KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Mid-Atlantic

Out-of-Area Preferred Provider Organization

Notice:

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

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

CIGNA INTEGRATION AMENDMENT RIDER

This Rider is issued and made part of the above referenced Group Policy/Certificate, to which it is attached. By attachment of this Rider, the Policy/Certificate is amended as follows:

The following provisions are in lieu of and replace the same provisions in the above Certificate.

I. The INTRODUCTION section is hereby revised, in part, to now incorporate the following Access to Care section:

Access to Care

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

NOTE: CIGNA PPO Network providers will obtain any necessary Precertification on Your behalf. Please refer to the PRE-CERTIFICATION, INTERNAL APPEALS, AND EXTERNAL REVIEW section for Precertification processes including a list of Covered Benefits subject to Precertification.

To verify the current participating status of a Provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Providers is available from Your employer, or You may call the phone number listed on Your ID card, or You may visit KPIC's Participating Provider network's web site at: kp.org/ooappo/mas. To request a printed copy at no cost, call the phone number on the back of your card If You receive Covered Services from a Non-Participating Provider, benefits under the Group Policy will be payable by KPIC at the Non-Participating Provider option level. Your financial responsibility is different for Covered Services rendered by Participating and Non-Participating Providers, and You should consult the Schedule of Coverage to determine the amount that KPIC will pay for a Covered Service.

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

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

CIGNA INTEGRATION AMENDMENT RIDER

II. The following provisions within the PRE-CERTIFICATION, INTERNAL APPEALS, AND EXTERNAL REVIEW section are revised in the "Medical Review Program" portion to read as follows:

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.

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

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

This Rider does not change, waive, or extend any part of the Group Policy/Certificate other than as set forth above. 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 is effective on the same date as the Group Policy to which it is attached, unless a different date is shown above. This Rider terminates on the same date as the Group Policy to which it is attached.

Chuck Bevilacqua
President

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Virginia

Out-of-Area PPO

Large Group

(*Non-Grandfathered Coverage)*

Certificate of Insurance

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

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

This Certificate is not an insurance policy. The complete terms of the coverage are set forth in the Group Policy. Benefit payment is governed by all the terms, conditions, and limitations of the Group Policy. If the Group Policy and this Certificate differ, the Group Policy will govern. The Group Policy and the Certificate are governed by the laws of the state in which the Group Policy was delivered. The Group Policy may be amended at any time without Your consent or prior notice to you. Any such amendment will not affect a claim starting before the amendment takes effect. The Group Policy is available for inspection at the Policyholder's office.

This Certificate automatically supersedes and replaces, any and all, certificates that may have been issued to You previously for the coverage described herein.

In this Certificate, Kaiser Permanente Insurance Company will be referred to as: "KPIC", "We", "Us", or "Our". The Insured Employee will be referred to as: "You" or "Your".

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

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，请拨打这个号码1-(800)-686-7100.

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

Please refer to the GENERAL LIMITATIONS AND EXCLUSIONS section of this Certificate for a description of this plan's general limitations and exclusions. Likewise, the Schedule of Coverage contains specific limitations for specific benefits.

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

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

TABLE OF CONTENTS

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

Schedule of Coverage*

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

INTRODUCTION

This Certificate 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 these definitions carefully.

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

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

Your coverage under the Group Policy includes coverage for Covered Services received from Participating Providers as well as Non-Participating Providers. (See Your Schedule of Coverage to determine if Your coverage includes Participating Providers.) To verify the current participating status of a Provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Providers is available from your employer, or call the phone number listed on Your ID card, or you may visit the network's web site at: www.multiplan.com/kpmas. If You receive Covered Services from a Non-Participating Provider, benefits under the Group Policy will be payable by KPIC at the Non-Participating Provider option level. Your financial responsibility is different for Covered Services rendered by Participating and Non-Participating Providers, and you should consult the Schedule of Coverage to determine the amount that KPIC will pay for a Covered Service.

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

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

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

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

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

If You have any questions regarding services, facilities, or care You receive from a Participating Provider, please call the toll-free number listed in the Participating Provider directory.
For Pre-certification of Covered Services or Utilization Review please call the number listed on Your ID card or 1-888-567-6847.

GENERAL DEFINITIONS

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 of a patient by rotary wing air ambulance (as defined in 42 CFR 414.605) or fixed wing air ambulance (as defined in 42 CFR 414.605).

Ancillary Service means Services that are:

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

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

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

Autism Spectrum Disorder (ASD) means any pervasive developmental disorder or autism spectrum disorder as defined in the most recent edition, or the most recent edition at the time of diagnosis, of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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

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

Birth Center means an outpatient facility which:

1. Complies with licensing and other legal requirements in the jurisdiction where it is located;
2. Is engaged mainly in providing a comprehensive Maternity Services program to pregnant individuals who are considered normal to low risk patients;
3. Has organized facilities for Maternity Services on its premises;
4. Has Maternity Services performed by a Physician specializing in obstetrics and gynecology, or by a Licensed Midwife or Certified Nurse Midwife under the direction of a Physician specializing in obstetrics and gynecology; and
5. Have 24-hour-a-day Registered Nurse services.

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

Calendar Year means a period of time: 1) beginning at 12:01 a.m. on January 1st of any year; and 2) terminating at midnight on December 31st of that same year.

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

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

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

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

Complications of Pregnancy means 1) conditions requiring hospital confinement when the pregnancy is not terminated and whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, pre-eclampsia, intrauterine fetal growth retardation, and similar medical and surgical conditions of comparable severity; 2) ectopic pregnancy which is terminated; 3) an act of rape of an insured which was reported to the police within seven (7) days following its occurrence. The 7-day requirement shall be extended to one hundred eighty (180) days in the case of an act of rape or incest of a female under thirteen (13) years of age.

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

Comprehensive Rehabilitation Facility means a facility primarily engaged in providing diagnostic, therapeutic, and restorative services through licensed health care professionals to injured, ill or disabled individuals. The facility must be accredited for the provision of these services by the Commission on Accreditation for Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association.

Confinement means being registered as an inpatient in a licensed medical facility as ordered by a Physician.

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

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

Co-payment means the predetermined amount, as shown in the Schedule of Coverage, which is to be paid by the Covered Person directly to a Provider. Co-payments are applied on a per visit or per service basis. Co-payments paid for Covered Services and those paid for prescription drugs under the Prescription Drug benefit count toward satisfaction of the Out-of-Pocket Maximum but do not count toward satisfaction of the Deductible.

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

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

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

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

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

Creditable Coverage means

1) Any individual or group policy, contract, or program that is written or administered by an insurer, health service plan or HMO, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation or conversion coverage but does not include accident only, credit, disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2) The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3) The Medicaid program pursuant to Title XIX of the Social Security Act.
4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
5) A health plan offered under 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).
6) A medical care program of the Indian Health Service or of a tribal organization.
7) A state health benefits risk pool.
8) A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
9) A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191.

10) A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504)).

Deductible means the amount of Covered Charges a Covered Person must incur, while insured under the Group Policy, before becoming eligible for benefits that will be payable during a Calendar Year. The Deductible will apply to each Covered Person separately, and must be met within each Calendar Year. When Covered Charges equal to the Deductible are incurred during that Calendar Year, and are submitted to Us, the Deductible will have been met for that Covered Person. Benefits will not be payable for Covered Charges applied to satisfy the Deductible**.** Covered Charges applied to satisfy the Deductible will be applied toward satisfaction of the Out-of-Pocket Maximum**.** Charges in excess of the Maximum Allowable Charge and additional expenses a Covered Person must pay because Pre-certification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

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

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

Dependent means a person designated by the Insured Employee as entitled to health care services, subject to acceptance by Us. Dependents include only: a) Your lawful Spouse or Domestic Partner, if covered under Your plan and b) Your or Your Spouse's child who is of an age within the Age Limits for Dependent Children shown in the Schedule of Coverage or is named in a Qualified Medical Child Support Order. The word "child" includes: a) Your biological child; b) step-child; c) foster child; d) lawfully adopted child or child in the process of being adopted (eligibility begins on the date of placement in Your home; e) child for whom You or Your Spouse has been granted legal custody, including custody as a result of a guardianship, other than a temporary guardianship of less than twelve (12) months duration, granted by a court or testamentary appointment; f) grandchild in Your or Your Spouse's court-ordered custody; or g) child for whom a Covered Person has the legal obligation to provide coverage pursuant to court order or court-approved agreement or testamentary appointment. A child shall be deemed to be a dependent of not more than one person. Other types of dependents eligible for coverage, if any, are shown in the Schedule of Coverage.

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

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

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

Durable Medical Equipment means medical equipment that 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; and
6. Appropriate for use in the home.

Durable Medical Equipment will not include:

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

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

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

Emergency Medical Condition Regardless of the final diagnosis rendered to a Member**,** 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:

- Placing the health of the Member or, with respect to a pregnant person, the health of the pregnant person or their unborn child in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Room Services means Covered Services which are Emergency Services provided in a Hospital emergency facility. Emergency Room Services do not include services provided after admission to a Hospital or other care facility.

Emergency Services with respect to an Emergency Medical Condition, means:

1. An appropriate medical screening examination, as required federal under the Emergency Medical Treatment and Active Labor Act (EMTALA), section 1867 of the Social Security Act, 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 such Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA, or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department, to Stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished; and
3. Except as further described in this paragraph 3, covered Services, also referred to as Post-Stabilization Care, that are furnished by a Non-Plan Provider after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the Visit in which the Emergency Services are furnished:
    a. When, under applicable federal law, the covered Services described in item #3 are not included as Emergency Services if the following condition is met:
        i. The attending emergency physician or Treating Provider determines that the Member is able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Hospital or Plan Facility located within a reasonable travel distance, taking into account the Member's medical condition;
    b. When the covered Services are rendered by a Health Care Provider who is subject to state law prohibiting balance billing.

Essential Health Benefits means the following general categories of benefits including the items and services covered within these categories of benefits that comprise an essential health benefit package as defined under the Patient Protection and Affordable Care Act of 2010 (PPACA) as then constituted or later amended: (i) ambulatory patient services; (ii) emergency services; (iii) hospitalization; (iv) laboratory services; (v) maternity and newborn care; (vi) mental health and substance use disorder services, including behavioral health treatment; (vii) pediatric services, including oral and vision care; (viii) prescription drugs; (ix) preventive and wellness services and chronic disease management; and (x) rehabilitative and habilitative services and devices. Essential Health Benefits are not subject to the Maximum Benefit while Insured or any dollar maximum.

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

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

1. The service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or
2. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

Facility means an institution providing health care related services or a health care setting, including hospitals and other licensed inpatient centers; ambulatory surgical or treatment centers; skilled nursing centers; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation and other therapeutic health settings.

Free-Standing Surgical Facility means a legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO), or other similar organization approved by KPIC that:

1. Has permanent operating rooms;
2. Has at least one recovery room;
3. Has all necessary equipment for use before, during and after surgery;
4. Is supervised by an organized medical staff, including Registered Nurses, available for care in an operating or recovery room;
5. Has a contract with at least one nearby Hospital for immediate acceptance of patients requiring Hospital care following care in the Free-Standing Surgical Facility;
6. Is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
7. Requires that admission and discharge take place within the same working day.

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

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

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.

Hospice Care means a coordinated program of home and inpatient care provided directly or under the direction of a hospice licensed and/or accredited within the jurisdiction within which the care is provided. Hospice Care is limited to individuals with a terminal illness whose condition has been diagnosed as terminal by a Physician, whose medical prognosis is death within six (6) months, and who elect to receive palliative rather than curative care. Hospice Care will include Palliative and supportive physical, psychological, psychosocial, and other health services to individuals with a terminal illness utilizing a medically directed interdisciplinary team.

Hospital means an institution that is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO), or other similar organization approved by KPIC, which:

1. Is legally operated as a Hospital in the jurisdiction where it is located;
2. Is engaged mainly in providing inpatient medical care and treatment for Injury and Sickness in return for compensation;
3. Has organized facilities for diagnosis and major surgery on its premises;
4. Is supervised by a staff of at least two Physicians;
5. Has 24-hour-a-day nursing services by Registered Nurses; and
6. Is not: a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; or a Skilled Nursing Facility or similar institution.

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

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 United States Food and Drug Administration.

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

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

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

Inpatient Treatment with regard to Mental Health Services or Substance Use Disorder Services, means treatment delivered on a twenty-four-hour per day basis in a Hospital, alcohol or drug rehabilitation facility, an Intermediate Care Facility or an inpatient unit of a Mental Health Treatment Center.

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

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

Intensive Care Unit means a section, ward, or wing within the Hospital which:
1. Is separated from other Hospital facilities;
2. Is operated exclusively for the purpose of providing professional care and treatment for critically-ill patients;
3. Has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
4. Provides Room and Board; and
5. Provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Intermediate Care Facility means a licensed, residential public or private facility that is not a Hospital and that is operated primarily for the purpose of providing a continuous, structured twenty-four-hour per day, state-approved program of inpatient Substance Use Disorder Services.

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

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

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

Maternity Services means prenatal or antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care in accordance with medical criteria outlined by the American College of Obstetricians and Gynecologists. This care is given with respect to: 1) uncomplicated pregnancy and labor and delivery; and 2) spontaneous vaginal delivery. Benefits payable for the treatment of Complications of Pregnancy will be covered on the same basis as a Sickness.

