Complaint within four (4) months following receipt of Our Grievance Decision;
(5) The Commissioner's address, telephone number, and facsimile number;
(6) A statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in filing a complaint with the Commissioner; and
(7) The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

We will communicate our decision to You orally and will sent a written notice of such the Grievance Decision, to You, Your Authorized Representative, and a Health Care Provider within five (5) working days after the Grievance Decision has been made to You and Your Authorized Representative. If We fail to make a Grievance Decision within the stated timeframes herein or an extension of such timeframe, You or Your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from Us.

3. Expedited Grievances for Emergency Cases

A Covered Person, Authorized Representative, or a Health Care Provider may seek an expedited review in the event of an Emergency Case as that term is defined in this Section of this Certificate. An expedited review of an Emergency Case may be initiated by calling 1-(800) 777-7902.

We will initiate the expedited procedure for an Emergency Case if the Covered Person or Authorized Representative requests the expedited review or the Health Care Provider or Covered Person or Authorized Representative attests that: (i) the Adverse Decision was rendered for Health Care Services that are proposed but have not been provided; and (ii) the services are necessary to treat a condition or illness that, without immediate medical attention, would: (1) seriously jeopardize the life or health of the Covered Person or Covered Person's ability to regain maximum functions; (2) cause the Covered Person to be in danger to self or others; or (3) cause the Covered Person to continue using intoxicating substances in an imminently dangerous manner.

Once an expedited review is initiated, clinical review will determine if the Covered Person has a medical condition which meets the definition of an Emergency Case. A request for expedited review must contain the telephone number where We may reach the Covered Person, Authorized Representative, or a Health

Care Provider in an effort to communicate regarding Our review. In the event that additional information is necessary for Us to make a determination regarding the expedited review, We will notify the Covered Person, Authorized Representative, or a Health Care Provider by telephone to inform him/her that review of the expedited review may not proceed unless certain additional information is received. Upon request, We will assist You or Your Authorized Representative, or a Health Care Provider in gathering such information so that a determination may be made within the prescribed timeframes.

If the clinical review determines that the Covered Person does not have the requisite medical condition, the request will be managed as a non-expedited Grievance pursuant to the procedure outlined in Section III, A, above. If We determine that an Emergency Case does not exist, We will verbally notify the Covered Person, Authorized Representative, or a Health Care Provider within twenty-four (24) hours, and inform You, the Authorized Representative, or a Health Care Provider of the right to file a Complaint with the Commissioner.

If We determine that an Emergency Case does exist, then the expedited review request will be reviewed by a Physician who is board certified or eligible in the same specialty as the treatment under review and who is not the individual (or the individual's subordinate) who made the initial decision. If additional information is needed to proceed with the review, We will contact the Covered Person, Authorized Representative, or a Health Care Provider by telephone or facsimile.

Within twenty-four (24) hours of the filing date of the expedited review request, We will verbally notify the Covered Person, Authorized Person, or a Health Care Provider of Our decision. We will send written notification to the Covered Person, Authorized Representative, and a Health Care Provider within one (1) calendar day after the decision is verbally communicated. If approval is recommended, then We will assist the Covered Person in arranging the authorized treatment or benefit. If the expedited review results in a denial, We will notify the Covered Person, Authorized Representative, and a Health Care Provider within one (1) calendar day after the decision is verbally communicated. This notification will include:

(1) State in detail in clear, understandable language the specific factual bases for Our Grievance Decision and the reasoning used to determine that the Health Care Service is not Medically Necessary and did not meet Our criteria and standards used in conducting the utilization review;
(2) Provide the specific reference, language, or requirements from the criteria and standards, including any interpretive guidelines used by Us, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary"; or language directing the member to review the additional coverage criteria in the member's policy or plan documents;
(3) The name, business address, and business telephone number the designated employee or representative who has the responsibility for Our internal Grievance process and the designated employee or representative's title and clinical specialty;
(4) A description of Your or Your Authorized Representative's right to file a Complaint within four (4) months following receipt of Our Grievance Decision;
(5) The Commissioner's address, telephone number, and facsimile number;
(6) A statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in filing a complaint with the Commissioner; and
(7) The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

If We fail to make a decision within the stated timeframes for an expedited review, You or Your Authorized Representative may file a Complaint with the Commissioner without waiting to hear from Us.

B. Internal Appeal Process: This process applies to Our Coverage Decisions and a Covered Person or his/her Authorized Representative or Health Care Provider must exhaust Our internal Appeal process prior to filing a Complaint with the Commissioner, except if Our Coverage Decision involved an Urgent Medical Condition.

The Covered Person, Authorized Representative or a Health Care Provider must file an Appeal within one hundred eighty (180) days from the date of receipt of the Coverage Decision. This Appeal should be sent to KPIC's Internal Grievance manager at the address shown below:

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

We will respond in writing to an Appeal within thirty (30) days for a Pre-service claim or sixty (60) days for a Post-service claim after Our receipt of the Appeal. If Our review results in a denial, We will notify the Covered Person, Authorized Representative, and the Health Care Provider acting on behalf of the Covered Person in writing within thirty (30) calendar days after the Appeal Decision has been made. This notification will include:

1. The specific factual basis for the decision in clear, understandable language;
2. A description of Your, Your Authorized Representative, or Health Care Provider's right to file a Complaint with the Commissioner within four (4) months following receipt of Our Appeals Decision;
3. The Commissioner's address, telephone number, and facsimile number;
4. A statement that the Health Advocacy Unit is available to assist You or Your Authorized Representative in both mediating and filing a Complaint with the Commissioner; and
5. The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

C. Independent External review: After We have rendered a final Adverse decision or Grievance Decision upon Your completing Our internal appeals process, You have a right, under applicable Maryland law, to request an independent external review of Our final Adverse decision or Grievance Decision through the Maryland Insurance Administration. You or Your Authorized Representative, or Health Care Provider, in accordance with the applicable regulations of the Maryland Insurance Administration, may file an Appeal. Your, Your Authorized Representative or Health Care Provider's Appeal must be filed within four (4) months of the final Adverse Decision or Grievance Decision.

IV. Definition of Terms Used With Regard to Medical Review and Grievances and Appeals

As used in this Section of this Certificate, the terms below have the following meanings:

Adverse Decision means a utilization review determination by Us that: (i) a proposed or delivered Health Care Service covered under the Group Policy is or was not Medically Necessary, appropriate, or efficient; and (ii) may result in noncoverage of the Health Care Service, or a denial by Us of a request by a Covered Person for an alternative standard or a waiver of a standard to satisfy the requirements of a wellness program (as defined by the Maryland Insurance Code). An Adverse Decision includes a utilization review determination based on a prior authorization or step therapy requirement. An Adverse Decision does not include a decision about Your status as a Covered Person.

Appeal means a protest filed by a Covered Person, his/her Authorized Representative, or a Health Care Provider with KPIC under its internal appeal process regarding a Coverage Decision concerning a Covered Person.

Appeal Decision means a final determination by KPIC that arises from an Appeal filed with Us under Our appeal process regarding a Coverage Decision concerning a Covered Person.

Authorized Representative means an individual authorized by the Covered Person or state law to act on the Covered Person's behalf to file claims and to submit Appeals or Grievances to Us or Complaints to the Commissioner. A Health Care Provider (as that term is defined in this Section of this Certificate) may act on behalf of a Covered Person with the Covered Person's express (written) consent, or without such consent.

Commissioner means the Maryland Insurance Commissioner.

Complaint means a protest filed with the Commissioner involving a Coverage Decision, Grievance Decision, or Adverse Decision as described herein.

Coverage Decision means (1) an initial determination by KPIC or a representative of KPIC that results in noncoverage of a Health Care Service including a determination of nonpayment for all or part of a claim because the eligibility of the person for such Health Care Service is in question; (2) a determination by KPIC that You are not eligible for coverage; or (3) any determination by KPIC that results in the recession of Your coverage. A Coverage Decision does not include an Adverse Decision or a pharmacy inquiry.

Emergency Case means a case involving an Adverse Decision for which an expedited review is required. Emergency Cases pertain to Covered Services which have yet to be delivered and such Covered Services are necessary to treat a condition or illness that, without medical attention would (1) seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function or (2) cause the Covered Person to be in danger to self or others or (3) cause the Covered Person to continue using intoxicating substances in an immediately dangerous manner.

Grievance means a protest filed by a Covered Person, Authorized Representative, or a Health Care Provider on behalf of a Covered Person with KPIC through Our internal grievance process regarding an Adverse Decision concerning a Covered Person. A Grievance does not include a verbal request for reconsideration of a utilization review determination.

Grievance Decision means a final determination by KPIC that arises from a Grievance filed with Us under Our internal grievance process regarding an Adverse Decision concerning a Covered Person.

Health Advocacy Unit means the Health Education and Advocacy Unit in the Division of Consumer Protection of the Office of the Attorney General.

Health Care Provider means an individual who is (1) licensed or otherwise authorized in this State to provide Health Care Services in the ordinary course of business or practice of a profession and is the treating Provider of the Covered Person; or (2) A Hospital.

Health Care Service means a health or medical care procedure or service rendered by a Health Care Provider that: (1) provides testing, diagnosis, or treatment of a human disease or dysfunction; (2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction; or (3) provides any other care, service or treatment of disease or injury, the correction of defects, or of the maintenance of physical or mental well-being of individuals.