Maximum Allowable Charge means the lesser of:
1. The Usual, Customary and Reasonable Charge (UCR):
   The UCR is the charge generally made by a Physician or other Provider of Covered Services. The charge cannot exceed the general level of charge made by other Providers within an area in which the charge is incurred for Injury or Sickness comparable in severity and nature to the Injury or Sickness being treated. The general level of

charges is determined in accord with schedules on file with the authorized Administrator. For charges not listed in the schedules, KPIC will establish the UCR. KPIC reserves the right to periodically adjust the charges listed in the schedules.

The term "area" as it would apply to any particular service, medicine or supply means a city or such greater area as is necessary to obtain a representative cross section of a particular level of charges.

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

2. The Negotiated Rate:
   KPIC or its authorized Administrator may have an arrangement with the Provider or supplier of Covered Services under which discounts have been negotiated for certain services or supplies. Any such discount is referred to as the Negotiated Rate.

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

3. The Actual Billed Charge for the Covered Service:
   The charges actually billed by the Provider for Covered Services.

IMPORTANT: Notwithstanding the foregoing, the Maximum Allowable Charge for a Hospital or other licensed medical facility Confinement may not exceed:

Hospital Routine Care Daily Limit: The Hospital's average semi-private room rate

Intensive Care Daily Limit: The Hospital's average Intensive Care Unit room rate

Other licensed medical facility Daily Limit: The facility's average semi-private room rate

Exception For Emergency Services rendered by a Non-Participating Provider and non-Emergency Surgical or ancillary services rendered at a Participating Provider facility by a Non-Participating Provider.

Charges for Emergency Services are processed under the in-network benefit level. For non-Emergency Surgical or ancillary services, the Maximum Allowable Charge will be a commercially reasonable amount based on payments for the same or similar services provided in a similar geographic area. Under Virginia law a Non-Participating Provider shall not balance bill You for: (i) emergency services provided by a Non-Participating Provider; or (ii) non-Emergency Services provided at a Participating Facility by a Non-Participating Provider if the non-emergency services involve Surgical or ancillary services. KPIC may deduct from its payment any Participating Provider Copayments, Coinsurance, and/or Deductible amounts that would have been paid had the Emergency Service been rendered by a Participating Provider.

For emergency air ambulance services, You will only be responsible for the amounts set forth in the Schedule of Coverage for emergency ambulance services. Under federal law, You do not have to pay any amount billed in excess of the amount We pay.

Medically Necessary means services that, in the judgment of KPIC, are:
1. Essential for the diagnosis or treatment of a Covered Person's Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Not provided solely for the convenience of the Covered Person or the convenience of the health care provider or facility; and
5. Not primarily custodial care.

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

Medically necessary prosthetic device includes any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of the enrollee's rehabilitation potential. A component of a medically necessary prosthetic device means the material and equipment needed to ensure the comfort and functioning of a prosthetic device.

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

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

Medication Management Visit means a visit no more than twenty (20) minutes in length with a licensed Physician or other licensed health care Provider with prescriptive authority for the sole purpose of monitoring and adjusting medications prescribed for mental health or substance use disorder treatment.

Mental Health Services means treatment of mental, emotional, or nervous.

Mental Health Treatment Center means a treatment facility organized to provide care and treatment for mental illness through multiple modalities or techniques pursuant to a written plan approved and monitored by a Physician, clinical psychologist, or a psychologist licensed to practice in state where treatment is provided. The facility must be (i) properly licensed in the state in which it operates, (ii) funded or eligible for funding under federal or state law, or (iii) affiliated with a Hospital under a contractual agreement with an established system for patient referral.

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.

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

Necessary Services and Supplies means any charges made by a Hospital on its own behalf for Medically Necessary Services and Supplies actually administered during any covered Hospital Confinement or other covered treatment. 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.

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

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

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

Your group administrator for a list of Participating Pharmacies or visit Multiplan's website at www.multiplan.com/kpmas.

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

Non-preferred Brand Name Drug means a drug that KPIC has not designated as a Preferred Drug.

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

Order means a valid court or administrative order that:

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

Orthotics means an appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.

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

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

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

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

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

Outpatient Treatment with regard to Mental Health Services or Substance Use Disorder Services, means treatment services rendered to a Covered Person as an individual or part of a group while not confined as an inpatient. Such

treatment shall not include services delivered through a Partial Hospitalization or intensive outpatient program as defined herein.

Palliative Care means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he/she experiences the stress of the dying process, rather than treatment aimed at investigation and intervention for the purposes of cure or prolongation of life.

Partial Hospitalization means a licensed or approved day or evening treatment program that includes the major diagnostic, medical, psychiatric, and psychological rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. The program provides treatment over a period of six (6) or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. The treatment program also includes intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

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. The Covered Person will be subject to in-network cost-sharing for a single case agreement and will not be responsible for any amounts above the allowed amount.

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. The Covered Person will be subject to in-network cost-sharing for a single case agreement and will not be responsible for any amounts above the allowed amount. Additionally, for purposes of this definition and in the context of non-emergency services, "health care facility" is limited to a hospital (as defined in section 1861(e) of the Social Security Act); a hospital outpatient department; a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

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

Participating Provider means 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. 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 or its Administrator 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. Please refer to Your Schedule of Coverage to determine if a PPO is applicable to Your plan.

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.

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 named in the Group Policy as the Policyholder and whom conforms to the administrative and other provisions established under the Group Policy.

Pre-certification/Pre-certified means the required assessment of the necessity, efficiency and/or appropriateness of specified health care services or treatment made by the Medical Review Program.

Preferred Brand Name Drug means a drug that KPIC has designated on its preferred drug list.

Preventive Services means medical services rendered to prevent diseases. Preventive services are limited to those services set forth in the **GENERAL BENEFITS** section.

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

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

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 United States Food and Drug Administration. External devices are limited to ostomy and urological supplies as well as breast prosthesis, including a mastectomy bra, needed following a mastectomy, including custom-made prosthetics.

Prosthetics will not include:

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

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

Qualifying Payment Amount means the amount calculated using the methodology described in 45 C.F.R. § 149.140(c), which is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or service that is: provided by a provider in the same or similar specialty or

facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished. The median contracted rate is subject to additional adjustments specified in federal regulations.

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

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

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

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

Rehabilitation Services means services provided to restore previously existing physical function when a physician determines that therapy will result in a practical improvement in the level of functioning within 60 days.

Room and Board means all charges commonly made by a Hospital or other inpatient medical facility on its own behalf for room and meals essential to the care of registered bed patients.

Routine Prenatal Care means an office visit that includes one or more of the following:

1. The initial and subsequent histories;
2. Physical examinations;
3. Recording of weight, blood pressures;
4. Fetal heart tones; and
5. Routine chemical urinalysis.

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 includes congenital defects or birth abnormalities and pregnancy.

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

Skilled Nursing Facility means a facility that provides inpatient Skilled Nursing Care Services, rehabilitation services, or other related health care services and is certified by Medicare.

Skilled Nursing Facility does not include:

a) Convalescent nursing home;
b) Rest facility; or
c) Facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

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 class of prescription drugs as designated by Kaiser Permanente that are unique, high cost, injected, infused, oral or inhaled prescription drugs (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions.

Spouse means the person to whom You are legally married under applicable law.

Stabilize means with respect to an Emergency Medical Condition, to provide such medical treatment 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, or, with respect to a pregnant woman, that the woman has delivered, including the placenta.

Substance 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.

Substance Use Disorder Services means treatment for alcohol or other drug dependence.

Surgical or ancillary services means any professional services, including surgery, anesthesiology, pathology, radiology, or hospitalist services and laboratory services.

Telemedicine Services, as it pertains to the delivery of health care services, means the use of electronic technology or media, including interactive audio, video for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment. "Telemedicine services" does not include an audio-only telephone, electronic mail message, or facsimile transmission, or online questionnaire. "Remote patient monitoring services" means the delivery of Home Health Services using telecommunications technology to enhance the delivery of home health care, including monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data; medication adherence monitoring; and interactive video conferencing with or without digital image upload.

Treating Provider means a physician or other health care provider who has evaluated the member's Emergency Medical Condition.

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

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

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

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

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

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

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

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

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

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

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

Eligibility Date
Your Eligibility Date is the effective date of the Group Policy if You are an Eligible Employee on that date, or the Policyholder's application for the Group Policy indicates that the eligibility waiting period does not apply to those employees who are employed by the Policyholder on the effective date of the Group Policy. Otherwise, Your Eligibility Date is the first day of the calendar month coinciding with or next following the date You complete the eligibility waiting period, if any elected by the Policyholder.

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

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

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Effective Date of Your Insurance

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

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

Eligibility of an Eligible Employee's Dependent

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

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

Age Limits for Dependent Children

The age limit for Dependent children is under twenty-six (26) years old, except a dependent child who is a full-time student and who is of an age within the Student Age Limit as shown in Your Schedule of Coverage may be covered.

Full-Time Student means a Dependent child who attends an accredited high school, college, university, technical school, trade school, or vocation school on a full-time basis for five (5) calendar months or more during the Calendar Year or was prevented from being so enrolled due to a Sickness or Injury. Proof of status as a **"Full-Time Student"** must be furnished to KPIC at time of enrollment or within thirty-one (31) days after attaining such status and subsequently as may be required by KPIC. Proof of Sickness or Injury that prevented the student from being enrolled, as certified by the attending Physician, must be given to KPIC. Coverage for such child shall continue in force until the earlier of (i) the date that is twelve (12) months from the date the child ceases to be a full-time student or (ii) the date the child no longer qualifies as a dependent child under the terms of the Group Policy. A child's status as a full-time student shall be determined in accordance with the criteria specified by the institution in which the child is enrolled.

Exceptions

The age limits shown above do not apply to a Dependent child who continues to be both: 1) incapable of self-sustaining employment due to an intellectual disability or physical handicap that occurred prior to the age limit and 2) chiefly dependent on You for support and maintenance. Such child will continue to qualify as a Dependent until the earlier of the following dates: a) the date the child recovers from the intellectual disability or physical handicap; or b) the date the child no longer chiefly depends on You for support and maintenance.

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

Eligibility Date

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

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

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

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

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

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

Special Enrollment Rules

I. Court or Administrative Ordered Coverage for a Dependent Child

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

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

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

II. Special Enrollment due to Newly Acquired Dependents

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

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

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

A. Newborns

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

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

B. Adopted Children

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

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

C. New Spouses

A new Spouse is insured from the date of marriage. If the cost of Your Dependent coverage would increase because of the addition of a Spouse, You must enroll the Spouse for insurance and agree to pay the additional cost within thirty-one (31) days of the Spouse's eligibility date in order for insurance to extend beyond the 31-day period. If you do not enroll the Spouse within the 31-day period, the Spouse will be considered a Late Enrollee and You must wait until the next Open Enrollment Period to enroll the Spouse for coverage. This provision also applies to any Dependents enrolled as a result of a new Spouse being added to the plan.

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

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

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

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

V. 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.

VI. Special Enrollment due to a Section 125 qualifying event:

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

VII. Late Enrollees

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

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

1. The person meets all of the following requirements:
   a At the time of initial enrollment, the person was covered under another employer's medical plan and certified, at the time of initial enrollment, that coverage under the other employer medical plan was the reason for declining coverage; and
   b The person has lost or will lose coverage under the other employer plan because of:
      i Termination or change in status of employment of the Eligible Employee or of the person through whom the individual was covered as a Dependent;
      ii Termination of the other employer's medical plan;
      iii Cessation of an employer's contributions toward an employee's or Dependents' medical coverage;
      iv Death of the Eligible Employee or person through whom the individual was covered as a Dependent;
      v Legal separation or divorce; or
2. The person is enrolled for the employee's medical coverage within thirty (30) days after termination of the other medical coverage or cessation of the other employer's contributions toward the other medical coverage.
3. The employee is employed by an employer who offers multiple health benefit plans and the individual elects coverage under a different plan during an annual Open Enrollment Period.
4. A court has ordered that coverage be provided for a Spouse or minor child under a covered employee's health benefit plan.
5. No written statement can be provided proving that prior to declining the medical coverage, the Eligible Employee was provided with, and signed acknowledgment of, written notice specifying that failure to

elect coverage during the 30-day period following the person's eligibility date could result in the person being subject to Late Enrollment rules.

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

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

Termination of an Insured Employee's Insurance

Your insurance will automatically terminate on the earlier of:

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

As a Policyholder, You are entitled to a grace period of not less than thirty-one (31) days for the payment of any premium due except the first premium. During the grace period, Your coverage will continue in force unless You have given Us written notice of discontinuance in accordance with the terms of the policy and in advance of the date of discontinuance.

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

Termination of Insured Dependent's Coverage

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

1. The date You cease to be covered by KPIC;
2. The last day of the of the calendar month in which the person ceases to qualify as a Dependent;
3. The date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. The date Your insurance ends, unless continuation of coverage is available to the Dependent under the provisions of the Group Policy;
5. The end of the grace period after the employer fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion;
6. The date the Group Policy is terminated; or
7. The date the Dependent, or the Dependent's representative, commits an act of fraud or makes an intentional misrepresentation of a material fact.