Notice of Coverage Decision will include:

(1) The specific factual basis for the decision in clear understandable language;

(2) That the Covered Person, Authorized Representative, or Health Care Provider acting on behalf of the Covered Person may file a complaint with the Commissioner without first filing an appeal, if the coverage decision involves an Urgent Medical Condition for which care has not been rendered;

(3) The Commissioner's address, telephone number, and facsimile number;

(4) That the Health Advocacy Unit is available to assist the Covered Person or the Covered Person's Authorized Representative in both mediating and filing an appeal under the KPIC's internal appeal process; and

(5) The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit

The notice will be sent to the Covered Person and Covered Person's Authorized Representative within thirty (30) calendar days after a coverage decision has been made.

Urgent Medical Condition, as used in this Section of this Certificate means a condition that satisfies either of the following:

(a) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within seventy-two (72) hours could reasonably be expected by an individual, acting on behalf of KPIC, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, to result in:

(i) Placing the Covered Person's life or health in serious jeopardy;

(ii) The inability of the Covered Person to regain maximum function;

(iii) Serious impairment to bodily functions;

(iv) Serious dysfunction of any bodily organ or part; or

(v) The Covered Person remaining seriously mentally ill with symptoms that causes the Covered Person to be a danger to self or others; or

(b) A medical condition, including a physical condition, a mental health condition, or a dental condition, where the absence of medical attention within seventy-two (72) hours in the opinion of a Health Care Provider with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Coverage Decision.

V. 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, ten percent (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).

ENGLISH: To obtain assistance, call 1-888-225-7202 (TTY 711).

SPANISH (Español): Para obtener asistencia en Español, llame al. 1-800-686-7100.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-686-7100.

CHINESE (中文): 如果需要中文的帮助,请拨打这个号码1-800-686-7100.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne 1-800-686-7100.

VI. Filing Complaints about KPIC

If You have any complaints about the operation of KPIC or Your care, You may file a Complaint with the Maryland Insurance Administration (MIA). When filing a Complaint with the MIA, You or Your Authorized Representative will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the Complaint.

How To File A Complaint

Complaints must be received in writing by the MIA, in one of the following three ways. You may

1. File a complaint on-line,
2. Download on-line forms to be completed by hand, or
3. Submit a written letter.

To file a complaint on-line, go to the MIA's website at: https://insurance.maryland.gov/. Select the "Consumer Information" option and then select the "File a Complaint" option. Follow the instructions to submit an on-line complaint.

To download on-line forms to be completed by hand, go to the MIA's website at: https://insurance.maryland.gov**/.** Select the "Consumer Information" option and then select the "File a Complaint" option. Follow the instructions to download complaint forms. These forms should be as complete and detailed as possible and be accompanied by copies of any relevant documentation of your complaint. They may be mailed or faxed to the MIA as directed below.

If You choose to submit a written letter, please include or provide the following:

1. Your name, address, and daytime and evening phone number,
2. Name of Your insurance company, type of insurance (health), policy number and claim number (if applicable),
3. Name of any other insurance company, agent, adjuster, etc. involved in Your problem (provide as many names and phone numbers as possible),
4. A detailed explanation of the problem or situation,
5. Copies of any documents that You think are important for the investigator to review. Do not send originals.
6. A copy of Your health insurance card or your policy.

Mail or fax this information to:

Maryland Insurance Administration
Attn: Life and Health Complaint Investigation
200 St. Paul Place
Suite 2700
Baltimore, MD 21202
Telephone: 410-468-2244 or 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2260

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 Contract 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 Contract Year and are submitted to Us, the Deductible will have been met for that Covered Person for that Contract 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 Contract Year Deductible.

Family Deductible Maximum

The Deductible for a family has been satisfied for a Contract 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 Contract 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 during the remainder of that Contract 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 or 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 Contract Year in which the accident occurs; or (2) in the next Contract 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 Deductible and/or 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, or Benefit Maximum and additional expenses a Covered Person must pay because

Precertification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

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

***Family Out-of-Pocket Maximums**:* When the Cost Share amounts for all Covered Persons in a family unit equal or exceed the Family Out-of-Pocket Maximum shown in the Schedule of Coverage during a Contract Year, then the Percentage Payable will be 100% of Covered Charges for all Covered Persons in a family enrollment unit for the remainder of the Contract Year.

Cost Shares for Essential Health Benefits contribute toward satisfaction of the Out-of-Pocket Maximum at the par provider level.

NOTE: Please refer to the Schedule of Coverage section for the actual amount of Your Individual/Self-Only and Family Out-of-Pocket Maximum.

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. **A Covered Person may not be held responsible for payment of amounts in excess of the Maximum Allowable Charge for Covered Services received from on-call physicians or hospital-based physicians who have accepted an assignment of benefits in accordance with § 14-205.2 of the Maryland Insurance Article**. (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 internal limits or maximums. These additional items 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

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 Contract 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. General limitations and exclusions are listed in the **GENERAL LIMITATIONS AND EXCLUSIONS** section. Benefits are set forth under the sections entitled **OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS.**

Insuring Clause

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

1. The claim for Covered Services while the Covered Person is insured or covered under the Extension of Benefits;
2. The claim is for a Covered Service and the Covered Services 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, subject to the Reinstatement of Your Maximum Benefit While Insured provision.

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

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

Covered Services:

1. Care in medical offices for treatment of illness or injury, including Primary Care Physician office Visits and Specialty Care Visits.
2. Inpatient Hospital Services, which includes:
   a) Room and Board, such as
      1. Ward, semi-private, or intensive care accommodations (private room is covered only if Medically Necessary).
      2. General nursing care;
      3. Meals and special diets.
   b) Other services and supplies provided by a hospital.
   c) For obstetrical admissions, coverage is provided for up to forty-eight (48) hours for a normal vaginal delivery or up to ninety-six (96) hours for a normal cesarean section. For a mother and newborn child who remain in the Hospital for the minimum period as specified above, KPIC will provide coverage for a home health visit to be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child. If the mother, in consultation with her attending Provider, determines that she wishes to have a shorter length of stay than the minimum above, KPIC shall provide coverage for: (a) one home health visit to occur within twenty-four (24) hours after Hospital discharge; and (b) additional home health visits may be prescribed by the attending Provider. If the mother is required to remain hospitalized after childbirth for medical reasons, and the mother

has requested that the baby remain in the Hospital, coverage is provided for the newborn for up to four (4) additional days of hospitalization.

3. Outpatient Hospital Services.
4. Mental Health and Substance Abuse Services. Medically Necessary services for mental disorders, mental illness, psychiatric conditions, and Substance Abuse for Covered Persons includes:
   a) Professional services by health care Providers who are licensed, registered, or certified professional mental health and Substance Abuse practitioners when acting within the scope of their license, registration, or certification, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.
      1. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:
         - Diagnostic evaluation;
         - Crisis intervention and stabilization for acute episodes;
         - Medication evaluation and management (pharmacotherapy);
         - Treatment and counseling (including individual and group therapy);
         - Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;
         - Professional charges for intensive outpatient treatment in a Provider's office or other professional setting;
      2. Electroconvulsive therapy;
      3. Inpatient professional fees;
      4. Outpatient diagnostic tests provided and billed by a licensed, registered, or certified mental health and Substance Abuse practitioner;
      5. Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility;
      6. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment
   b) Inpatient hospital and inpatient residential treatment centers services, which includes:
      1. Room and board such as:
         - Ward, semi-private, or intensive care accommodations (private room is covered only if Medically Necessary. If private room is not Medically Necessary, We will cover only the Hospital's average charge for semi-private accommodations.)
         - General nursing care;
         - Meals and special diets.
   c) Outpatient services such as partial hospitalization or intensive day treatment programs provided at a facility which is equipped to provide Mental Health and Substance Abuse Services.
5. Emergency services are covered as an In-Plan benefit. Please see Health Plan EOC
6. Ambulance services are covered as an In-Plan benefit. Please see Health Plan EOC.
7. Home Health Care Services:
   a) As an alternative to otherwise covered services in a Hospital or related institution; and
   b) For Covered Person who receive less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or removal of a testicle or who undergoes a mastectomy or removal of a testicle on an outpatient basis:
      1. One home visit scheduled to occur within twenty-four (24) hours after discharge from the Hospital or outpatient health care facility, and
      2. An additional home visit if prescribed by the Covered Person's attending physician.

8. Hospice care services;
9. Outpatient surgery in a Free-Standing Surgical Facility, other licensed medical facility, or in a doctor's office.
10. Durable Medical Equipment and Prosthetic Devices, including:
    a) DME such as nebulizers, peak flow meters, and Home Ultraviolet (UV) Light boxes;
    b) Leg, arm, back, or neck braces;
    c) Internally implanted devices such as monofocal intraocular lens implants;
    d) Artificial legs, arms, or eyes and the training to use these prosthetics; and
    e) Ostomy and urological supplies.
    f) Training required to use the prosthetic device.