Rescission for Fraud or Intentional Misrepresentation

Subject to any applicable state or federal law, if KPIC makes a determination that You performed an act, practice or omission that constitutes fraud or made an intentional misrepresentation of material fact under the terms of

the Group Policy, KPIC may rescind Your coverage under the Group Policy by giving You no less than thirty-one (31) days advance written notice. The notice will contain:

1. A clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact;
2. An explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact;
3. Notice that the Covered Person or the Covered Person's Authorized Representative, prior to the date the advance notice of the proposed rescission ends, may immediately file an internal appeal to request a reconsideration of the rescission;
4. A description of KPIC's internal appeal process for rescissions, including any time limits applicable to those procedures; and
5. The date when the advance notice ends and the date back to which the coverage will be rescinded.

The rescission will be effective, on:

1. The effective date of Your coverage, if we relied upon such information to provide coverage; or
2. The date the act of fraud or intentional misrepresentation of a material fact occurred, if the fraud or intentional misrepresentation of a material fact was committed after the Effective Date of Your coverage.

Your premium will be refunded from date of coverage being rescinded.

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

PRE-CERTIFICATION, INTERNAL APPEALS, AND EXTERNAL REVIEW

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

A Covered Person must obtain Pre-certification of all Hospital stays and certain other services and procedures. Request for Pre-certification may be made by the Covered Person, the Covered Person's attending Physician, or the Covered Person's authorized representative prior to the commencement of any service or treatment or within forty-eight (48) hours of an admission after an emergency room visit or as soon as reasonable possible; however, Pre-certification is the Covered Person's responsibility. If Pre-certification is required, it must be obtained to avoid a possible reduction in benefits.

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

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

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

The following treatment or services must be Pre-certified by the Medical Review Program
1. Inpatient admissions
2. Inpatient Rehabilitation Therapy admissions
3. Inpatient Skilled Nursing Facility, long term care, and sub-acute admissions
4. Inpatient mental health and chemical dependency admissions
5. Inpatient Residential Treatment
6. Non-Emergent (Scheduled) Air or Ground Ambulance
7. Pediatric Medically Necessary contact lenses
8. Amino Acid-Based Elemental Formulas
9. Low Protein Modified Foods
10. Clinical Trials
11. Medical Foods
12. Bariatric Surgery
13. Pulmonary Rehabilitation
14. Dental & Endoscopic Anesthesia
15. Durable Medical Equipment
16. Genetic Testing
17. Home Health & Home Infusion Services
18. Hospice (home, inpatient)

19. Infertility Procedures
20. Imaging Service (Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computed Tomography (CT), Computerized Tomography Angiography(CTA), Positron Emission Tomography (PET), Electronic Beam Computed Tomography (EBCT), SPECT, not including x-ray or ultrasound)
21. Outpatient Injectable Drugs
22. Outpatient Surgery (performed at hospital, ambulatory surgery center of licensed facility)
23. Orthotics/Prosthetics
24. Implantable prosthetics (includes breast, bone conduction, cochlear)
25. Pain Management services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections)
26. Radiation Therapy Services
27. Reconstruction Surgery
28. TMJ/Orthognathic Surgery
29. Transplant Services (Including PRE & POST)
30. The following outpatient procedures:
    a) Hyperbaric oxygen
    b) Sclerotherapy
    c) Plasma Pheresis (MS)
    d) Anodyne Therapy
    e) Sleep Studies
    f) Vagal Nerve Stimulation
    g) Hemispherectomy
    h) Implants
    i) Pill Endoscopy
    j) Stab phlebotomy
    k) Radiofrequency abalation
    l) Enhanced External Counterpulsation (EECP)
    m) Resection
    n) Corpus Colostomy surgery
    o) Uvulo-palato-pharyngoplasty (UPPP) & laser-assisted UPPP

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

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

1. Forty-eight (48) hours for a normal vaginal delivery; and
2. Ninety-six (96) hours for a Cesarean section delivery.

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

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

Hysterectomy Pre-certification: When a Covered Person is admitted to a Hospital for delivery either a laparoscopy-assisted vaginal hysterectomy or a vaginal hysterectomy, the minimum authorized Hospital stay will be:

1. Twenty-three (23) hours for laparoscopy-assisted vaginal hysterectomy; or
2. Forty-eight (48) hours for vaginal hysterectomy.

A stay longer than the above noted minimums may be allowed provided the attending Provider obtains authorization for an extended confinement through KPIC's Medical Review Program.

Pre-certification Procedures
The Covered Person, or Provider acting on behalf of the Covered Person, must notify the Medical Review Program as follows:

1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a Hospital Confinement, but at least three (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 treatments or procedures requiring Pre-certification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring Pre-certification but at least three days prior to performance of any other treatment or service requiring Pre-certification.

A Covered Person, or Provider acting on behalf of the Covered Person, must provide all necessary information to the Medical Review Program in order for it to make its determination. This means the Covered Person, or Provider acting on behalf of the Covered Person, may be required to:

1. Obtain a second opinion from a Physician selected from a panel of three (3) or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second opinion, it will be provided at no charge to the Covered Person;
2. Participate in the Medical Review Program's case management, Hospital discharge planning and long-term case management programs; and/or
3. Obtain from the attending Physician information required by the Medical Review Program relating to the Covered Person's medical condition and the requested treatment or service. If the Covered Person or the Covered Person's Provider does not provide the necessary information or will not release necessary information, Pre-certification will be denied.

Pre-Service Reviews: Within two (2) days of receiving all necessary information, the Medical Review Program will make its determination. 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. If an admission, procedure, or service is Pre-certified, KPIC will:

1. Notify the Provider by telephone within one (1) working day of Pre-certification; and
2. Confirm the Pre-certification with the Covered Person and Provider in writing or electronically within two working days of the initial Pre-certification.

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

1. Notify the Provider by telephone within one (1) working day of making the denial or alternate treatment or service recommendation; and
2. Confirm the adverse decision with the Covered Person and Provider in writing or electronically within one (1) working day of making the denial or alternate treatment or service recommendation.

Concurrent Reviews: The Medical Review Program will make concurrent review determinations within one (1) working day of obtaining all the necessary information. If the Medical Review Program certifies an extended stay or additional services under the concurrent review, KPIC will:

1. Notify the Provider by telephone within one (1) working day of the certification;
2. Confirm the certification in writing or electronically with the Covered Person and Provider within one working day after the telephone notification. 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 of the denial by telephone within one (1) working day of making the adverse determination;

2. Confirm the denial in writing or electronically with the Covered Person and Provider within one working day of the telephone notification. Coverage will continue for Covered Services until the Covered Person and Provider rendering the service have been notified of the adverse determination.

Post-Service Reviews: The Medical Review Program will make its determination on post-service reviews within thirty (30) working days of receiving all necessary information. If the treatment or service is certified, KPIC may notify the Covered Person and Provider of the certification. If the treatment or service is not certified, KPIC will notify the Covered Person, and the Provider acting on behalf of the Covered Person, of the adverse determination in writing within five (5) working days of making the adverse determination.

Standing Referrals to Specialist: If a Covered Person suffers from a life-threatening, degenerative, chronic, or disabling disease or condition that requires specialized care, the primary care physician may determine, in consultation the Covered Person and the treating physician that the Covered Person would best be served through the continued care of a specialist. In such instances, the primary care physician will issue a standing referral to the specialist. For a Covered Person who is pregnant, after the Covered Person receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the Covered Person's pregnancy, including the issuance of referrals in accordance with KPIC's policies and procedures, through postpartum period. For a Covered Person who has been diagnosed with cancer, a standing referral to a board-certified physician in pain management or oncologist who is authorized to provide services will be covered. With the exception of standing referrals to obstetricians for pregnant women as stated above, all standing referral will be made in accordance with a written treatment plan developed by the primary care physician, specialist, and the Covered Person. The treatment plan may limit the number of visits to the specialist or the period of time in which visits to the specialist are authorized. KPIC retains the right to require the specialist to provide the primary care physician with ongoing communication regarding the Covered Person's treatment and health status.

Referrals to Non-Participating Providers: A Covered Person may request a referral to a Non-Participating Provider in accordance with the requirements listed below:

1. The Covered Person is diagnosed with a condition or disease that requires specialized medical care; and
2. KPIC does not have in its Provider panel a specialist with the professional training and expertise to treat the condition or disease; and
3. The specialist agrees to accept the same reimbursement as would be provided to a specialist who is part of the carrier's Provider panel.

Written Denial Notices and the Internal Review (Appeal) Process: A written notification of an adverse determination will include:

1. The principal reasons for the determination;
2. Instructions for initiating an appeal or reconsideration of the determination; and
3. Instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make that determination.

If a request for Pre-certification is denied, in whole or in part, the Covered Person, or Provider acting on behalf of the Covered Person, that received notice of the adverse determination, will be given an opportunity for review. Requests for review will not be granted unless proper procedures are followed in making the request.

Upon receipt of a request for review, the Medical Review Program will reconsider a denied request for Pre-certification within three (3) working days of receiving the request for review and notify the Covered Person or Provider of its decision. Unresolved denials may be appealed, as follows:

1. Standard appeals initiated by a Covered Person, or Provider acting on behalf of the Covered Person. Written request will be entered into a complaint record. Evaluation will be by a Physician and/or clinical peer. The Covered Person and Provider will be notified within thirty (30) working days following the appeal request. The written decision will include:
    a. The name of the decision maker(s), and their qualifications to make this decision;
    b. The reviewer's decision in clear terms, with supporting medical detail;
    c. The reference sources on which the decision was based, including clinical criteria and instructions for requesting the criteria; and

d. In the case of an unresolved difference of opinion, instructions to be used by the Covered Person or Provider for submitting a written appeal requesting a further review, unless state or federal law prohibits the Provider from making such a request.

2. Expedited appeals for adverse determinations will be provided if completing the standard review procedure would seriously jeopardize the life, health, or ability of the Covered Person to regain maximum function. The review procedure will apply to all requests regarding an admission, availability of health care and continued stay for a Covered Person who had received Emergency Care but has not yet been released from a facility. The review will occur within twenty-four (24) hours of receiving the request and will:
   a. Be conducted by clinical peers in the same specialty who were not involved in the initial determination.
   b. Allow all necessary information, including the decision, to be transmitted between the parties involved by telephone, facsimile, or a similarly available method.
   c. Render a decision and notify the Covered Person and Provider within twenty-four (24) hours of the start of the review process. The decisions must also be provided in writing within seventy-two (72) hours of the initial notification.
   d. Include, in the case of an unresolved difference of opinion, instructions to be used by the Covered Person or Provider for submitting a written request for further review, unless law prohibits the Provider from making such a request.
   e. Not include reviews for retrospective adverse determinations.

Independent External Review

After We have rendered a final adverse determination involving an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational, upon Your completing our internal appeals process, as described above, You have a right, under applicable Virginia law, to request an independent external review of Our final adverse determination through the Virginia Bureau of Insurance. You or Your treating health care Provider, with Your consent, in accordance with the applicable regulations of the Bureau of Insurance may file an appeal and have the right to have our decision reviewed by health care professionals who have no association with Us. Your appeal must be filed one hundred twenty (120) days of the date of the final adverse determination. The appeal must also be on a form prescribed by the Bureau of Insurance, and You must include a general release for all medical records pertinent to the appeal.

The appeal may be filed with:

State Corporation Commission
Bureau of Insurance – External Review
Life and Health Division
PO Box 1157
Richmond, VA 23218
(804) 371-9741

If the Covered Person's adverse determination involves (i) treatment of cancer or (ii) a medical condition where the time frame for completion of an expedited internal appeal of an adverse determination would seriously jeopardize the life and health of the covered person or would jeopardize the Covered Person's ability to regain maximum function, the Covered Person or his authorized representative may file a request for an expedited external review.

NOTE: You may have other appeal rights under Title 1 of the Employee Retirement Income Security Act (ERISA). These rights are explained under the section of this Certificate entitled **ERISA CLAIMS AND APPEALS PROCEDURES**.

The Managed Care Ombudsman is available to assist Virginia consumers who have health care insurance provided by a Managed Care Health Insurance Plan (MCHIP). A major responsibility of the office involves educating consumers about their rights and how to advocate on their own behalf when they have a problem or concern about

a MCHIP. The Ombudsman will collect information from MCHIPs regarding complaint, grievance and appeal procedures, and upon request, use this information to answer questions and assist covered individuals.

If You have questions regarding any of the above, You may contact the Office of the Managed Care Ombudsman for assistance at:

Office of the Managed Care Ombudsman
Bureau of Insurance
PO Box 1157
Richmond, VA 23218
(804) 371-9032
(877) 310-6560
E-Mail: ombudsman@scc.virginia.gov
Web Page: http://www.scc.virginia.gov

DEDUCTIBLES AND MAXIMUMS

Individual Deductible
The Deductible for an individual, as shown in the Schedule of Coverage, applies to all Covered Services incurred by a Covered Person during a Calendar Year, unless otherwise indicated in the Schedule of Coverage. The Deductible may not apply to some Covered Services, as shown in the Schedule of Coverage. When Covered Charges equal to the Deductible are incurred during the Calendar Year and are submitted to Us, the Deductible will have been met for that Covered Person for that Calendar Year. Benefits will not be payable for Covered Charges applied to the Deductible.
In addition, some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles do not contribute toward the satisfaction of the Individual and the Family Deductible.

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

Family Deductible Maximum
The Deductible for a family has been satisfied for a Calendar Year when a total of Covered Charges**,** shown in the Schedule of Coverage, has been applied toward the covered family members' Individual Deductibles.