    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.
11. Outpatient laboratory and diagnostic services;
12. Outpatient Rehabilitation Services:
    a) Physical therapy rendered by a certified physical therapist.
    b) Speech therapy rendered by a certified speech therapist or certified speech pathologist.
    c) Occupational therapy rendered by a certified occupational therapist.
13. Cardiac Rehabilitation for Covered Persons who have been diagnosed with significant cardiac disease, have suffered a myocardial infarction or have undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation. "Cardiac Rehabilitation" is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education, and counseling. Services include: (1) Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, physician's revision of exercise prescription and follow-up examination for physician to adjust medication or change regimen; and (2) Up to ninety (90) visits per therapy, per contract year of physical therapy, speech therapy and occupational therapy for Cardiac Rehabilitation.
14. Pulmonary rehabilitation for Covered Persons diagnosed with significant pulmonary disease for one pulmonary rehabilitation program per lifetime.
15. 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 ninety (90) 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.
16. Biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition that is supported by medical and scientific evidence.
    a) Biomarker 1) means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention including known gene-drug interactions for medications being considered for use or already being administered and (2) includes gene mutations, characteristics of genes, or protein expressions.

b) Biomarker testing is the analysis of a Member's tissue, blood, or other biospecimen for the presence of a biomarker and includes single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.
Benefits for biomarker testing are available to the same extent as benefits provided for other similar Services.

17. Chiropractic services.
18. Acupuncture services
19. Skilled nursing facility services as an alternative to Medically Necessary inpatient hospital services.
20. Infertility services, except for those services listed in the **GENERAL LIMITATIONS AND EXCLUSIONS** section.
21. Professional Nutritional Counseling and Medical Nutrition Therapy Services
    a) Coverage is provided for unlimited Medically Necessary nutritional counseling provided by a licensed dietician-nutritionist, physician, physician assistant or nurse practitioner for an individual at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition; and
    b) Coverage is provided for unlimited medical nutrition therapy provided by a licensed dietician-nutritionist, working in coordination with a primary care physician, to treat a chronic illness or condition.
22. Coverage of benefits through patient centered medical homes for individual with chronic conditions, serious illnesses or complex health care needs who agree to participate in a patient centered medical home program. This includes associated costs for coordination of care, such as:
    1. Liaison services between the individual and the health care Provider, nurse coordinator, and the care coordination team;
    2. Creation and supervision of a care plan;
    3. Education of the individual and family regarding the individual's disease, treatment compliance and self-care techniques; and
    4. Assistance with coordination of care, including arranging consultations with specialists and obtaining Medically Necessary supplies and services, including community resources.
23. Transplant services are covered as an In-Plan benefit. Please see Health Plan EOC.
24. Medical food for persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.
25. 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.
26. Chemotherapy
27. Infusion therapy. Infusion therapy is treatment by placing therapeutic agents into the vein including therapeutic nuclear medicine and parenteral administration of medication and nutrients. Infusion Services also include enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract. These Services include coverage of all medications administered intravenously and/or parentally. We will also provide coverage for Medically Necessary diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric
    syndrome, including the use of intravenous immunoglobulin therapy.
28. Coverage for one (1) hair prosthesis for hair loss when prescribed by a Provider.
29. Renal Dialysis/Hemodialysis/Peritoneal (home or in renal dialysis center) (includes diagnostic, supplies, equipment & drugs)

30. Habilitative services for Medically Necessary Speech Therapy, Occupational Therapy, Physical Therapy, including Speech Therapy, Occupational Therapy, Physical Therapy and Applied Behavioral Analysis (ABA) coverage for Autism Spectrum Disorder (ASD), and assistive technology services and devices for Covered Persons. Covered Persons coverage has no visit limit, per therapy, per year of speech and language therapy, occupational therapy, and physical therapy.

    These Services are provided in addition to the physical, occupational, speech therapy and multidisciplinary rehabilitation services described in this Certificate of Insurance.

    "Habilitative Services" means services and devices, including Occupational Therapy, Physical Therapy, and Speech Therapy, that help a child keep, learn, or improve skills and functioning for daily living.
31. All cost recovery expenses for blood, blood products, derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, plasma, immunoglobulin, and albumin.
32. Pregnancy and maternity services, including abortion care.
33. Birthing classes, one (1) course per pregnancy
34. Coverage for Standard Fertility Preservation Procedures that are:
    (1) performed on a Covered Person and
    (2) Medically Necessary to preserve fertility due to a need for medical treatment that may directly or indirectly cause "Iatrogenic Infertility". Medical treatment that may directly or indirectly cause Iatrogenic Infertility means medical treatment with a likely side effect of infertility as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, or the American College of Obstetricians and Gynecologists, or the American Society of Clinical Oncology.
35. Prescription drugs and devices as described in the **OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS** section.
36. Additional hospitalization for the newborn for up to four (4) days, whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital.
37. Coverage for one home visit to occur within twenty-four (24) hours of hospital discharge for a mother and newborn that have a shorter hospital stay than forty-eight (48) hours of inpatient hospitalization after an uncomplicated vaginal delivery or ninety-six (96) hours of inpatient hospitalization after an uncomplicated cesarean section. An additional home visit if prescribed by the Covered Person's attending Physician. One home visit for a mother and newborn child who remain in the hospital for the minimum length of stay if prescribed by the attending Physician.
38. Clinical Trials. Coverage for patient cost to a member in a Clinical Trials provided on an inpatient and an outpatient basis of treatment for a prevention, early detection, and treatment studies on cancer or life-threatening disease or condition. The coverage shall be required if:
    a) The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or any other life-threatening disease or condition;
    b) The treatment is being provided in a clinical trial approved or funded by:
        (1) One of the National Institutes of Health (NIH);
        (2) An NIH cooperative group or an NIH center;
        (3) The FDA in the form of an investigational new drug application or the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
        (4) Cooperative group or center of The Department of Defense or Department of Veterans Affairs; or
        (5) An Institutional review board of an institution in the State which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH.
        (6) Cooperative group or The Centers of Disease Control and prevention
        (7) Cooperative group or center of The Agency for Health Care Research and Quality
        (8) Cooperative group or The Centers for Medicare & Medicaid Services
        (9) The Department of Energy

(10) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

c) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
d) There is no clearly superior, non-investigational treatment alternative, and
e) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

Coverage for patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

A Cooperative Group means a formal network of facilities that collaborate on research projects and have an established NIH-approved (National Institutes of Health) Peer Review Program operating within the group.

“Cooperative group" includes: the National Cancer Institute Clinical Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and Community Programs for Clinical Research in AIDS.

A Multiple project assurance contract means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

Patient cost means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Covered Person for purposes of the clinical trial. Patient cost does not include: 1) the cost of an investigational drug or device; 2) the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of the clinical trial; 3) costs associated with managing the research associated with the clinical trial; or 4) costs that would not be covered under the patient’s policy, plan, or contract for non-investigational treatments.

39. Any other service approved by KP for case management program.
40. Diabetes treatment, equipment, and supplies. Coverage includes insulin pumps, insulin syringes, needles and test strips for glucose monitoring equipment under the prescription coverage if Pharmacy dispensed, and insulin pumps under the Durable Medical Equipment coverage if not purchased at a Pharmacy.
41. Inpatient and outpatient services arising from orthodontics, oral surgery and otologic, audio logical, and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.
42. Reconstructive surgery. Coverage is limited to surgeries that: (1) will correct significant disfigurement resulting from (a) non-congenital injury or Medically Necessary surgery; or (b) are performed to significantly improve physical function. Coverage does not include: cometic surgery, plastic surgery, or other Services, supplies, dermatological preparations and ointments that are intended primarily to improve your appearance, or will not result in significant improvement in bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies.
43. Reconstructive breast surgery and breast prosthesis. “Reconstructive breast surgery” means surgery performed as a result of a mastectomy to reestablish symmetry between two breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

    “Mastectomy” means the surgical removal of all or part of a breast.

    Coverage shall be provided for:
    a. Breast prosthesis;

b. All stages of reconstructive breast surgery performed on the non-diseased breast to achieve symmetry with the diseased breast when reconstructive surgery is performed on the diseased breast, regardless of the patient's insurance status at the time the mastectomy, or the time lag between the mastectomy and reconstruction; and
c. Physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

44. General anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care provided to the following:
    a. Individual who are seven (7) years old or younger or developmentally disabled and for whom a:
        (1) Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Covered Person, and
        (2) Superior result can be expected from dental care provided under general anesthesia; and
    b. Individuals seventeen (17) years old or younger who:
        (1) Are extremely uncooperative, fearful, or uncommunicative,
        (2) Have dental needs of such magnitude that treatment should not be delayed or deferred, and
        (3) Are individuals for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.
45. Accidental Dental. Dental Services for Accidental Injury and Other Related Medical Services. For benefits to be payable, all of the following conditions must be satisfied:
    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 be requested within sixty (60) days of the injury;
    d. The restorative services are provided within the twelve (12) consecutive month period commencing from the date that treatment for the injury began.

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

    For purposes of this Covered Service, 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; or
    b. Have not been previously restored by a crown, inlay, onlay, porcelain restoration, or treatment by endodontics.

    Restorative Services will not include:
    a. Oral prostheses and appliances.
46. Hearing aids and related hearing exam for a Covered Person.
47. Diagnostic and surgical treatment of morbid obesity that is:
    - recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity; and
    - consistent with guidelines approved by the National Institutes of Health.

    Surgical treatment of morbid obesity shall occur in a facility that is: designated by the American Society for Metabolic and Bariatric Surgery as a Bariatric Surgery Center of Excellence.

48. Physician services, including diagnosis, consultation, and treatment appropriately provided via Telemedicine. Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, , audio-only or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of health care Provider. Telemedicine is provided regardless of the location of the patient at the time of the Telemedicine services are provided. Telemedicine shall be subject to the same Deductible, Coinsurance and/or Copayments as are otherwise applicable to Physician office visits and based on whether the provider is a Primary Care Physician or a specialist, except maternity related ACA preventive care services.

49. Allergy testing and treatment, services, material, and serums.
50. Vision services, including routine exams, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses.
51. Wellness benefits, which include:
    a. A health risk assessment that is completed by each individual on a voluntary basis, and
    b. Written feedback to the individual who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.

52. Urgent Care Services received at an Urgent Care Facility.
53. Medically Necessary coverage of diseases and injury to jaw. Orthognathic surgery, including 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.
54. Removable appliances for TMJ repositioning.
55. Routine foot care limited to Medically Necessary treatment of patients.

Pediatric Vision (children up to age 19. Services available 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 under Your In-Plan Provider benefit and Out of Network Provider benefit:

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 (in lieu of eyeglasses, one pair of contact lenses per year or multiple pairs of disposable prescription contact lenses per year)
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 Care

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

Preventive Care Exams and Services

As shown in the Schedule of Coverage, the following preventive services are not subject to Deductibles, Copayments or Coinsurance as required by section 2713 of the Public Health Service Act (42 U.S.C. 300gg-13) and the "A" or "B" recommendations of the United States Preventive Services Task Force (USPSTF), the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP), and the guidelines of the Health Resources and Services Administration (HRSA), when received from a Participating Provider. Consult with Your physician to determine what preventive services are appropriate for You.

Exams

1. Well-Baby, Child, Adolescent Exam according to HRSA guidelines. This includes all visits for, and costs of, developmental screening as recommended by the American Academy of Pediatrics.
2. Well-woman preventive visit to obtain the recommended preventive services, including preconception counseling and routine prenatal 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.
3. All visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;
4. A physical examination, developmental assessment, and parental anticipatory guidance services at each of the visits required under:
   a) childhood and adolescent immunizations;
   b) hereditary and metabolic newborn screening and follow-up;
   c) screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision;
   d) obesity evaluation and management; and
   e) developmental screening.

Screenings

1. Abdominal aortic aneurysm screening
2. Anxiety screening
3. Asymptomatic bacteriuria screening
4. Breast cancer mammography screening. Coverage for Diagnostic Breast Examination and Supplemental Breast Examination. Diagnostic Breast Examination means Medically Necessary and appropriate examination of the breast that is used to evaluate an abnormality that is: (1) seen or suspected from a prior screening examination for breast cancer; or (2) detected by another means of prior examination. Diagnostic Breast Examination includes an examination using diagnostic mammography, breast Magnetic Resonance Imaging (MRI) or breast ultrasound. Supplemental Breast Examination means a Medically Necessary examination of the breast that is used to screen for breast cancer when: (1) there is no abnormality seen or suspected from a prior examination; and (2) there is a personal or family medical history or additional

factors that may increase a Member's risk of breast cancer. Supplemental Breast Examination includes an examination using breast MRI or breast
ultrasound.

5. Behavioral/Social/Emotional Screening
6. Cervical cancer and dysplasia screening including HPV screening.
7. Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy
8. Depression screening including suicide risk as an element of universal depression screening
9. Diabetes screening
10. Gestational and postpartum diabetes screening
11. Hepatitis B and Hepatitis C virus infection screening
12. Hematocrit or Hemoglobin screening
13. Hypertension (High blood pressure) screening
14. Lead Screening
15. Lipid disorders screening
16. Lung cancer screening with low-dose computed tomography including a counseling visit to discuss the screening. Coverage also includes recommended follow-up diagnostic imaging, such as diagnostic ultrasound,
    MRI, Computed Tomography (CT), and image-guided biopsy, to assist in the diagnosis of lung cancer.
17. Newborn congenital hypothyroidism screening
18. Newborn hearing loss screening
19. Newborn metabolic/hemoglobin screening.
20. Newborn sickle cell disease screening
21. Newborn Phenylketonuria screening
22. Obesity screening and management
23. Osteoporosis screening
24. Pre-eclampsia screening with blood pressure measurements throughout pregnancy
25. Rh (D) incompatibility screening for pregnant Covered Person
26. Sexually transmitted infection screening
27. Sudden cardiac arrest and sudden cardiac death risk assessment
28. Type 2 diabetes mellitus screening
29. Tuberculin (TB) Testing
30. Urinary incontinence screening according to HRSA guidelines
31. Visual impairment screening

Health Promotion

1. Screening by asking questions about unhealthy drug use. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
2. Unhealthy alcohol use and drug misuse assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse.
3. Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular diseases.
4. Offer Intensive counseling and behavioral interventions to promote sustained weight loss.
5. Counseling 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 non-pregnant Covered Persons.
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 risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, with Covered Persons who are at increased risk for breast cancer and at low risk for adverse medication effects according to USPSTF.
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 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 Covered Persons according to the HRSA guidelines.
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 postpartum period, breast milk storage supplies; any equipment and supplies as clinically indicated to support women and babies with breast feeding difficulties; and the purchase of a breast pump. A hospital-grade electric breast pump, including any equipment that is required for pump functionality is covered when Medically Necessary and prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.
13. All prescribed FDA-approved contraceptive methods including but not limited to drugs, cervical caps, vaginal rings, continuous extended oral contraceptives, patches, condoms and the lactation amenorrhea method according to the HRSA guidelines. This includes all FDA-approved cleared or granted contraceptive products that are determined by an individual's medical Provider to be medically appropriate. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, sterilization procedures, follow-up and management of side effects; counseling for continued 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. All contraceptive drugs approved by the U.S. Food and Drug Administration and available by prescription and over the counter. In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, is covered for women desiring an alternative method. A non-preferred contraceptive or drug will be covered at the preferred cost share level when Your physician determines a generic or preferred contraceptive drug or device is not medically appropriate.
14. Screening, counseling, and other interventions such as education, harm reduction strategies and referral to appropriate supportive services for interpersonal and domestic violence.
15. Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions

16. Counseling intervention for pregnant and postpartum Covered Persons who are at increased risk of perinatal depression.

Disease Prevention

1. Immunizations as recommended by the Centers for Disease Control and HRSA. This includes all visits for and costs of childhood and adolescent immunizations recommended by the ACIP.
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.
4. Pre exposure prophylaxis (PrEP) with at least one drug providing effective antiretroviral therapy to Covered Persons who are at high risk of HIV acquisition as well as the following baseline and monitoring services:
   a) HIV testing – to confirm the absence of HIV infection before PrEP is started and testing for HIV every 3 months while PrEP is being taken.
   b) Hepatitis B testing before PrEP is started.
   c) Hepatitis C testing before PrEP is started and periodically during treatment according to CDC guidelines.
   d) Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) is covered as follows:
      i) eCrCl or eGFR testing before starting PrEP to assess kidney function.
      ii) Creatinine and eCrCL or eGFR testing periodically consistent with CDC guidelines during treatment.
   e) Pregnancy testing for persons of childbearing potential before PrEP is started and periodically during treatment consistent with CDC guidelines.
   f) Sexually transmitted infection screening and counseling before PrEP is started and periodically during treatment consistent with CDC guidelines.
   g) Adherence counseling for assessment of behavior consistent with CDC guidelines.

Exclusions for Preventive Care

Preventive services may change upon Policy renewal according to federal guidelines in effect as of January 1 of each year in the Contract 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 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 may be Covered Services elsewhere in this **GENERAL BENEFITS** section:

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

Other Preventive Care

This Benefit section contains preventive care not required by the Patient Protection and Affordable Care Act. These preventive care services are not subject to the Medical Necessity requirement but may be subject to the Deductibles, Copayments, or Coinsurance set forth 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. Please refer to the Schedule of Coverage to see how the following Preventive benefits are covered under the Policy.

1. Adult routine physical examinations. Covered Services at each examination are limited to: a) examination; and b) history. Any X-rays or laboratory tests ordered in connection with the examination will be subject to your plan's Deductibles, Copayments, and/or Coinsurance requirements as set forth in the Schedule of Insurance.
2. Iron deficiency anemia screening for pregnant Covered Persons
3. Iron supplementation for children from 6 months to 12 months of age.
4. The following services and items are covered as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
   a) Hemoglobin A1C testing for individuals diagnosed with diabetes.
   b) Retinopathy Screening for individuals diagnosed with diabetes.
   c) Low Density Lipo Protein testing for individuals diagnosed with heart disease.
   d) International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders.
   e) DME items
      i) Peak flow meters for individuals diagnosed with Asthma
      ii) Glucometers including lancets, strips, control solution and batteries for individuals diagnosed with Diabetes.

5. Family planning limited to:
   a) The charge of a Physician for consultation concerning the family planning alternatives available to a male Covered Person, including any related diagnostic tests;
   b) Vasectomies;
   c) Services and supplies for diagnosis and treatment of involuntary infertility for females and males unless otherwise excluded; and,
   d) Abortion care as permitted under Maryland 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 related to in vitro fertilization including, but not limited to, gamete intrafallopian tube transfer; ovum transplants; zygote intrafallopian transfer, and prescription drugs related to such services.

6. Diagnostic examination which shall include a digital rectal exam and a blood test called the prostate-specific antigen (PSA) test:

a) For men who are between forty and seventy-five (40 and 75) years of age;
b) When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
c) When used for staging in determining the need for a bone scan in patients with prostate cancer; or
d) When used for male patients who are at high risk for prostate cancer.

Prostate cancer screening is not subject to in-network or out-of-network cost-sharing. This coverage does not cover the surgical and other procedures known as radical prostatectomy, external beam radiation therapy, radiation seed implants, or combined hormonal therapy.