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

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 toward satisfaction of the Individual Deductible, Family Deductible Maximum or the Out-of-Pocket Maximums.

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

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

Doctor Office Visit Co-payment Exception - For PPO Plans only
Unless otherwise noted in the Schedule of Coverage, the Deductible does not apply to practitioner charges incurred for an office visit. Instead, the Covered Person pays the office visit Co-payment for each visit to a Participating Provider.

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.

DEDUCTIBLES AND MAXIMUMS

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

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

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

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

Maximum Allowable Charge
Payments under the Group Policy are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the Provider. Covered Persons are responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service. (Refer to the definition of Maximum Allowable Charge shown in the **GENERAL DEFINITIONS** section of the Certificate.)

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

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

Other Maximums
In addition to the Maximum Benefit While Insured, certain treatments, services, and supplies are subject to benefit-specific limits or maximums. These additional limits or maximums are shown in the Schedule of Coverage. Terminated providers who render continuity of care services will be paid at the Participating Provider reimbursement level.

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. When a Participating Provider terminates, for reason other than cause, from the Provider panel, You have the right to receive continued treatment from the terminated Provider under the following circumstances:

- In active treatment, ninety (90) days from the date of termination of the Provider;
- For pregnancy, from second trimester through postpartum care;
- For terminal illness, for remainder of life.

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 Calendar Year.

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

GENERAL BENEFITS

This section describes the general benefits under the Group Policy. The limitations and exclusions are listed in the **GENERAL LIMITATIONS AND EXCLUSIONS** section. Optional benefits are set forth under the **OPTIONAL BENEFITS** section. Please refer to Your Schedule of Coverage to determine which, if any, optional benefits Your employer elected.

Insuring Clause

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

1. The expense is incurred while the Covered Person is insured for this benefit;
2. The expense is for a Covered Service that is Medically Necessary;
3. The expense is for a Covered Service prescribed or ordered by an attending Physician or by a Provider duly licensed to provide medical services without the referral of a Physician;
4. The Covered Person has satisfied the applicable Deductibles, Co-payments, and other amounts payable; and
5. The Covered Person has not exceeded the Maximum Benefit While Insured or any other maximum shown in the Schedule of Coverage, subject to the Reinstatement of Your Maximum Benefit While Insured provision.

Payments under the Group Policy:

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

Covered Services

1. Room and Board in a Hospital.
2. Room and Board in a Hospital Intensive Care Unit.
3. Room and Board and other Skilled Nursing services in a Skilled Nursing Facility or other licensed medical facility. Care in a Skilled Nursing Facility must be in lieu of Hospital Confinement, and is limited to: a) the maximum number of covered days shown in the Schedule of Coverage; b) care in a licensed Skilled Nursing Facility; c) care under the active medical supervision of a Physician; and d) services consistent with medical needs. Covered Services will include Durable Medical Equipment furnished during a Confinement in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish such Durable Medical Equipment. A Benefit Period specific to care in a Skilled Nursing Facility begins when a Physician admits a Covered Person to a Hospital or Skilled Nursing Facility and ends when the Covered Person has not been a patient in either a Hospital or Skilled Nursing Facility for sixty (60) consecutive days.
4. Necessary Services and Supplies, including medication dispensed while confined in a Hospital to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration (FDA) for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Coverage will not be denied for any drug approved by the FDA for use in the treatment of cancer on the basis that the drug has not been approved by the FDA for the treatment of the specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia. Coverage shall not be denied for any drug approved by the FDA for use in the treatment of cancer pain on the basis that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription in excess of the recommended dosage has been

prescribed in compliance with §§ 54.1-2971.01, 54.1-3303 and 54.1-3408.1 for a patient with intractable cancer pain.

5. Emergency Room Services. When Emergency Room Services are received from a Non-Participating Hospital emergency facility, the Covered Person will not be responsible for payment of charges in excess of the Maximum Allowable Charge for the Emergency Room Services.
6. Emergency Admission Services. When Emergency Admission Services are received from a Non-Participating Provider Hospital, the Covered Person will not be responsible for payment of charges in excess of the Maximum Allowable Charge.
7. Emergency Services for medical emergencies anywhere in the world. If a Covered Person is admitted to a Non-Participating Hospital, the Covered Person, or someone acting on behalf of the Covered Person, must notify the Medical Review Program within forty-eight (48) hours, or as soon as reasonably possible. Upon such notification, a decision will be made as to whether the Covered Person can be safely transferred to a facility that We so designate. Failure to provide such notification may result in the loss of coverage that would otherwise have been covered after transfer would have been possible.
8. Physicians' services, including office visits.
9. Ambulance service of a licensed ground or air ambulance only if, the judgment of a physician, Your medical condition requires either the basic life support, advance life support, or critical care life support capabilities of an ambulance for interfacility or home transfer and the ambulance transportation has been ordered by a physician.
10. Nursing services by an RN, LVN, or LPN, as certified by the attending Physician if an RN is not available. Outpatient private duty nursing will only be covered for the period for which KPIC validates a Physician's certification that: a) the services are Medically Necessary and b) that, in the absence of such nursing care, the Covered Person would be receiving Covered Services as an inpatient in a Hospital or Skilled Nursing Facility. Private duty nursing will not be covered unless otherwise indicated in the Schedule of Coverage.
11. Services by a Certified Nurse Practitioner; Clinical Nurse Specialist; Licensed Midwife; Physician's Assistant or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
12. 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. Proton radiation therapy for cancer treatment will not be held to a higher standard of clinical evidence than for decisions regarding coverage of other types of radiation therapy treatment.
13. Chemotherapy.
14. Coverage for one hair prosthesis for hair loss as a result of chemotherapy or radiation treatment for cancer. Limited to a Benefit Maximum of $350 per course of chemotherapy and/or radiation therapy per Calendar Year.
15. Emergency medical transportation provided through the 911 emergency response system.
16. Outpatient X-ray, laboratory tests, and other diagnostic services.
17. Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.
18. Home Health Care, provided in a Covered Person's home when:
    a. The institutionalization of the Covered Person in a Hospital or related institution or Skilled Nursing Facility would otherwise have been required if Home Health Care was not provided; and
    b. The plan of treatment covering the Home Health Care service is established and approved in writing by the health care practitioner; and
    c. As an alternative to otherwise Covered Services in a Hospital or related institution; or for Covered Persons who receive less than forty-eight (48) hours of inpatient hospitalization following a mastectomy or removal of a testicle on an outpatient basis:
        i. One home visit scheduled to occur twenty-four (24) hours after discharge from the Hospital or outpatient health care facility, and
        ii. An additional home visit if prescribed by the Covered Person's attending physician.
19. Outpatient surgery in a Free-Standing Surgical Facility, other licensed medical facility or in a doctor's office.

20. Hospital charges for use of a surgical room on an outpatient basis.
21. Pre-admission testing, limited to diagnostic, x-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital Confinement for which a Room and Board charge is made.
22. Maternity Services including those performed in a Birth Center.
23. Services and supplies for the diagnosis and treatment of involuntary infertility for females and males including artificial insemination.
24. Rental of Durable Medical Equipment, limited to Expenses Incurred during the 3-month period following:
    a. A Hospital Confinement;
    b. A Confinement in a sub-acute facility;
    c. A Confinement in a specialized rehabilitation facility; or
    d. An outpatient surgical procedure.

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

    Purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental.
    We decide whether to rent or purchase the equipment, and We select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse. You must return the equipment to Us or pay Us the fair market price of the equipment when it is no longer prescribed.

25. Equipment, supplies and in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, glucometers, diabetic test strips, and noninsulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such items. For benefits to be payable, diabetes in-person outpatient self-management training and education must be provided by a certified, registered, or licensed health care professional.
26. Multidisciplinary Rehabilitative Services.
27. Physical therapy rendered by a certified physical therapist. To be eligible for coverage the therapy must be 1) progressive therapy (not maintenance therapy); 2) rendered according to the attending Physician's written treatment plan; 3) for a condition that the attending Physician determines is subject to significant improvement in the level of functioning within sixty (60) days; and 4) completed by the Covered Person as prescribed. As used in this provision "maintenance therapy" means ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
28. Speech therapy rendered by a certified speech therapist or certified speech pathologist. To be eligible for coverage the speech disorder must be a result of an Injury or Sickness of specific organic origin. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within sixty (60) days.

29. Habilitative services for Medically Necessary speech therapy, occupational therapy, and physical therapy for Dependents, with congenital or genetic birth defects, from birth to age twenty-one (21), to enhance the child's ability to function. As used herein, congenital or genetic birth defects means a defect existing at or from birth, including a hereditary defect including, but not limited to, autism or an autism spectrum disorder; and cerebral palsy. Habilitative services delivered through early intervention or school services are not covered. The limiting age of twenty-one (21) in this provision shall not apply to the treatment of Autism Spectrum Disorder.
30. Occupational therapy rendered by a certified occupational therapist. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. To be eligible for coverage the therapy must be progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan for a condition that the attending Physician determines is subject to significant improvement within sixty (60) days. As used in this provision "maintenance therapy" is defined as ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
31. Respiratory therapy rendered by a certified respiratory therapist. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within sixty (60) days and may not be maintenance therapy.
32. Medically Necessary early intervention services related to speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices for Dependents, from birth to age three (3), who are certified as disabled by the Virginia Department of Behavioral Health and Developmental Services in accordance with applicable federal requirements. Early intervention services are Medically Necessary when such services are designed to help a Dependent attain or retain the capability to function age-appropriately within his or her environment, and shall include services that enhance functional ability without effecting a cure, except school services.
33. Rehabilitation services while confined in a Hospital or any other licensed medical facility. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program including those provided in a Comprehensive Rehabilitation Facility. To be eligible for coverage the therapy must be: 1) progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan for a condition that the attending Physician determines is subject to significant improvement within sixty (60) days. As used in this provision, "maintenance therapy" is defined as ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
34. Treatment, services, or supplies covered under the Group Policy if received as an inpatient or outpatient in a Hospital or other licensed medical facility in connection with Mental Illness.
35. Treatment in connection with Mental Health Services or Substance Use Disorder Services. For purposes hereof, "treatment" means services including diagnostic evaluation, medical, psychiatric and psychological care, and psychotherapy for mental, emotional or nervous disorders or alcohol or other drug dependence rendered by a Hospital, alcohol or drug rehabilitation facility, Intermediate Care Facility, Mental Health Treatment Center, a Physician, psychologist, clinical psychologist, licensed clinical social worker, licensed professional counselor, licensed substance use disorder treatment practitioner, marriage and family therapist or clinical nurse specialist who renders mental health services. Treatment for physiological or psychological dependence on alcohol or other drugs shall also include the services of counseling and rehabilitation as well as services rendered by a state certified alcoholism, drug, or substance use disorder counselor or substance use disorder counseling assistant, operating within the scope of his/her license, employed by a facility or program licensed to provide such treatment. Medication Management Visits will be covered in the same manner as a medication management visit for the treatment of a Sickness and will not be counted as an Outpatient Treatment Visit. Medical complications of alcoholism, which include, but are not limited to: a) cirrhosis of the liver; b) gastrointestinal bleeding; c) pneumonia; and d) delirium tremens are otherwise covered under the plan. Up to ten (10) days of the inpatient benefit may be converted when Medically Necessary at the option of the person or the parent of which the child or adolescent receiving such treatment

to a partial hospitalization which shall be no less favorable than an exchange of 1.5 days of partial hospitalization coverage for each inpatient day of coverage.

36. Covered Services rendered to treat Mental Health Services and Substance Use Disorder Services.
37. Detoxification services, in a hospital or related institution, will be limited to the removal of the toxic substance or substances from the system.
38. Blood, blood products and its derivatives and components, the collection and storage of autologous blood for elective surgery, and as well as cord blood procurement and storage. In addition, benefits will be payable for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center. Covered Services will not include directed blood donations.
39. Coverage for inpatient care following a mastectomy or lymph node dissection. Coverage includes:
    a. A minimum hospital stay of not less than forty-eight (48) hours following a radical or modified mastectomy; and
    b. Not less than twenty-four (24) hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for the treatment of breast cancer.

    If, the physician, in consultation with the patient, determines that a shorter period of hospital stay is appropriate, coverage will include:
    a. One home visit scheduled to occur within twenty-four (24) hours after discharge from the hospital or outpatient health care facility; and
    b. An additional home visit if prescribed by the patient's attending physician.
40. Physical complications of mastectomy, including Medically Necessary treatment of lymphedemas.
41. Laparoscopy-assisted vaginal hysterectomy and vaginal hysterectomy. The minimum authorized Hospital stay when undergoing either procedure will be:
    a. Twenty-three (23) hours for laparoscopy-assisted vaginal hysterectomy; or
    b. Forty-eight (48) hours for vaginal hysterectomy. Hospital stays beyond the minimums noted above will be subject to the normal Precertification procedures as outlined in the **PRE-CERTIFICATION, INTERNAL APPEALS, AND EXTERNAL REVIEW** section of this Certificate.
42. Transplant services limited to autologous and non-autologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants. Charges incurred or in connection with non-human and artificial organs and their implantation are not covered under the transplant benefit. Services for, or related to, the removal of an organ from a Covered Person for purposes of transplantation into another person will not be covered unless: a). Transplant recipient is covered under the plan and is undergoing a covered transplant, and b). Services are not payable by another carrier.
43. Allergy testing and treatment, services, material, and serums.
44. Musculoskeletal Therapy.
45. Cardiac Rehabilitation.
46. Pulmonary Rehabilitation.
47. Dialysis.
48. Urgent Care.
49. Sleep Studies.
50. Sleep Labs.
51. Coverage for reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast.
52. Vision services, including routine exams, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses.