7. 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.
8. 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.
9. Aspirin when prescribed by a licensed health care professional authorized to prescribe for the prevention of cardiovascular disease and colorectal cancer screening.

Continuity of Care When Transitioning Carriers

At the request of the Covered Person, the Covered Person's authorized representative, or the Covered Person's health care Provider; KPIC shall allow the Covered Person to continue to receive health care services being rendered by a Non-Participating Provider at the time of the Covered Person's transition to KPIC.

The services a Covered Person shall be allowed to continue to receive are services for the following conditions:

1. Acute conditions;
2. Serious chronic conditions;
3. Pregnancy;
4. Mental health conditions and Substance Abuse, and
5. Any other condition which the Non-Participating Provider and KPIC reach agreement.

The Covered Person shall receive coverage for the following time periods:

1. The lesser of the course of treatment or ninety (90) days;
2. The duration of the three (3) trimesters of a pregnancy and the initial postpartum visit.

KPIC shall pay the Non-Participating Provider the rate or method of payment KPIC would pay and use for Participating Providers who provide similar services in the same or similar geographic area.

The Non-Participating Provider may decline to accept the rate or method of payment by giving ten (10) days prior notice to the Covered Person and KPIC.

If the Non-Participating Provider does not accept the rate or method of payment, the Non-Participating Provider and KPIC may reach agreement on an alternative rate or method of payment for the provision of covered services.

The rates and methods of payment shall: be subject to any State or federal requirements applicable to reimbursement for health care Providers, including:

1. §1302(g) of the Affordable Care Act, which applies to reimbursement rates for Federally Qualified Health centers; and

2. Title 19, Subtitle 2 of the Health-General Article, under which the Health Services Cost Review Commission establishes Provider rates; and
3. Ensure that the Covered Person is not subject to balance billing; and
4. The copayments, deductibles, and any coinsurance required of a Covered Person for the services rendered are the same as those that would be required if the Covered Person were receiving the services from a KPIC Participating Provider.

Extension of Benefits

Covered Services under the Group Policy will be extended for the condition causing the Total Disability of a Covered Person when:

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

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

1. The date on which the Total Disability ends; or
2. Twelve (12) months after the date coverage under the Group Policy terminates; or
3. The date on which the Covered Person becomes covered under any plan that: a) replaces this insurance; and b) covers the disabling condition so that benefits are not limited due to the Total Disability having started before that plan was in effect.

A Covered Person other than a Dependent minor is totally disabled only if, in the judgment of a Physician, a Sickness or Injury: a) is expected to result in death or has lasted or is expected to last for a continuous period of at least 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.

The extension of benefits provided by this provision will not be subject to a premium charge.

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 uncomplicated vaginal delivery and not less than ninety-six (96) hours following an uncomplicated 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.

Emergency Services

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 the Group Policy (subject to the **GENERAL LIMITATIONS AND EXCLUSIONS** section of the Group Policy) 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 payment made with respect to Emergency Services provided by a Non-Participating Provider or a nonparticipating 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 nonparticipating 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 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 under 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:

1. Covered Services rendered by a health care Provider for which payment is required under § 19-710.1 of the Health-General Article
2. Ancillary Services; and
3. 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 Copayment amount, Coinsurance percentage, and/or other Cost-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, Co-insurance 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.

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 or in the Schedule of Coverage, 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. Services that are not Medically Necessary. This exclusion does not apply to preventive or other Covered Services specifically covered under the Group Policy.
4. Services performed or prescribed under the direction of a person who is not a heath care practitioner.
5. Services that are beyond the scope of practice of the health care practitioner performing the service.
6. Services 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.
7. Charges for services for which a Covered Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan.
8. Charges for personal care services and domiciliary care services.
9. 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 Emergency Services were rendered in connection with an Emergency Medical Condition will be determined by KPIC.
10. Covered Services other than Emergency Services outside the United States.
11. Except for Emergency Services, weekend admission charges for Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive, and does not include admissions for maternity.
12. Services provided by a health care practitioner who is a Covered Person's spouse, mother, father, daughter, son, brother, or sister.
13. Charges for experimental services.
14. Charges from a practitioner, hospital, or for clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
15. Covered Services 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.
16. Injury or Sickness for which benefits are payable under any state or federal workers' compensation, employer's liability, or occupational disease or similar law.
17. 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.

18. In vitro fertilization, ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures.

19. Services to reverse a voluntary sterilization procedure for an Adult or a Dependent minor.

20. Services for sterilization for a Dependent minor, except FDA approved sterilization procedures for women with reproductive capacity.

21. Medical or surgical treatment for reducing or controlling weight, except as provided under "the Covered Services" in the **GENERAL BENEFITS** section of this Certificate.

22. Services incurred before the effective date of coverage for a Covered Person.

23. Services incurred after a Covered Person's termination of coverage, except as provided in the Extension of Benefits provision.

24. Personal Care Services and Domiciliary Care Services.

25. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups.

26. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment.

27. Charges for telephone consultations except for services covered under Telehealth, failure to keep a scheduled visit, or completion of any form.

28. Inpatient admissions primarily for diagnostic studies, unless authorized by KPIC.

29. The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, unless otherwise specified under the "Covered Services" in the **GENERAL BENEFITS** section of this Certificate.

30. Immunizations related to foreign travel.

31. Dental care and dental x-rays; dental appliances; orthodontia; and dental services resulting from medical treatment, or medical condition, including surgery on the jawbone and radiation treatment. 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. This exclusion also does not include: (1) 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 or (2) removable appliances for TMJ repositioning. In addition, this exclusion does not include visits for repairs or treatment of cleft lip, cleft palate or both. This exclusion does not include visits for repairs or treatment of accidental injury to sound natural teeth when performed or rendered within six (6) months following the accident.

32. Routine foot care , except as set forth under the "Covered Services" in the **GENERAL BENEFITS** section of this Certificate.

33. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary.

34. Inpatient admissions primarily for physical therapy, unless authorized by KPIC.

35. Treatment of sexual dysfunction not related to organic disease.

36. Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs.

37. Non-human organs and their implantation.

38. Non-replacement fees for blood and blood products.

39. Lifestyle improvements, including nutrition counseling, or physical fitness programs, Except as provided under the "Covered Services" in the **GENERAL BENEFITS** section of this Certificate.

40. Outpatient orthomolecular therapy, including non-prescription drugs or medicines; vitamins, nutrients, and food supplements, even if prescribed or administered by a Provider unless otherwise covered under this Plan or required by state or federal law.

41. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is clearly demonstrable radiographic evidence of joint abnormality due to disease or injury.

42. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.

43. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution.

44. Services for, or related to, the removal of an organ from a covered person for purposes of transplantation into another person.

45. Physical examinations required for obtaining or continuing employment, insurance, or government licensing.

46. Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy.

47. Private hospital room, unless authorized by KPIC.

48. Private duty nursing, unless authorized by KPIC.

49. Experimental Services. This exclusion does not apply to services covered under clinical trials in the "General Benefits" section.

50. 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.

51. Care in an intermediate care facility. This is a level of care for which a Provider determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.

52. Services for which no charge is normally made in the absence of insurance.

53. Any claim, bill, or other demand or request for payment for health care services that were provided as a result of a prohibited referral as determined by the appropriate regulatory board.

54. Adult vision hardware in HDHP/HSA plans.

55. Services in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Covered Person who is a surrogate.

OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

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 exceeds this limit will not be considered a Covered Charge.

This Outpatient Prescription Drug Benefit uses an open Formulary. The Formulary consists of Generic and preferred and Non-preferred Brand Drugs including Specialty Drugs.

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. Any drugs not found on the Formulary list will be considered non-Formulary. The most current Formulary can be obtained by visiting: https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/flexible-choice-and-out-of-area-ppo-formulary-mas-en.pdf

Drugs Covered

Charges for the items listed below are also considered Covered Charges. Except as specifically stated below or on Your Schedule of Coverage, such Covered Charges are subject to the Outpatient Prescription Drug Percentage Payable.

1. FDA-approved drugs for which a prescription is required by law.
2. Compounded preparations that contain at least one ingredient requiring a prescription.
3. Insulin and the following diabetic supplies:
   a) syringes and needles; and
   b) blood glucose and ketone test strips or tablets.
4. Oral Chemotherapy drugs.
5. Any contraceptive drug or device that is approved by the United States Food and Drug Administration (FDA);
6. Over-the-counter contraceptives devices for women when prescribed by a Physician.
7. Contraceptives drugs for women approved by the U.S. Food and Drug Administration and available by prescription and over-the-counter when filled at a Participating Pharmacy.
8. Any prescription drug approved by the FDA as an aid for the cessation of the use of tobacco products. Tobacco products include cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco, and candy-like products that contain tobacco.
9. Nicotine replacement prescription drugs for Nicotine Replacement Therapy courses and drugs that are approved by the FDA as an aid for the cessation of the use of tobacco products.
10. Off-label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.

11. Growth hormone therapy (GHT) for treatment of children under age eighteen (18) with a growth hormone deficiency; or when prescribed by a Physician, pursuant to clinical guidelines for adults.

12. Limited Distribution Drugs (LDD).

13. Prescription eye drops and refills in accordance with guidance for early refills of topical ophthalmic products provided by the Centers for Medicare and Medicaid Services if: (1) the original prescription indicates additional quantities are needed and (2) the refill requested does not exceed the number of refills indicated on the original prescription.