53. Prosthetic devices and expense incurred for components to a prosthetic device and repair of a prosthetic device. Covered Services will be limited to coverage for Medically Necessary prosthetic devices, their repair, fitting, replacement, and components. Coverage will not include repair or replacement due to neglect, misuse, or abuse nor will it include devices designed primarily for an athletic purpose.
54. Prosthetics. Coverage will include fitting and adjustment of these devices, repair, or replacement, and services and supplies to determine whether You need the prosthetic. Covered Services will be limited to the standard device that adequately meets Your medical needs. Coverage will include internally implanted and external Breast Prosthetics following a mastectomy. Breast Prosthetics will also be provided for the non-diseased breast to achieve symmetry with the diseased breast.
55. Orthotics. Coverage will include rigid and semi-rigid external Orthotic devices that are used for the purpose of supporting a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured part of the body. Examples of covered Orthotic devices include, but are not limited to leg, arm, back and neck braces.
56. Coverage for participation in an approved clinical trial and coverage for routine patient cost for items and services furnished in connection with participation in such clinical trial.

    "Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and the study or investigation is (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration, or (iii) a drug trial that is exempt from having an investigational new drug application.

    "Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of disease or condition is interrupted.

    "Qualified individual" means a Covered Person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual's participation in such trial is appropriate to treat the disease or condition, or the individual's participation is based on medical and scientific information.

    "Routine patient costs" means all items and services consistent with the coverage provided under the health benefit plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include the investigational item, device, or service itself; items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

57. Other services or treatment approved through the Medical Review Program.
58. Diagnostic and surgical treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed Medically Necessary to attain functional capacity of the affected part.
59. Treatment of morbid obesity (including Bariatric surgery). Morbid obesity means a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender, a body mass index (BMI) equal to or greater than thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of forty (40) kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.
60. Medical foods and low protein modified food products for the treatment of inherited metabolic disorders caused by an inherited abnormality of body chemistry including a disease for which the State screens newborn babies. Coverage is provided if the medical foods and low protein food products are prescribed as Medically

Necessary for the therapeutic treatment of inherited metabolic disorders, and are administered under the direction of a Physician. Regarding Medically Necessary formula and enteral nutrition products, inherited metabolic disorders means an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids. Coverage includes medical equipment, supplies, and Services that are required to administer the covered formula or enteral nutrition products

61. Medical Nutrition Therapy and Counseling. Medically Necessary nutritional counseling provided by a licensed dietician-nutritionist, physician assistant or nurse practitioner for an individual at risk due to nutritional history, current dietary intake, medication use or chronic illness or condition.
62. Hospice Care.
63. Anesthesia for dental services, limited to general anesthesia and Hospital or outpatient surgery facility charges for outpatient surgical procedures for dental care provided to a Covered Person who is determined by a licensed dentist, in consultation with the Covered Person's treating Physician, to require general anesthesia and admission to a Hospital or outpatient surgery facility to effectively and safely provide dental care and (i) is under the age of five, or (ii) is severely disabled, or (iii) has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment. For the purpose of this Covered Service, a determination of medical necessity will include but not be limited to a consideration of whether the age, physical condition or mental condition of the Covered Person or mental condition of the Covered Person requires the utilization of general anesthesia and the admission to a Hospital or outpatient surgery facility to safely provide the underlying dental care. This provision does not provide coverage for any dental procedure or the professional fees or services of the dentist.
64. Covered Services, including orthodontics, oral surgery and otologic, audiological and speech/language treatment, necessary to treat the result of the congenital defect known as cleft lip, cleft palate, or both.
65. Hearing screenings for newborn children, including all necessary audiological examinations using any technology approved by the United States Food and Drug Administration, and as recommend by the most current position statement of the Joint Committee on Infant Hearing. Coverage will include any follow-up audiological examinations as recommend by the Covered Person's Physician or audiologist when performed by a licensed audiologist to confirm the existence or absence of hearing loss.
66. Accidental Dental Injury Services. Dental services for accidental injury and other related medical services. For benefits to be payable the Covered Services must be requested within sixty (60) days of the injury.
67. Treatment of Lymphedema, to include equipment, supplies, complex decongestive therapy, and outpatient self-management training and education, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.
68. Physician services, including diagnosis, consultation, and treatment appropriately provided via Telemedicine. Telemedicine shall be subject to the same Deductible, Coinsurance and/or Copayments as are otherwise applicable to Physician office visits, except maternity related ACA preventive care services.
69. Covered Services rendered for the diagnosis and treatment of Autism Spectrum Disorder for a Covered Person. Autism Spectrum Disorder (ASD) means any pervasive developmental disorder or autism spectrum disorder as defined in the most recent edition, or the most recent edition at the time of diagnosis, of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Diagnosis of ASD means Medically Necessary assessments, evaluations, or tests to diagnose whether a Covered Person has ASD. Medically Necessary defined in this section means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age. Treatment of ASD shall be identified in a written treatment plan and may include the following care when prescribed or ordered for a Covered Person diagnosed by a licensed Physician or a licensed psychologist who determines the care to be Medically

Necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavior analysis when provided or supervised by a board certified behavior analyst licensed by the Board of Medicine. The prescribing practitioner must be independent of the Provider of applied behavior analysis.

A Treatment Plan means a plan for the treatment of ASD developed by a licensed physician or a licensed psychologist pursuant to a comprehensive evaluation or re-evaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

70. Routine foot care limited to Medically Necessary treatment of patients.
71. 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.
72. Removable appliances for TMJ repositioning

Pediatric Vision (until the end of the month in which the child turns age 19)
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:

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

Eyewear
The following eyewear is covered:

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

   Note: Lenses include choice of glass or plastic lenses, all lens powers (single vision, bifocal). Polycarbonate lenses are covered in full. All lenses include scratch resistant coating.
2) Eyeglass frames -non-deluxe (designer) frames
3) Contact lenses including evaluation, fitting, or follow-up care relating to contact lenses
4) Medically Necessary contact lenses in lieu of other eyewear for the following conditions:
   a. Keratoconus,
   b. Pathological Myopia,
   c. Aphakia,
   d. Anisometropia,
   e. Aniseikonia,
   f. Aniridia,
   g. Corneal Disorders,
   h. Post-traumatic Disorders,
   i. Irregular Astigmatism.

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

Preventive Services

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

The following preventive services are covered under this Group Policy as required by the Patient Protection Affordable Care Act (PPACA) and may be subject to Deductibles, Copayments or Coinsurance as described in the Schedule of Coverage.

Consult with Your physician to determine what preventive services are appropriate for You.

Exams

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

Screenings

1. Abdominal aortic aneurysm screening
2. Anxiety screening in adolescent and adult women, including those who are pregnant or postpartum
3. Asymptomatic bacteriuria screening
4. Behavioral/Social/Emotional Screening for children newborn to age twenty-one (21)
5. Breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (mammogram)
6. Cervical cancer and dysplasia screening including HPV screening (pap smear),
7. Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the latest screening guidelines issued by the American Cancer Society.
8. Depression screening for children and adults including suicide risk as an element of universal depression screening for children ages twelve to twenty-one (12-21).
9. Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus
10. Gestational and postpartum diabetes screening
11. Hepatitis B and Hepatitis C virus infection screening
12. Hematocrit or Hemoglobin screening in children
13. Hypertension (High blood pressure) screening
14. Lead Screening
15. Lipid disorders screening
16. Lung cancer screening with low-dose computed tomography in adults who have a 20 pack-year smoking history and currently smoke or have quit within the past fifteen (15) years. One pack year is equal to smoking one pack per day for one year, or two packs per day for half a year.
17. Newborn congenital hypothyroidism screening
18. Newborn hearing loss screening
19. Newborn metabolic/hemoglobin screening
20. Newborn sickle cell disease screening
21. Newborn Phenylketonuria screening
22. Obesity screening (Body Mass Index) and management, and counseling for obesity
23. Osteoporosis screening
24. Pre-eclampsia screening with blood pressure measurements throughout pregnancy

25. Rh (D) incompatibility screening for pregnant women
26. Sexually transmitted infection screening such as chlamydia, human papillomavirus screening, gonorrhea, syphilis and HIV screening. Annual routine Chlamydia screening test for women who are under the age of twenty (20) years old if they are sexually active; and at least twenty (20) years old if they have multiple risk factors; and men who have multiple risk factors. Human papillomavirus screening at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.
27. Sudden cardiac arrest and sudden cardiac death risk assessment in children ages twelve to twenty-one (12-21).
28. Type 2 diabetes mellitus screening
29. Tuberculin (TB) Testing
30. Urinary incontinence screening in women
31. Visual impairment in children screening

Health Promotion

1. Screening by asking questions about unhealthy drug use in adults ages eighteen (18) years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.
2. Unhealthy alcohol and drug use assessment and behavioral counseling interventions in a primary care setting to reduce alcohol use.
3. Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease.
4. Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children
5. Counseling for midlife women with normal or overweight body mass index to maintain weight or limit weight gain to prevent obesity.
6. Offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
7. Tobacco use screening and tobacco-caused disease counseling and interventions, FDA approved tobacco cessation prescription or over-the-counter medications prescribed by a licensed health care professional authorized to prescribe drugs are also covered for individuals who are not pregnant
8. Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and BRCA mutation testing
9. Sexually transmitted infections counseling
10. Discuss use of the risk-reducing medications such as tamoxifen, raloxifene, or aromatase inhibitors with women who are at increased risk for breast cancer and at a low risk for adverse medication effects.
11. When prescribed by a licensed health care professional authorized to prescribe drugs:
    a) Aspirin in the prevention of cardiovascular disease and preeclampsia in pregnant women.
    b) Iron supplementation for children from six (6) months to twelve (12) months of age.
    c) Oral fluoride supplementation at currently recommended doses to preschool children older than six (6) months of age whose primary water source is deficient in fluoride.
    d) Topical fluoride varnish treatments applied in a primary care setting by primary care Providers, within the scope of their licensure, for the prevention of dental caries in children
    e) Folic acid supplementation for women planning or capable of pregnancy for prevention of neural tube defects.
    f) Vitamin D to prevent falls in community-dwelling adults aged sixty-five (65) years or older who are at increased risk for falls
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 manual breast pump is one that does not require a power source to operate. In lieu of purchase of a manual breast pump, rental of a hospital-grade electric breast pump, including any equipment that is required for pump functionality, is covered when Medically Necessary and prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.

13. All prescribed FDA-approved contraceptive methods for women with reproductive capacity, including but not limited to drugs, cervical caps, vaginal rings, continuous extended oral contraceptives and patches. This includes all FDA-approved cleared or granted contraceptive products that are determined by an individual's medical Provider to be medically appropriate. Also included are contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, female sterilization procedures, follow-up and management of side effects; counseling for continued adherence, device removal and patient education and counseling. Over-the-counter FDA approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs.
14. Screening, counseling, and other interventions such as education, harm reduction strategies, and referral to appropriate supportive services for interpersonal and domestic violence.
15. Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions.
16. Low-to-moderate dose statins for adults without a history of cardiovascular disease (CVD) who meet the USPSTF criteria.
17. Counseling young adults, adolescents, children and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged six (6) months to twenty-four (24) years with fair skin types to reduce their risk for skin cancer.
18. Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.

Disease Prevention

1. Immunizations as recommended by the Centers for Disease Control and HRSA. This includes all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
2. Prophylactic gonorrhea medication: for newborns to protect against gonococcal ophthalmia neonatorum.
3. Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met: 1) individuals are aged forty to seventy-five (40-75) years; 2) they have 1 or more cardiovascular risk factors; and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.
4. Pre-exposure prophylaxis (PrEP) effective antiretroviral therapy to persons who are at high risk of HIV acquisition as well as the following baseline and monitoring services:
    - 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
    - Hepatitis B testing before PrEP is started.
    - Hepatitis C testing before PrEP is started and periodically during treatment according to CDC guidelines.
    - Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) is covered as follows:
        - eCrCl or eGFR testing before starting PrEP to assess kidney function.
        - Creatinine and eCrCL or eGFR testing periodically consistent with CDC guidelines during treatment.
    - Pregnancy testing for persons of childbearing potential before PrEP is started and periodically during treatment consistent with CDC guidelines.

- Sexually transmitted infection screening and counseling before PrEP is started and periodically during treatment consistent with CDC guidelines.
- Adherence counseling for assessment of behavior consistent with CDC guidelines.

Exclusions for Preventive Care

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

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

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

Note: The following services are not Covered Services under this Preventive Exams and Services benefit but 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 are subject to the Deductible and Coinsurance requirements unless otherwise stated below or in the Schedule of Coverage. In the event of a duplication of benefits, duplicate benefits will not be paid but the higher of the applicable benefits will apply.

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

1. Adult routine physical examinations. Covered Services at each examination are limited to: a) examination; and b) history. Any X-rays or laboratory tests ordered in connection with the examination will be subject to Your plan's Deductibles, Copayments, and/or Coinsurance requirements as set forth in the Schedule of Coverage.
2. Other identified labs and screenings. The following services and items are treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
   a) Hemoglobin A1C testing for individuals diagnosed with diabetes.
   b) Retinopathy Screening for individuals diagnosed with diabetes.
   c) Low Density Lipo-Protein testing for individuals diagnosed with heart disease.
   d) International Normalized Ratio (INR) testing for individuals diagnosed with liver disease of bleeding disorders
3. Double contrast barium enema as an alternative to colonoscopy
4. Screening prostate specific antigen test (PSA)
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) Voluntary termination of pregnancy (abortion).

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

Family planning charges do not include any charges for the following:
a) The cost of donor semen and donor eggs including retrieval of eggs;
b) Storage and freezing of eggs and/or sperm;
c) Services to reverse voluntary, surgically induced infertility;
d) Services other than artificial insemination, related to conception by artificial means, including, but not limited to, in vitro fertilization, gamete intrafallopian tube transfer; ovum transplants; zygote intrafallopian transfer, and prescription drugs related to such services.

6. Iron deficiency anemia screening for pregnant women

7. Diagnostic examination which shall include a digital rectal exam and a blood test called the prostate-specific antigen (PSA) test:
   - For men who are between forty (40) and seventy-five (75) years of age;
   - When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
   - When used for staging in determining the need for a bone scan in patients with prostate cancer; or
   - When used for male patients who are at high risk for prostate cancer.

   This coverage does not cover the surgical and other procedures known as radical prostatectomy, external beam radiation therapy, radiation seed implants, or combined hormonal therapy.
8. Venipuncture for ACA preventive lab screenings. If a venipuncture is for the purpose of drawing blood for both ACA preventive and Non-ACA preventive labs, a cost share may apply.
9. Behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular Disease (CVD) prevention in adults with CVD risk factors and type 2 diabetes mellitus.

Extension of Benefits

Except with regard to any Optional Outpatient Drug Benefit that may be provided under the Group Policy, the benefits for the disabling condition of a Covered Person will be extended if:
1. The Covered Person becomes Totally Disabled while insured for that insurance under the plan; and
2. The Covered Person is still Totally Disabled on the date this Plan terminates.

The extended benefits will be paid only for treatment of the Injury or Sickness that causes the Total Disability. The extension will start on the day that follows the last day for which premiums are paid for the insurance of the Covered Person. It will end on the first of these dates that occur:
1. The date on which the Total Disability ends;
2. The last day of the 12-month period that follows the date the Total Disability starts; or
3. The date on which the Covered Person becomes covered under any plan that: a) replaces this insurance; and b) covers the disabling condition so that benefits are not limited due to the Total Disability having started before that plan was in effect.
4. The Group Policy Terminates.

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

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

Benefits for Inpatient Maternity Care

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

A stay longer than the above may be allowed provided the attending Provider obtains authorization for an extended confinement through KPIC's Medical Review Program.

For stays shorter than forty-eight (48) hours following normal vaginal delivery and 96 hours following a Caesarean section, a home visit within twenty-four (24) hours of hospital discharge will be scheduled, and additional home visits if prescribed by the attending physician.

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

Note: Prior authorization is not required for the interhospital transfer of (i) a newborn infant experiencing a life-threatening emergency condition or (ii) the hospitalized mother of such newborn infant to accompany the infant.

Emergency Services

Emergency Services are covered twenty-four (24) hours per day, seven (7) days per week no matter when or where in the world they occur without Prior Authorization and without regard to whether the health care provider furnishing the services is a Participating Provider.

If You think you have a medical emergency, call 911 (where available) or go to the nearest Hospital emergency department or Independent Freestanding Emergency Department. You do not need Prior Authorization for Emergency Services. When You have an Emergency Medical Condition, We cover Emergency Services that You receive from Participating Providers or Non-Participating Providers anywhere in the world, as long as the services would be covered under the **GENERAL BENEFITS** section of this Certificate (subject to the **GENERAL LIMITATIONS AND EXCLUSIONS** section of this Certificate) if You had received them from Participating Providers. Emergency services are available from Participating Hospital emergency departments twenty-four (24) hours a day, seven (7) days a week. 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 applicable Cost-sharing.

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

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

Cost-sharing Requirements, Payment, and Balance Billing Protections for Surgical and Ancillary Services Performed by Non-Participating Providers at Participating Facilities

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

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

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

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

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

If a Covered Person is furnished, by a Non-Participating Provider, an item or service that would otherwise be covered if provided by a Participating Provider, and the Covered Person relied on a database, provider directory, or information regarding the provider's network status provided by Us through a telephone call or electronic, web-

based, or Internet-based means which incorrectly indicated that the provider was a Participating Provider for the furnishing of such item or service, then the following apply:

1. The Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement for such item or service furnished by a Non-Participating Provider is the same as the Co-payment amount, Coinsurance percentage, and/or other Cost-sharing requirement listed in the Group Policy for the item or service when provided by a Participating Provider; and
2. Any Cost-sharing payments made with respect to the item or service will be counted toward any applicable in-network Deductible and in-network Out-of-Pocket Maximum.
3. The member will not be liable for an amount that exceeds the Cost-sharing that would have applied to the member if the provider was a Participating Provider.

You will incur the same cost sharing (Deductible, Coinsurance and/or Co-payment, as applicable) for Emergency Services furnished by Non-Participating Providers as Participating Providers and such cost sharing will be calculated based on the Maximum Allowable Charge in accordance with applicable law if your cost sharing is not a fixed amount.

If Emergency Services are provided by a Non-Participating Provider, We will make payment for the covered Emergency Services directly to the Non-Participating Provider. The payment amount will be equal to the amount by which the Maximum Allowable Charge exceeds your cost sharing amount for the services.

You will not be liable for an amount that exceeds the Maximum Allowable Charge.

Emergency Services, with respect to an Emergency Medical Condition, means:

1. A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a Hospital, including Surgical or Ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and,
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under the Emergency Medical Treatment and Active Labor Act.

Under Virginia law, a Non-Participating Provider cannot balance bill for: (i) Emergency Services or (ii) non-emergency services provided at a Participating Facility if the non-emergency services involve Surgical or Ancillary Services provided by a Non-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, no payment will be made under any benefit of the plan for Expenses Incurred in connection with the following unless required to be covered under state or federal laws and regulations:

1. Charges for services approved by or reimbursed by Health Plan
2. Charges in excess of the Maximum Allowable Charge.
3. Charges for non-Emergency Care in an Emergency Care setting, except for non-Emergency surgical or ancillary services provided at a Participating Provider facility by a Non-Participating Provider, to the extent that such charges exceed charges that would have been incurred for the same treatment in a non-Emergency Care setting. Final determination as to whether non-Emergency Services were appropriately in an Emergency Care setting will rest solely with KPIC. Charges for the screening and treatment necessary for stabilization will be processed at the in-network benefit level.
4. Weekend admission charges for non-Emergency Care Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
5. Confinement, treatment, services, or supplies not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically set forth in this Certificate as a Covered Service.
6. Confinement, treatment, services, or supplies received outside the United States, if such confinement, treatment, services, or supplies are of the type and nature that are not available in the United States.
7. Injury or Sickness for which benefits are payable under any state or federal workers' compensation, employer's liability, occupational disease, or similar law.
8. Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third-party coverage.
9. Injury or Sickness arising out of or in the course of past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.
10. Services for military service-related conditions regardless of service in any country or international organization.
11. Treatment, services, or supplies provided by the Covered Person; his or her Spouse; a child, sibling, or parent of the Covered Person or of the Covered Person's Spouse; or a person who resides in the Covered Person's home.
12. Confinement, treatment, services, or supplies received where care is provided at government expense. This exclusion does not apply if: a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or b) payment is required by law
13. Dental care and treatment, dental x-rays; dental appliances; orthodontia; and dental surgery. This exclusion will not apply to the extent that diagnostic and surgical treatment is required because of a medical condition or Injury that prevents normal function of the joint or bone of the head, face or jaw to attain functional capacity of the affected part. This exclusion includes, but is not limited to: services to correct malocclusion; extraction of wisdom teeth (third molars); injury to teeth resulting from chewing; Dental appliances; dental implants; orthodontics; dental services associated with medical treatment.
14. Cosmetic services, plastic surgery, or other services that: a) are indicated primarily to change the Covered Person's appearance; and b) will not result in significant improvement in physical function. This exclusion does not apply to services that: a) will correct significant disfigurement resulting from a non-congenital Injury or Medically Necessary surgery; or b) are incidental to a covered mastectomy; or c) are necessary for treatment of a form of congenital hemangioma known as port wine stains.
15. Non-prescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician.

16. Any treatment, procedure, drug or equipment, or device which KPIC determines to be Experimental or Investigational. This means that one of the following is applicable:
    a. The service is not recognized as efficacious as the term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technology that is current when care is rendered; or
    b. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

    Experimental or Investigational procedures do not include Clinical Trials.

17. Special education and related counseling or therapy; or care for learning deficiencies.
18. Confinement, treatment, services or supplies that are required: a) only by a court of law except when Medically Necessary and otherwise covered under the plan; or b) only for insurance, travel, employment, school, camp, government licensing, or similar purposes.
19. Personal comfort items such as telephone, radio, television, or grooming services.
20. Custodial care. Custodial care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
21. Routine foot care except as set forth under the Covered Services.
22. Confinement or services that are not Medically Necessary or treatment that is not completed in accordance with the attending Physician's orders.
23. Services of a private duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility, or in the Covered Person's home;
24. Medical social services except those services related to discharge planning in connection with: a) a covered Hospital Confinement; b) covered Home Health Care Services; or c) covered Hospice Care.
25. Living expenses or transportation, except as provided under Covered Services.
26. Reversal of sterilization.
27. Services provided in the home other than Covered Services provided through a Home Health Care Agency.
28. Maintenance therapy for rehabilitation.
29. The following Home Health Care Services:
    a. meals,
    b. personal comfort items,
    c. housekeeping services.
30. 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.
31. Services in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Covered Person who is a surrogate.
32. Any drug, procedure or treatment for sexual dysfunction regardless of cause, including but not limited to Inhibited Sexual Desire, Female Sexual Arousal Disorder, Female Orgasmic Disorder, Vaginismus, Male Arousal Disorder, Erectile Dysfunction and Premature Ejaculation.
33. Biofeedback or hypnotherapy.
34. Health education, including but not limited to: a) stress reduction; b) weight reduction; or c) the services of a dietitian. This exclusion will not apply to treatment of Morbid Obesity.
35. Hearing exams; hearing therapy; or hearing aids. This exclusion includes hearing exams to determine appropriate hearing aid, as well as hearing aids or tests to determine their efficacy. Internally implanted hearing aids are also excluded. This exclusion does not apply to newborn hearing screenings.
36. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
37. Services for which no charge is normally made in the absence of insurance.

38. Purchases of Durable Medical Equipment. Purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental.
39. Acupuncture.
40. Chiropractic Services.
41. Treatment for in vitro fertilization such as: a) gamete intrafallopian tube transfer; b) ovum transplants; c) zygote intrafallopian transfer; d) cryogenic or other preservation techniques used in these or similar techniques.
42. Family planning services except as a limited benefit as set forth in the **GENERAL BENEFITS** section of this Certificate;
43. Treatment of craniomandibular, myofascial pain and temporomandibular joint disorders. Coverage is limited to Medically Necessary surgical treatment only.
44. Second medical opinion, except when required under the Medical Review Program.
45. Artificial Insemination shall not include (a) the cost of donor semen and donor eggs including retrieval of eggs, and (b) storage and freezing of eggs and/or sperm.
46. Early Intervention Services shall not include services provided through federal, state or local early intervention programs, including school programs.
47. Cardiac Rehabilitation, except as a limited benefit as set forth in the Schedule of Coverage for Covered Persons with: a) stable angina pectoris; b) history of acute myocardial infarction; c) surgery for coronary artery bypass; d) percutaneous therapeutic coronary artery intervention; e) heart or heart/lung transplant; or f) repair or replacement of a heart valve.
48. Long-term therapy.

OPTIONAL OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

Outpatient Prescription Drug Benefits

To determine if You are covered for the following optional benefits You must refer to the Schedule of Coverage. If outpatient prescription drugs are not listed as covered under Your Schedule of Coverage, then outpatient prescription drugs are excluded from coverage as provided under the **GENERAL LIMITATIONS AND EXCLUSIONS** section of this Certificate. You have the freedom to choose a Non-Participating Pharmacy, if the pharmacy or its intermediary agrees in writing to accept reimbursement at the same rate as participating pharmacies, including copayment amounts.

Prescribed drugs, medicines and supplies purchased on an outpatient basis are covered provided they: a) can be lawfully obtained only with the written prescription of a Physician or dentist; b) are purchased by Covered Persons on an outpatient basis; c) are covered under the Group Plan; d) do not exceed the maximum daily supply shown in the Schedule of Coverage, except that in no case may the supply be larger than that normally prescribed by a Physician or dentist; and e) do not exceed: an amount equal to 150 percent of the average wholesale price of the ingredients contained in the prescription, plus a dispensing fee. No prescription drugs shall be excluded from coverage solely on the basis of the length of time since the drug obtained FDA approval. The part of a charge that does not exceed this limit will not be considered a Covered Charge.