14 Up to a 90-day supply of a maintenance drug in a single dispensing of the prescription;

15. Self-administered injectable drugs.

Outpatient Prescription Drugs Limitations and Exclusions

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

1. Administration of a drug or medicine;

2. Any drug or medicine administered as Necessary Services and Supplies (See the General Definitions section of this Certificate.);

3. Drugs not approved by the FDA;

4. Drugs and injectables for the treatment of sexual dysfunction disorders 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.;

5. Drugs and injectables for the treatment of cosmetic services;

6. Replacement of lost or damaged drugs and accessories;

7. 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 clinical trial has a meaningful potential to benefit the Covered Person. Additionally, this exclusion will not apply to off-label use of a FDA approved drug if the drug is recognized for treatment in any of the standard reference compendia or in the medical literature.

8. Internally Implanted time-release drugs and medicines;

9. Drugs associated with non-covered services;

10. Infant formulas, except for amino acid-based elemental formulas and special food products to treat PKU as set forth as a limited benefit under the GENERAL BENEFITS section of this Certificate;

11. Human Growth Hormone (HGH), except for children with either Turner's syndrome or with classical growth hormone deficiency.

12. Anorectic or any drug solely prescribed for the purpose of weight loss or weight loss management unless prescribed in the treatment of morbid obesity or, unless covered under the Preventive Services benefits as required by PPACA.

13. Non-prescription drugs or medicines; vitamins, nutrients, and food supplements, even if prescribed or administered by a Physician unless otherwise required by state or federal law, unless covered under the preventive Services benefits as required by PPACA and except as otherwise allowed for over-the-counter contraceptives as set forth under the Drugs Covered provision above.

14. 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.

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 must 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.

UTILIZATION MANAGEMENT PROGRAM

Quantity Limits

Quantity limits apply to outpatient prescription drugs for safety and cost reasons and follow the manufacturer's FDA approved guidelines from the package inserts. Prescribers must obtain authorization for quantities higher than those allowed under the Utilization Management Program.

Age Limits

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

Step Therapy Process

Selected outpatient prescription drugs require step therapy. Step therapy is a process that defines how and when a particular outpatient prescription drug can be dispensed by requiring the use of one or more prerequisite drugs (first line agents), as identified through Your drug history, prior to the use of another drug (second line agent). The step therapy process encourages safe and cost-effective medication use. Under this process, a "step" approach is required to receive coverage for certain high-cost medications. Refer to the formulary for a complete list of medications requiring step therapy. This means that to receive coverage, You may first be required to try a proven, cost-effective medication before using a more costly medication. Treatment decisions are always between You and Your Provider.

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

"Supporting medical information" (as used in the provision below) means: 1) A paid claim from an insurer for a Member; 2) A pharmacy record that documents that a prescription has been filled and delivered to a Member or a representative of a Member; or 3) Other information mutually agreed on by KPIC and the Member.

An exception to the step therapy process described above may be provided when:

1. The step therapy drug has not been approved by the U.S. Food & Drug Administration (FDA) for the medical condition being treated; or
2. A prescriber provides supporting medical information to Us that a prescription drug We cover:
    a. Was ordered by the prescriber for the Member within the past one hundred eighty (180) days; and
    b. Based on the professional judgement of the prescriber, was effective in treating the Member's disease or medical condition; or
3. A prescription drug was approved by the FDA; and
    a. Is used to treat a Member's stage four advanced metastatic cancer; and
    b. Use of the drug is:
        i. Consistent with the FDA approved indication or the National Comprehensive Cancer Network Drugs & Biologics Compendium indication for the treatment of stage four advanced metastatic cancer; and
        ii. Supported by peer reviewed medical literature.
4. The step therapy exception request determinations must be made in real time if no additional information is needed to process the request and the request meets the criteria for approval. Otherwise, determinations must be made within 1 working day after receipt of all necessary information. If We fail to make a determination within the time limits required, the request will be deemed approved.]

If additional information is needed to make a determination after confirming through a complete review of the information already submitted by the Health Care Provider, We shall request the information promptly, but not later than 3 calendar days after receipt of the initial request, by specifying:

1. the information, including any lab or diagnostic test or other medical information, that must be submitted to complete the request; and
2. the criteria and standards to support the need for the additional information.

If We fail to make a determination within the time limits required, the request will be deemed approved.

Prior Authorization

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

The purpose of prior authorization is to ensure that You receive the right medication for Your medical condition. This means that when Your Physician prescribes a drug that has been identified as subject to prior authorization, the drug must be reviewed by the utilization management program to determine Medical Necessity before the prescription is filled. Prior authorization reviews address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.

If a drug requires prior authorization, Your prescribing Physician must work with Us to authorize the drug for Your use. Drugs requiring prior authorization have specific clinical criteria that You must meet in order for the prescription to be eligible for coverage. Refer to the formulary for a complete list of medications requiring prior

authorization. The most current formulary can be obtained by visiting: https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/mas/marketplace-formulary-effective-upon-renewal-mas-en-2023.pdf].

If You have questions about prior authorization or about the outpatient prescription drugs covered under Your plan, You can call 1-800-788-2949 or 711 (TTY), 24 hours a day, 7 days a week (closed holidays).

"Exigent circumstances" (as used in the provision below) means exists when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health or ability to regain maximum function or when a Member is using a drug while undergoing a current course of treatment.

When an outpatient prescription drug requiring prior authorization has been prescribed, You or the prescribing Physician must notify the Utilization Management Program as follows:

1. You or Your prescribing Physician can begin the prior authorization process by calling 1-800-788-2949;
2. Following completion of the prior authorization intake process as set forth in item 1 above, We will notify, You or Your designee and the prescribing Physician (or other prescriber, as appropriate), within seventy-two (72) hours for non-urgent requests and within twenty-four (24) hours when exigent circumstances exist, that:
    a. The request is approved; or
    b. The request is disapproved due to:
        i. Not Medically Necessary; or
        ii. Missing material information required to determine Medical Necessity; or
        iii. The patient is no longer eligible for coverage.
3. If We fail to respond within seventy-two (72) hours for non-urgent requests or within 24 hours when exigent circumstances exist, the request shall be deemed to have been approved.
4. In the event the prior authorization request is disapproved:
    a. The notice of disapproval will contain an accurate and clear written explanation of the specific reasons for disapproving the request.
    b. If the disapproval is due to missing material information required to determine Medical Necessity, the notice of disapproval will contain an accurate and clear explanation that specifically identifies the missing material information.
5. The prior authorization request shall be deemed approved if the notice of disapproval is not sent to, You or Your designee and the prescribing Physician (or other prescriber, as appropriate), within seventy-two (72) hours for non-urgent request or within twenty-four (24) hours when exigent circumstances exit.
6. Notices required to be sent to, You or Your designee and the prescribing Physician (or other prescriber, as appropriate), shall be delivered by Us in the same manner the request was submitted to Us or by any other mutually agreeable accessible method of notification.

If the prescribing Physician indicates the outpatient prescription drug is used to treat a chronic condition, We will not request a reauthorization for a repeat prescription for a drug for one (1) year or for the standard course of treatment for the chronic condition being treated, whichever is less.

In accordance with Insurance Article §15- 854(g), We will not issue an adverse decision on a reauthorization for the same prescription drug or request additional documentation from the prescribing Physician for the reauthorization request if:

1. The prescription drug is:
    a. An immune globulin (human) as defined in 21 C.F.R. §640.100; or
    b. Used for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association;
2. We previously approved a prior authorization for the prescription drug for the member;
3. The member has been treated with the prescription drug without interruption since the initial approval of the prior authorization; and

4. Your prescribing Physician attests that, based on the prescribing Physician's professional judgment, the prescription drug continues to be necessary to effectively treat the Your condition.
5. If the prescription drug that is being requested has been removed from the formulary or has been moved to a higher deductible, copayment, or coinsurance tier, We shall provide You and Your health care provider the information required under Insurance Article §15-831.

If We implement a new prior authorization requirement for an outpatient prescription drug, we will provide notice of the new requirement at least sixty (60) days before the effective date of the new requirement. Notice will be made in writing to any Member who is prescribed the prescription drug; and either in writing or electronically to Participating Providers**.** The notice will indicate You may remain on the prescription drug at the time of reauthorization.

We will not require more than one prior authorization if two or more tablets of different dosage strengths of the same prescription drug are:

1. prescribed at the same time as part of an insured's treatment plan; and
2. manufactured by the same manufacturer

An exception to the prior authorization process will be granted under the following circumstances:

1. If You or Your prescribing Physician provides documentation of a prior authorization from Your immediate prior carrier, We will honor the previous authorization for at least the initial ninety (90) days of Your coverage or the length of the course of treatment. After this time period, We may perform our own review to grant a prior authorization for the prescription drug.
2. We will honor a prior authorization previously issued under another KPIC health plan and not require a Health Care Provider to submit a request for prior authorization if:
   a. The prescription drug is a covered benefit under the Group Policy; or
   b. The dosage for the approved prescription drug changes and the change is consistent with federal Food and Drug Administration labeled dosage

We will not accept a previously granted prior authorization for a change in dosage for an opioid.

To request an exception please call MedImpact at: 1-800-788-2949

If Your request for reimbursement of a Non-Participating Pharmacy claim is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **PRE-CERTIFICATION, MEDICAL REVIEW, GRIEVANCE AND APPEALS** section of Your Certificate of Insurance for details regarding the grievance and appeals process and the **subsection titled "Independent External Review** for Your right to an Independent external review by the Maryland Insurance Administration of Our final adverse decision.