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

Outpatient Prescription Drugs Covered

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

1. Prescription drugs listed as Generic Drugs;
2. Prescription drugs listed as Preferred and Non-Preferred Brand Drugs;
3. If a health care practitioner prescribes a Brand Name Drug and the Covered Person selects the Brand Name Drug when a Generic Drug is available, the Covered Person shall pay the applicable Co-payment plus the difference between the price of the Brand Name and the Generic Drug.
4. Drugs and medicines, including nicotine patches and chewing gum, in connection with smoking cessation therapy or a behavior modification program.
5. Internally implanted time-release medications;
6. Insulin and the following diabetic supplies:
   a. syringes and needles
   b. blood glucose and ketone strips or tablets and glucose ketone test strips or tablets

   The standard prescription amount for insulin is one 10-milliliter vial.

7. Compounded dermatological preparations which must be prepared by a pharmacist in accord with a Physician's prescription;
8. Up to a 90-day supply of a Maintenance Drug in a single dispensing of the prescription.

9. Oral or nasal inhalers. The standard prescription amount for oral and nasal inhalers is the smallest standard package unit.
10. Compounded dermatological preparations which must be prepared by a pharmacist;
11. Spacer devices;
12. Migraine medications. The standard prescription amount for migraine medications is the smallest package size available.
13. Ophthalmic, optic and topical medications. The standard prescription amount for ophthalmic, optic and topical medications is the smallest package available.
14. Any contraceptive drug or device that is approved by the United States Food and Drug Administration (FDA). Up to a 12-month supply may be obtained at one time.
15. Self-administered Injectable Medications. Coverage for Self-administered Injectable medications must meet the following criteria:
    a. does not require administration by medical personnel;
    b. administration does not require observation;
    c. patient's tolerance and response to the drug does not need to be tested, or has already been satisfactorily tested; and
    d. prescribed for self-administration by the patient at home.

    Self-administered Injectable Medications must be written on a prescription, filled by a pharmacy, and self-administered by the patient or caregiver at home (not administered by Providers in the medical offices).

16. FDA-approved drugs for use in the treatment of cancer pain to the extent that the dosage is in excess of the recommended dosage when prescribed according to the stated guidelines for a patient with intractable cancer pain.
17. FDA-approved drugs for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed but provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
18. Any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
19. Cancer chemotherapy drugs administered orally and intravenously or by injection.
20. Covered Person 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 prescribing provider or the pharmacist determines the fill or refill to be in the best interest of the Covered Person and the Covered Person requests or agrees to a partial supply for the purpose of synchronizing the Covered Person's medications, provided that such a proration for any prescription shall not occur more frequently than annually.

Outpatient Prescription Drugs Limitations and exclusions

The following items are excluded from Outpatient Prescription Drug coverage in addition to those set forth in the **GENERAL LIMITATIONS AND EXCLUSIONS** section:

1. All office injectable drugs (except insulin and migraine).
2. Administration of a drug or medicine.
3. Any drug or medicine administered as Necessary Services and Supplies. (See the **GENERAL DEFINITIONS** section.)
4. Drugs not approved by the FDA.
5. Drugs and injectables for the treatment of sexual dysfunction disorders.
6. Drugs or injectables for the treatment of involuntary infertility.
7. Drugs and injectables for the treatment of cosmetic services.

8. Replacement of lost or damaged drugs and accessories.
9. Experimental Drugs and Medicines. This exclusion will not apply if such experimental or investigational drug, device, or procedure, as certified by the Physician is the only procedure, drug or device medically appropriate to the Covered Person's condition. In addition, this exclusion will not apply to routine patient care costs related to Clinical Trial if the Covered Person's treating Physician recommends participation in the Clinical Trial after determining that participation in such Controlled Clinical Trial has a meaningful potential to benefit the Covered Person.
10. Drugs associated with non-covered services;
11. Infant formulas, except for amino acid-modified products used to treat congenital errors of amino acid metabolism;
12. Human Growth Hormone (HGH), except for children with either Turner's syndrome or with classical growth hormone deficiency; and
13. Anorectic or any drug or injectable used for the purpose of weight loss or weight management unless prescribed in the treatment of morbid obesity.
14. Non-prescription drugs or medicines; vitamins, nutrients, and food supplements, even if prescribed or administered by a Physician
15. 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.

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.

If the Non-Participating Pharmacy has submitted a reimbursement agreement to KPIC to accept reimbursement for their services at rates applicable to Participating Pharmacies, including any copayment consistently imposed by KPIC, as payment in full; the member will not be responsible for amounts that may be charged by the Non-Participating Pharmacy in excess of the copayment and the insurer's reimbursement applicable to all of its Participating Pharmacies.

FEDERAL CONTINUATION OF COVERAGE PROVISIONS

This section only applies to Participating Employers who are subject to Public Law 99-271 (COBRA)
You or a covered Dependent may have a right to have health coverage continued under the Policy when coverage terminates under the provisions of the Policy. Continued coverage will be: (A) available only to those Covered Persons who qualify at the time a qualifying event occurs; and (B) subject to the terms and conditions of the Policy.
A child that is born to or placed with an Insured Employee during a period of COBRA coverage is eligible for coverage as a Dependent provided proper written notice and election takes place.

Qualifying Events

A. If Your health insurance coverage ends due to (1) termination of employment; or (2) a reduction in hours, You may continue health coverage under the policy for the continuation of coverage period.
B. If Your Dependent's insurance coverage ends due to: (1) Your death; (2) Your legal divorce or legal separation from Your Spouse; or (3) Your child reaching the limiting age for a Dependent, the terminated Dependent has the option to continue health coverage under the policy for the continuation of coverage period.
C. If You retired from employment with the employer and Your health insurance coverage, or the health insurance coverage of Your Dependents, including Your surviving Spouse:
    a) Is substantially eliminated as a result of the employer's filing of a Title XI bankruptcy; or
    b) Was substantially eliminated during the Calendar Year preceding the employer's filing of a Title XI bankruptcy,
    c) You and Your Dependents may continue health coverage under the policy for the continuation of coverage period.
D. If You become entitled to Medicare benefits under Title XVIII of the Social Security Act, Your Medicare ineligible Spouse and Dependent eligible children may continue health coverage under the policy for the continuation of coverage period.

Continuation of Coverage Period

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

1. Eighteen (18) months following qualifying event (A) except if a qualifying event (B) occurs during this eighteen (18) months, the continuation of coverage period will be extended an additional 18 months for a total period of thirty-six (36) months.
2. Thirty-six (36) months following qualifying event (B);
3. For a qualifying event (C):
    a) the date of Your death, at which time Your dependents (other than Your surviving Spouse in (i) below) will be entitled to continue coverage on the same basis as if a qualifying event (B) had occurred.
    b) if You died before the occurrence of a qualifying event (C), Your surviving Spouse is entitled to lifetime coverage.
4. The end of a 36-month period following an event described in qualifying event (D), without regard to whether that occurrence is a qualifying event, or for any subsequent qualifying event;
5. The date You or Your dependents become covered under any other group coverage providing hospital, surgical or medical benefits, insured or self-insured, which does not contain any limitation with respect to any preexisting condition;
6. The date a Covered Person, other than those provided continuation of coverage under qualifying event (C) becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
7. The date the employer ceases to provide any group health coverage for its employees;
8. The date any premium for continuation of coverage is not timely paid; or

9. the date that the privilege for conversion to an individual or family policy is exercised.

Requirements

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

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

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

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

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

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

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

Extension for Disabled Covered Persons

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

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

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

Continued Health Coverage from a Prior Plan

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

STATE CONTINUATION OF COVERAGE PROVISIONS

Continuation of coverage under the Group Policy is available if the insurance on a person covered under such a policy ceases because of the termination of the person's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits. This provision shall not be applicable if the Group Policyholder is required by federal law to provide for continuation of coverage under its group health plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

The insured's present coverage shall continue under the policy for a period of twelve (12) months immediately following the date of the termination of the person's eligibility, without evidence of insurability, subject to the following requirements:

1. The application and payment for the extended coverage is made to the Group Policyholder within 31 days after issuance of the written notice, but in no event beyond the 60-day period following the date of the termination of the person's eligibility;
2. Each premium for such extended coverage is timely paid to the Group Policyholder on a monthly basis during the 12-month period;
3. The premium for continuing the group coverage shall be at the insurer's current rate applicable to the Group Policy plus any applicable administrative fee not to exceed two percent of the current rate;
4. Continuation shall only be available to an employee or member who has been continuously insured under the Group Policy during the entire three-month period immediately preceding termination of eligibility; and
5. Continuation shall not be available to an individual whose eligibility for coverage under the Group Policy ceased because the individual was discharged from employment by the Group Policyholder for gross misconduct. As used in this subdivision, "gross misconduct" means any conduct connected with the individual's work that would constitute misconduct under Section 60.2-618, including deliberately and willfully engaging in conduct evincing a complete disregard for the employer's workplace standards and policies.

The Group Policyholder shall provide each employee or other person covered under such a policy written notice of the availability of continuation of coverage and the procedures and timeframes for obtaining continuation of the Group Policy. Such notice shall be provided within fourteen (14) days of the policyholder's knowledge of the employee's or other Covered Person's loss of eligibility under the policy.

COORDINATION OF BENEFITS

Application

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

The benefits of this Plan:

1. Will pay first when this Plan is primary;
2. Will coordinate when another Plan is primary and This Plan is secondary. The benefits of This Plan coordinate so that they and the benefits payable under all other Plans do not total more than 100 percent of the Allowable Expenses during any Calendar Year; and
3. Will not exceed the benefits payable in the absence of other coverage.

Order of Benefit Determination Rules

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

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

   However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the primary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the Provider, if the custodial parent so requests.
5. Active/Inactive Service: The primary Plan is the Plan, which covers the person as a Covered Person who is neither laid off nor retired (or as that employee's Dependent). The secondary Plan is the Plan, which covers that person as a laid off or retired Covered Person (or as that Covered Person's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
6. 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 Covered Person as an employee or retiree or covering the Covered Person as a dependent of an employee 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 Paragraph (1) can determine the order of benefits.

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

Effect of Medicare

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

Coordination in this Plan's Benefits

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

Right to Receive and Release Information

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

Facility of Payment

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

Right of Recovery

If the amount of the payments made by KPIC is more than it should have paid, KPIC may recover the excess if related to payments made under any workers' compensation laws or federal or state programs, to the extent allowed by VA law.

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

Definitions Related to Coordination of Benefits

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

COORDINATION OF BENEFITS

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

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

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

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

Plan does not include any:

1. Individual or family policies or contracts.
2. Public medical assistance programs.
3. Group or group-type Hospital indemnity benefits of $100 per day or less.
4. School accident-type coverages.
5. Medical expense or medical payments insurance provided in conjunction with liability coverage.

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

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

Closed Panel Plan

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

- If the primary plan is a closed panel plan with no Out-of-Plan benefits and the secondary plan is not a closed panel plan, the secondary plan must pay or provide benefits as if it were primary when no benefits are available from the primary plan because the Covered Person used a non-panel Provider, except for emergency services that are paid or provided by the primary plan

- If, however, the two plans are closed panels, the two plans will coordinate benefits for services that are Covered Services for both plans, including emergency services, authorized referrals, or services from Providers that are participating in both plans. There is no COB if there is no covered benefit under either plan.

CLAIM PROVISIONS

All claims under This Plan will be administered by:

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

Questions about claims: For assistance with questions regarding claims filed with KPIC, please have Your ID Card available when You call 1-888-225-7202 (TTY 711) or You may write to the address listed above. Claim forms are available from Your employer.

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

Non-Participating Provider claims
If You receive services from a Non-Participating Provider, that Provider may file the claims on Your behalf. For emergency services and non-emergency Surgical or ancillary services provided by a Non-Participating Provider at a Participating Provider facility, benefits will be paid directly to the Non-Participating Provider. In all other instances; if You do no assign benefits, benefits will be paid to You. Under those circumstances, it is Your responsibility to apply the plan payment to the claim from such Non-Participating Provider.

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

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

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

Proof of Loss
Written proof of loss must be sent to Us at the address shown on the preceding page or Our Administrator within ninety (90) days after the date of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible, but in no event, later than one year from the time proof is otherwise required, except in the absence of legal capacity.

"Proof of Loss" means sufficient information to allow KPIC to decide if a claim is payable under the terms of the Group Policy. The information needed to make this determination may include but is not limited to: necessary

consent forms, releases and assignments, medical records, information regarding Provider services, information regarding medical necessity or other necessary information requested by KPIC.

Time for Payment of Benefits
In accordance with the terms of Your coverage, benefits will be paid immediately upon receipt of proper written Proof of Loss.

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

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

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

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

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

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 proof of loss was required to be filed.

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

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

If all of these conditions have been met, KPIC will:
1. Provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Policy;

2. Accept claim forms and requests for claim payment from the custodial parent; and
3. Make claim payments directly to the custodial parent for claims submitted by the custodial parent, subject to all the provisions stated in the Policy.
   Payment of claims to the custodial parent, which are made in good faith under this provision, will fully discharge KPIC's obligations under the Policy to the extent of the payment.

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

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

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

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

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

GENERAL PROVISIONS

Assignment
Payment of benefits under the Group Policy for treatment or services that are not provided, prescribed, or directed by a Health Plan Physician:

a. Are not assignable and thereby not binding on KPIC, unless previously approved by KPIC in writing;
b. Shall be made by KPIC, in its sole discretion, directly to the Provider or to the Insured Person or, Insured Dependent or, in the case of the Insured Person's death, to his or her executor, administrator, Provider, Spouse or relative.