FEDERAL CONTINUATION OF COVERAGE PROVISIONS

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

Federal Continuation of Health Insurance (COBRA)

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 PROVISIONS

Surviving Spouse and Dependent Child Continuation:

As used in this provision, the terms listed below are defined as follows:

"Dependent Child" means a child of the Insured Employee who: (i) was covered under the Group Policy as a qualified or eligible dependent of the Insured Employee immediately before the death of the Insured Employee; or (ii) was born to a Qualified Secondary Beneficiary after the death of the Insured Employee.

"Election Period**"** means the period that begins on the date of death of the Insured Employee and ends forty-five (45) days after that date.

"Insured Employee" means an employee of the Group Policyholder who is a resident of the State of Maryland and covered under the Group Policy current or predecessor group contract with the same employer for at least three (3) months before death.

"Qualified Secondary Beneficiary" means an individual who is: (i) a beneficiary under the Group Policy as the spouse of the Insured Employee for at least thirty (30) days immediately preceding the death of the Insured Employee; or (ii) a Dependent Child of the Insured Employee.

A Qualified Second Beneficiary is eligible to elect continuation coverage under the Group Policy within the Election Period. To elect continuation, a Qualified Secondary Beneficiary or authorized representative must submit a signed election notification form to the Group Policyholder during the Election Period. Requests for election forms are to be directed to the Group Policyholder. If elected, such continuation coverage will begin on the date of the Insured Employee's death and end on the earliest of the following dates:

(a) Eighteen (18) months after the date of death of the Insured Employee;
(b) the date on which the Qualified Secondary Beneficiary fails to make timely payment of premium;
(c) the date the Qualified Secondary Beneficiary becomes eligible for hospital, medical, or surgical benefits under another insured or self-funded group health benefit program or plan that is written on an expense-incurred basis or is with a health maintenance organization;
(d) the date the Qualified Secondary Beneficiary becomes entitled to benefits under Medicare;
(e) the date the Qualified Secondary Beneficiary accepts hospital, medical, or surgical coverage under any non-group plan or policy written on an expense-incurred basis or is with a health maintenance organization;
(f) the date on which the Qualified Secondary Beneficiary elects to terminate coverage under the Group Policy;
(g) the date the employer ceases to provide group benefits to his/her employees; or
(h) for Dependent Children, the date the Qualified Secondary Beneficiary would no longer be covered under the Group Policy if the Insured Employee had not died.

Continuation coverage for the Qualified Secondary Beneficiary will be subject to all changes, options and modifications that a Covered Person would otherwise be subject to, such as: transfer to another group contract; or plan changes or options for which a Covered Person would be subject to or otherwise eligible

Continuation coverage provided under this section will: (1) be provided without evidence of insurability or additional waiting periods; and (2) require the Qualified Secondary Beneficiary to pay the required premium payments to the Group Policyholder. If elected by the Qualified Secondary Beneficiary, the Group Policyholder must allow the premium required by item (2) above, to be paid in monthly installments.

STATE CONTINUATION PROVISIONS

Spouse and Dependent Child Continuation Upon Divorce:

As used in this provision, the terms listed below are defined as follows:

"Change in Status" means the divorce of the Insured Employee and his/her spouse.

"Dependent Child" means a child of the Insured Employee who: (i) was covered under the Group Policy as a qualified or eligible dependent of the Insured Employee immediately before the Change in Status; or (ii) was born to a Qualified Secondary Beneficiary after the Change in Status.

"Insured Employee" means an employee of the Group Policyholder who is a resident of the State of Maryland and covered under the Group Policy.

"Qualified Secondary Beneficiary" means an individual who is: (i) a beneficiary under the Group Policy as the spouse of the Insured Employee for at least thirty (30) days immediately preceding the Change in Status; or (ii) a Dependent Child of the Insured Employee.

A Qualified Secondary Beneficiary is entitled to continuation coverage under the Group Policy after a Change in Status. Continuation coverage under this provision will begin on the date of the Change in Status and end on the earliest of the following dates:

(a) the date the Qualified Secondary Beneficiary becomes eligible for hospital, medical, or surgical benefits under another insured or self-funded group health benefit program or plan that is written on an expense-incurred basis or is with a health maintenance organization;
(b) the date the Insured Employee becomes entitled to benefits under Medicare;
(c) the date the Qualified Secondary Beneficiary accepts hospital, medical, or surgical coverage under any non-group plan or policy written on an expense-incurred basis or is with a health maintenance organization;
(d) the date on which the Qualified Secondary Beneficiary elects to terminate coverage under the Group Policy;
(e) the date the employer ceases to provide group benefits to his/her employees;
(f) for Dependent Children, the date the Qualified Secondary Beneficiary would no longer be covered under the Group Policy if there had not been a Change in Status; or
(g) for an individual who is a Qualified Secondary Beneficiary by reason of having been the Insured Employee's spouse, the date on which the individual remarries.
(h) the date the coverage under the Group Policy terminates with respect to the Insured Employee.
(i) the premium due date on which the premium payable is not timely made.

In order to be eligible for the continuation coverage described in this section, the Insured Employee or divorced spouse of the Insured Employee, must notify the Policyholder of the applicable Change in Status not later than:

1. Sixty (60) days after the applicable Change in Status if on the date of the applicable Change in Status the employee is covered under the Group Policy or under another group contact issued to the same employer replacing the Group Policy. The coverage will be retroactive to the applicable Change in Status.

2. Thirty (30) days after the date the Insured Employee becomes eligible for coverage under a group contact issued to another employer, if the Insured Employee becomes covered under the new employer's group contract after the applicable Change in Status. The coverage will be retroactive to the date of eligibility.

Continuation coverage for the Qualified Secondary Beneficiary will be subject to all changes, options and modifications that a Covered Person would otherwise be subject to, such as: transfer to another group contract; or plan changes or options for which a Covered Person would be subject to or otherwise eligible.

STATE CONTINUATION PROVISIONS

Continuation coverage provided under this provision will: (1) be provided without evidence of insurability or additional waiting periods; and (2) require the Insured Employee to make arrangements with the Group Policyholder to pay the entire cost for the coverage for a Qualified Secondary Beneficiary.

Continuation of Coverage Upon Termination of Employment:

As used in this provision, the terms listed below are defined as follows:

"Change in Status" means (i) involuntary termination of the Insured Employee's employment other than for cause; or (ii) voluntary termination of the Insured Employee's employment by the Insured Employee.

"Election Period**"** means the period that begins on the date of the Change in Status and ends Forty-five (45) days after that date.

"Insured Employee" means an employee of the Group Policyholder who is a resident of the State of Maryland and covered under the Group Policy current or predecessor group contract with the same employer before the Change in Status.

An Insured Employee, or someone acting on his/her behalf, is eligible to elect continuation coverage under the Group Policy after a Change in Status if done within the Election Period. If elected, continuation coverage under this provision will begin on the date of the Change in Status and end on the earliest of the following dates:

(a) Eighteen (18) months after the date of the Change in Status;
(b) the date on which the Insured Employee fails to make timely payment of premium;
(c) the date the Insured Employee becomes eligible for hospital, medical, or surgical benefits under another insured or self-funded group health benefit program or plan that is written on an expense-incurred basis or is with a health maintenance organization;
(d) the date the Insured Employee becomes entitled to benefits under Medicare;
(e) the date the Insured Employee accepts hospital, medical, or surgical coverage under any non-group plan or policy written on an expense-incurred basis or is with a health maintenance organization;
(f) the date on which the Insured Employee elects to terminate coverage under the Group Policy; or
(g) the date the employer ceases to provide group benefits to his/her employees;

Continuation coverage provided under this provision will: (1) be provided without evidence of insurability or additional waiting periods; and (2) require the Insured Employee to pay the required premium payments to the Group Policyholder (If elected by the Insured Employee, the Group Policyholder must allow the premium to be paid in monthly installments); and (3) be available to the spouse and Dependent Children of the insured if: (a) the Group Policy provides benefits for spouses and Dependent Children; and (b) the Insured Employee's spouse and Dependent Children were covered under the Group Policy before the Change in Status.

Continuation coverage for the Insured Employee will be the same as other covered employees and is subject to all changes, options and modifications that another covered employee would be subject to, such as: transfer to another group contract; or plan changes or options for which a covered employee would be subject to or otherwise eligible.

COORDINATION OF BENEFITS

Application

This Coordination of Benefits provision applies when the Covered Person has health care coverage under more than one Plan. Plan is defined below. If this provision applies, the benefit determination rules state the order in which each Plan will pay a claim for benefits.

The Plan that pays first is called the Primary plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

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 Contract 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 Covered Under More Than One Plan - Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
   a) Dependent Child--Parents who are married or are living together, whether or not they have ever been married: When this Plan and another Plan cover the same child as a Dependent of different parents, benefits for the child are determined as follows:
      i. 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.
      ii. 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.
   b) Dependent Child: Separated or Divorced Parents or are not living together: If two or more Plans cover a person as a Dependent child of divorced or separated parents or parents that are not living together benefits for the child are determined as follows:
      i. If a court decree states 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. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This paragraph does not apply with respect to any Contract Year during which any benefits actually paid or provided before the entity has actual knowledge.

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions under number 3.a) of this paragraph shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions under number 3.a) of this paragraph shall determine the order of benefits.

iv. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

a. The plan covering the custodial parent;
b. The plan covering the custodial parent's spouse;
c. The plan covering the non-custodial parent; and then
d. The plan covering the non-custodial parent's spouse.

c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under number 3.a) or 3.b) of this paragraph as if those individuals were parents of the child.

i. For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in Paragraph 6. applies.

ii. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in Subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.

4. Active/Inactive Service:
   a) 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).
   b) 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.
   c) This rule does not apply if the rule in number 1 can determine the order of benefits.
5. COBRA or State Continuation Coverage:
   a) If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.
   b) 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 is ignored.
   c) This rule does not apply if the rule in number 1 can determine the order of benefits.
6. Longer/Shorter Length Of Coverage:
   a) 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.
   b) To determine the length of time a person has been covered under a plan, two successive plans shall be treated as one if the covered person was eligible under the second plan within twenty-four (24) hours after coverage under the first plan ended.
   c) The start of a new plan does not include:
      i. A change in the amount or scope of a plan's benefits;
      ii. A change in the entity that pays, provides or administers the plan's benefits; or

iii. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

d) The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

7. If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.
8. Effect of Medicare:
   a) If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations, Medicare is:
      i. Secondary to the plan covering the person as a dependent; and
      ii. Primary to the plan covering the person as other than a dependent (e.g. a retired employee)
   b) Then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

Reduction in This Plan's Benefits

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

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

Right to Receive and Release Information

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

Facility of Payment

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

Right of Recovery

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

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

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

COORDINATION OF BENEFITS

Definitions Related to Coordination of Benefits

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

Allowable Expenses means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the person.

1. If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C) of the Internal Revenue Code of 1986.

2. An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense.

3. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.

4. The following are examples of expenses that are not allowable expenses:

    a. If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.

    b. If a person is covered by two (2) or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, an amount charged by the provider in excess of the highest reimbursement amount for a specified benefit is not an allowable expense.

    c. If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.

    d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

5. The definition of "allowable expense" may exclude certain types of coverage or benefits such as dental care, vision care, prescription drug or hearing aids. A plan that limits the application of COB to certain coverages or benefits may limit the definition of allowable expense in its contract to expenses that are similar to the expenses that it provides. When COB is restricted to specific coverages or benefits in a contract, the definition of allowable expense shall include similar expenses to which COB applies.

6. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

7. The amount of the reduction may be excluded from allowable expense when a covered person's benefits are reduced under a primary plan:

    a. Because the covered person does not comply with the plan provisions concerning second surgical opinions or precertification of admissions or services; or

    b. Because the covered person has a lower benefit because the covered person did not use a preferred provider.

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 excludes benefits for services provided by other providers, except in the cases of emergency or referral by a Plan Provider.

- 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 or authorized referral 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.

Coordination of Benefits means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total Allowable Expenses.

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

1. This Plan.
2. Group and nongroup insurance contracts and subscriber contracts;
3. Uninsured arrangements of group or group-type coverage;
4. Group and nongroup coverage through closed panel plans;
5. Group-type contracts;
6. The medical care components of long-term care contracts, such as skilled nursing care;
7. The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts;
8. Medicare or other governmental benefits, as permitted by law, except as provided in Paragraph (4)(h). That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program; and
9. Group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

Plan does not include any:

1. Group or group-type Hospital indemnity benefits or other fixed indemnity coverage
2. Accident only coverage.
3. Specified disease or specified accident coverage.
4. Specified disease or intensive care policy and personal injury protection under a motor vehicle liability insurance policy.

5. Limited benefit health coverage, as defined in Section 7 of the NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act.
6. School accident-type coverage.
7. Benefits provided in long-term care insurance policies for non-medical services.
8. Medicare supplement policies
9. A state plan under Medicaid
10. A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

This Plan means that portion of the Group Policy which provides the benefits that are subject to this provision.

Primary Plan means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration. A plan is a primary plan if:

1. The plan either has no order of benefit determination rules, or its rules differ from those permitted by this regulation; or

2. All plans that cover the person use the order of benefit determination rules required by this regulation, and under those rules the plan determines its benefits first.

Secondary Plan a plan that is not a primary plan.

CLAIM PROVISIONS

All claims under the Group Policy 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, 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 shown in Your Schedule of Coverage. The notice should be mailed to Our Claims Administrator at the address provided below:

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 at Our Claims Administrator's at the address listed above within one year after the date of the loss. 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. A Covered Person's legal incapacity shall suspend the time to submit the claim and the suspension period ends when legal capacity is regained. KPIC may require information to validate the occurrence, character and extent of the loss. Such information may include, but will not be 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.

"Proof of Loss" means written proof of the occurrence, character and extent of the loss.

CLAIM PROVISIONS

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 thirty (30) days upon receipt of written Proof of Loss subject to all of the terms and conditions set forth in the Group Policy.

Subject to written proof of loss, all accrued indemnities for loss of time will be paid not less frequently than monthly during the continuance of the period for which the carrier is liable, and any balance remaining unpaid at the termination of the period will be paid as soon as reasonably possible after receipt of proof.

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 Proof of Loss, KPIC will notify You of any contest to or denial of the claim within thirty (30) days of the date the Proof of Loss was received by KPIC. Please see the section titled **PRE-CERTIFICATION, INTERNAL APPEALS, AND EXTERNAL REVIEW** for information on how you may file an appeal or grievance.

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 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. the adjustment or correction is for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18-month period after the date that KPIC paid the health care provider; and
2. except as provided in item (i) of this paragraph, may only make an adjustment or correction during the 6-month period after the date that KPIC paid the health care provider.

The restriction on adjustments and/or corrections noted above do not apply if KPIC makes an adjustment and/or correction to a health care provider because:

1. the information submitted to KPIC was fraudulent;
2. the information submitted to KPIC was improperly coded and the KPIC has provided to the health care provider sufficient information regarding the coding guidelines used by Us at least 30 days prior to the date the services subject to the adjustment and/or correction were rendered; or
3. the claim submitted to KPIC was a duplicate claim.

Information submitted to KPIC may be considered to be improperly coded if the information submitted by the health care provider:

1. uses codes that do not conform with the coding guidelines used by KPIC applicable as of the date the service or services were rendered; or
2. does not otherwise conform with the contractual obligations of the health care provider to KPIC applicable as of the date the service or services were rendered.

If KPIC makes an adjustment and/or correction under this provision for services as a result of coordination of benefits, the health care provider will have six (6) months from the date of denial, to submit a claim to for reimbursement for the service to KPIC, the Maryland Medical Assistance Program, or the Medicare Program responsible for payment.

GENERAL PROVISIONS

Assignment

Payment of benefits under the Group Policy for treatment or services that are not provided, prescribes 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 or Insured Dependent or, in the case of the Insured Person's death, to his or her executor, administrator, provider, spouse or relative.

Contestability of Coverage

In the absence of fraud, any statement made by the Policyholder or a Covered Person in applying for insurance under the Group Policy will be considered a representation and not a warranty. After the Group Policy has been in force for two (2) years, its validity cannot be contested except for nonpayment of premiums. 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 a statement made by the Covered Person relating to insurability under the Group Policy. Only statements that are in writing and signed by the Policyholder or a Covered Person can be used in a contest. A copy of the statement will be given to the Policyholder, the Covered Person or his or her beneficiary.

Money Payable

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

Rights of an Insuring Parent

Insuring Parent means a parent who:(i) is required under a court or administrative order to provide health insurance coverage for a child; or(ii) otherwise provides health insurance coverage for a child.

If the parents of a covered Dependent child are:

1. Divorced or legally separated or are not living together; and
2. Subject to the same Order.

The Insuring Parent will have the rights stated below without the approval of the non- insuring parent. However, for this provision to apply, the non- insuring parent must be a Covered Person approved for family health coverage under the Policy, and KPIC must receive:

1. A request from the Insuring 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. Allow the non-insuring Parent, who is not a Covered Person under the policy, child support enforcement agency, or Maryland Department of Health to apply for enrollment on behalf of the Dependent child and include the Dependent child in the coverage regardless of enrollment period restrictions;
2. Provide the non-insuring Parent with membership cards, claims, and other information necessary for the child to obtain benefits (the terms, conditions, benefits, exclusions, and limitations of the Policy) through this policy;
3. Accept claim forms and requests for claim payment from the Insuring Parent; and
4. Make claim payments directly to the non-insuring Parent, health care provider, or Department of Health and Mental Hygiene for claims submitted by the Insuring Parent, subject to all the provisions stated in the Policy. Payment of claims to the Insuring 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 in effect;
2. The Dependent child has become covered, or will be enrolled, under other reasonable health insurance or health coverage that will take effect on or before the effective date of the termination;
3. In the case of employer-provided coverage, the employer has stopped providing family coverage for all employees;
4. The employer no longer employs the Insuring Parent, except that if the parent elects to exercise the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), coverage shall be provided for the child consistent with the employer's plan for postemployment health insurance coverage for dependents; or
5. The Dependent child is no longer a Covered Person under the Policy.

If the employee's health insurance plan requires that the employee be enrolled in order for the Dependent child to be enrolled and the employee is not currently enrolled, the We shall enroll both the employee and the Dependent child, without regard to enrollment period restrictions, within 20 business days after receipt of a medical support notice.

If a Dependent child is eligible for enrollment, then We shall complete the enrollment without regard to enrollment period restrictions, within 20 business days after receipt of a medical support notice.

"Order" means a ruling that:

1. is issued by a court of the State of Maryland or another state or an administrative agency of another state; and
2. (a) creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage; or (b) establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, California 94612
POS SG 2025