When KPIC is presented with an assignment of benefits for Ambulance services, KPIC will make payment directly to the ambulance provider. When KPIC is presented with an assignment of benefits made to a dentist or oral surgeon by an Insured, KPIC will accept the assignment.

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

Incontestability
The validity of the policy shall not be contested, except for nonpayment of premiums, after it has been in force for two years from its date of issue.

No statement made by any person insured under the policy relating to his insurability or the insurability of his insured dependents shall be used in contesting the validity of the insurance with respect to which such statement was made:

1. After the insurance has been in force prior to the contest for a period of two years during the lifetime of the person about whom the statement was made; and
2. Unless the statement is contained in a written instrument signed by him.

This provision shall not preclude the assertion at any time of defenses based on the person's ineligibility for coverage under the policy or upon other provisions in the policy.

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

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

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

Entire Contract
The entire contract between the Policyholder and KPIC consists of the Group Policy, certificates, amendments or riders attached or incorporated by reference, the attached application of the Policyholder; and the applications of the Insured Employees. All statements made by the Policyholder or by the persons insured shall be deemed representations and not warranties. No statement made by the Policyholder or Insured Employees will be used to void insurance, reduce benefits, or in defense of a claim under the Group Policy, unless it is contained in a written application and the statement is furnished to the Policyholder, the person or to his beneficiary or personal representative.

ERISA CLAIMS AND APPEALS PROCEDURES

If Your employee benefit plan is covered by Title I of the Employee Retirement Income Security Act of 1974 (ERISA), the following claims and appeals procedures will apply to benefit claims arising under the Group Policy. The provisions below preempt any conflicting provisions in this Certificate to the extent that the conflicting provisions prohibit implementation of requirements under ERISA. To determine whether Your employee benefit plan is covered by ERISA, check with Your employer.

Definitions
For the purpose of this Section of the Certificate, the following definitions apply:

Adverse Benefit Determination (Denial) means either a failure or decision not to provide or make payment, in whole or in part, for a Claim for Benefits. It can be in the form of either a Pre-Service Claim Denial, Concurrent Care Claim Denial or Post Service Claim Denial that results in:

1. A reduction in benefits (other than by cancellation of the Group Policy);
2. A failure or refusal to cover an item or service;
3. A determination that an expense is Experimental or Investigational;
4. A determination that an expense is not Medically Necessary or appropriate.
5. A retroactive termination of Your membership (rescission) for a reason other than
   A failure to pay premiums or contributions toward the cost of coverage.

Benefit Determination means a decision, either positive or negative, concerning the claimant's right to receive benefits under a group health plan.

Claims Procedures means 1) procedures governing the filing and adjudication of benefit claims, whether Pre-Service Claims, Concurrent Care Claims, or Post-Service Claims; 2) notification of Benefit Determinations; and 3) appeals of a Denial.

Claim for Benefits means a request for plan benefits made by a claimant in accordance with Our Claims Procedures. Claims for Benefits include Pre-Service Claims, Concurrent Care Claims and Post-Service Claims.

Concurrent Care Claim means a request for approval of a benefit or treatment where the terms of the Group Policy condition continued receipt of the benefit, in whole or in part, on approval of the benefit in advance of continuing medical care. Concurrent care review requirements, explained elsewhere in this Certificate, apply to Concurrent Care Claims. Concurrent Care Claims can be either Urgent Care Claims or Non-urgent Care Claims.

Non-Urgent Care Claim means anything that is not an Urgent Care Claim.

Post-Service Claim means a Claim for Benefits involving the payment or reimbursement of costs for medical care that has already been received.

Pre-Service Claim means a request for approval of a benefit or treatment where the terms of the Group Policy condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. The Pre-Certification requirements, explained elsewhere in this Certificate (if applicable), apply to Pre-Service Claims. Pre-Service Claims can be either Urgent Care Claims or Non-urgent Care Claims.

Urgent Claim means a request for approval of benefits or treatment where delay could seriously jeopardize Your life, health or ability to regain maximum function, or would, in the opinion of a Physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without the services You are requesting.

The Claims Process (Initial Review)

A Benefit Determination will be made in accordance with the following rules:

1. Urgent Claims - We will notify You within twenty-four (24) hours of Our decision. We will also notify You within twenty-four (24) hours if We need additional information to determine such claims, or if You or Your representative failed to follow proper procedures that would result in a claim Denial. If additional information is requested, You will be allowed forty-eight (48) hours in which to provide such information. We will make a final determination for this type of claim within twenty-four (24) hours following the earlier of: a) receipt of the requested information from You; or b) the end of the period allowed for providing the information. Decisions regarding Urgent Care Claims will be communicated to You by telephone within twenty-four (24) hours. They will be confirmed in writing within three (3) calendar days of the initial decision.
2. Concurrent Care Claims for Ongoing Course of Treatment– We will make decisions involving an approved ongoing course of treatment, provided over a period of time, sufficiently in advance of limiting or ending treatment, when a course of treatment will be limited or ended early as a result of a concurrent claim review.
3. Concurrent Care Claims for Additional Treatment – We will make decisions involving a request for additional treatment, when a previously approved course of treatment is about to end, within twenty-four (24) hours following receipt of such a request, provided that You make this type of request at least twenty-four (24) hours prior to the time that treatment is scheduled to end. If the request for concurrent care review is urgent, such request will be handled like any other Urgent Claim.
4. Non-Urgent Pre-Service Care Claims – We will make decisions within a maximum of fifteen (15) calendar days after receipt of the Pre-certification request. 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 due to matters beyond Our control and notify You of the extension within the initial 15-day period. Any such notice will detail the circumstances requiring the extension and the date upon which We expect to render a decision on Your Claim for Benefits. If such an extension is necessary due to Your failure to submit any necessary information, the notice of extension will describe the required information.
5. Post-Service Claims – We will adjudicate such claims within an initial period of thirty (30) calendar days. 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 due to matters beyond Our control and notify You of the extension within the initial 30-day period. Any such notice will detail the circumstances requiring the extension and the date upon which We expect to render a decision on Your Claim for Benefits. If such an extension is necessary due to Your failure to submit any necessary information, the notice of extension will describe the required information.

You must respond to requests for additional information within forty-five (45) calendar days or We will make Our decision on Your Claim for Benefits based upon the information We have available to Us at that time. In the case of an Urgent Care Claim, You must respond to Our request for information within forty-eight (48) hours.

We will allow You to review the claim file and to present evidence and testimony in support of Your claims request.

We will notify You when We approve or deny a Claim for Benefits. If We deny Your Claim for Benefits the notification will include the following information:

1. Information sufficient to identify the claims being denied including but not limited to:
   a. The date of service;
   b. The name of the Provider;
   c. Claim amount, if applicable;
2. The specific reason or reasons for the Denial;

3. Reference to the specific provisions in Your Certificate on which the Denial is based;
4. A description of any additional material or information needed for Us to reevaluate Your Claim for Benefits;
5. An explanation of why such material or information is necessary in order for Us to approve or deny Your Claim;
6. A description of the review (appeal) procedures and the time limits applicable to such procedures;
7. A statement of Your rights under section 502(a) of ERISA following a Denial on Your appeal.
8. If any internal rule, guideline, protocol or other similar criterion was relied upon in making the Denial, an offer to provide the rule;
9. If the Denial was based upon Medical Necessity, experimental treatment or similar exclusions or limitations, an offer to provide the specific basis for the Denial;
10. In the case of a Denial, a description of the available appeals process.

The Appeals Process

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

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

As part of the appeals process, We will allow You to review the claim file and to present evidence and testimony in support of Your claim.

Pending the outcome of an Appeal, You will continue to receive benefits. Any ongoing course of treatment during the appeals process will not be reduced or terminated without providing you an advance notice and an opportunity for advance review and an opportunity to respond prior to the mailing of such notice.

You must either mail Your Appeal to Us, or fax Your Appeal to Us at:

Pre-Service, Concurrent and Expedited Medical Review Appeals

Permanente Advantage
Appeals Department
8954 Rio San Diego Dr., 4th Floor, Ste 406
San Diego, CA 92108
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

ERISA CLAIMS AND APPEALS PROCEDURES

Post-Service Appeals

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

We will generally notify You of Our decision on Your appeal within the following time frames:

1. For Urgent Claims, We will provide You with Our decision within seventy-two (72) hours after We receive Your request for an appeal of a Denial.
2. For Pre-service Claims, We will provide You with Our decision within thirty (30) days after We receive Your request for an appeal of a Denial.
3. For Post-service Claims, We will provide You with Our decision within sixty (60) days after We receive an appeal of a Denial.

Our appeal Decision will exhaust Your internal appeal rights with respect to that Denial. Contact Us at 877- 847-7572 with any questions about Your appeal rights.

Prior to the mailing of any notice required of final internal Adverse Benefit Determination, we will provide You with any new additional evidence considered, relied upon or generated by us and the rationale of our decision. This notice will be sent to You as soon as possible to give You sufficient time and the opportunity to respond prior to the mailing of such notice.

We will notify You when We approve or deny Your appeal. If We deny Your appeal, the notification will include the following information:

1. Information sufficient to identify the claims being denied including but not limited to:
   a) The date of service;
   b) The name of the Provider;
   c) Claim amount, if applicable;
2. The specific reason or reasons for the Denial;
3. Reference to the specific provisions in the Group Policy on which the Denial was based;
4. Your right to obtain reasonable access to, and copies of, all documents, records and other information relevant to Your Claim for Benefits;
5. An explanation of any procedures for You to follow to request a voluntary level of appeal, if applicable;
6. A statement of Your rights under section 502(a) of ERISA following a Denial on Your appeal;
7. If any internal rule, guideline, protocol or other similar criterion was relied upon in making the Denial, an offer to provide the rule, guideline, protocol or similar criterion;
8. If the Denial was based upon Medical Necessity, experimental treatment or similar exclusions or limitations, an offer to provide the specific basis for the Denial.

If You are not satisfied with Our decision after You have exhausted the appeals process, Your remaining remedies may include:

1. A voluntary review of Your Claim for Benefits by Us;
2. The right to bring suit in Federal Court under Section 502(a) of ERISA;
3. Additional rights under state law, including the right to pursue independent external review when the following has occurred:
   a) Covered Person has completed standard internal appeals process;
   b) Covered Person has not received timely decision from KPIC;
   c) Expedited internal appeals of Adverse Determination has been requested; or
   d) KPIC waives exhaustion requirement;

4. Voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact Your local U.S. Department of Labor Office and Your State insurance regulatory agency;
5. If You believe that health care services have been improperly denied, modified, or delayed, You may have the right to an independent medical review. For more information about how to obtain this review, please call KPIC at 1-888-225-7202 (TTY 711).

Help With Your Appeal

If You have any questions regarding an appeal or grievance concerning the health care services that You have been provided that have not been satisfactorily addressed by Your plan, You may contact the Office of the Managed Care Ombudsman for assistance:

State Corporation Commission
Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218
www.scc.virginia.gov/boi
Toll free 1-877-310-6560; Fax# (804) 371-9944

You may call KPIC to make a complaint at 1-888-225-7202 (TTY 711) or You may contact the Virginia Department of Health, Office of Licensure and Certification Complaint Unit:

Complaint Intake
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1463
Toll Free: (800) 955-1819
Richmond Metro Area: (804) 367-2106
Fax: (804) 527-4503
Email: OLC-Complaints@vdh.virginia.gov

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

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, California 94612
(877) 847-7572

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Virginia Bureau Of Insurance
Tyler Building, 1300 E. Main Street
Richmond, VA 23219
1-877-310-6560 (national toll-free number)
1-800-552-7945 (Virginia Only)
804-371-9741 (Bureau of Insurance main phone)

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company, or the Bureau of Insurance, have Your policy number available.

Important Notice:
KPIC is a Managed Care Health Insurance Plan (MCHIP) licensee subject to regulation in the Commonwealth of the state of Virginia by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

The Commonwealth of Virginia is the service area.

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, California 94612
GC-OOA-PPO-VA 2023 (NGF)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network facility, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Insurers are required to tell you which providers and facilities are in their networks. Providers and facilities must tell you with which provider networks they participate. This information is on the insurer's, provider's or facility's website or on request.

You're protected from balance billing for:

Emergency services

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

Certain services at an in-network facility

When you get services from an in-network facility, certain providers there may be out-of- network. In these cases, the most those providers can bill you is your plan's in-network cost- sharing amount. This applies to emergency medicine, laboratory, surgeon and assistant surgeon services, and

professional ancillary services such as anesthesia, pathology, radiology, neonatology, hospitalist, or intensivist services. These providers **can't** balance bill you and **can't** ask you to give up your protections not to be balance billed.

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

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

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

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

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and in-network out-of-pocket limit.

If you think you've been wrongly billed, call the federal agencies responsible for enforcing the federal balance billing protection law at: **1-800-985-3059** and/or file a complaint with the Virginia State Corporation Commission Bureau of Insurance at: scc.virginia.gov/pages/File-Complaint-Consumers or call **1-877-310-6560**.

Visit cms.gov/nosurprises/consumers for more information about your rights under federal law.

Consumers covered under (i) a fully-insured policy issued in Virginia, (ii) the Virginia state employee health benefit plan; or (iii) a self-funded group that opted-in to the Virginia protections are also protected from balance billing under Virginia law. Visit scc.virginia.gov/pages/Balance-Billing-Protection for more information about your rights under Virginia law.