Kaiser Permanente Insurance Company

California Comprehensive Major Medical (PPO) for Large Groups Certificate of Insurance

This policy and the application of the employer constitute the entire contract between the parties, and any statement made by the employer shall, in the absence or fraud, be deemed a representation and not a warranty.

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverage funded through a Group Insurance Policy issued to Your group by Kaiser Permanente Insurance Company. It becomes Your Certificate of Insurance 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. Any amendment to the Group Policy will not affect a claim initiated before the amendment takes effect. The Group Policy is available for inspection at the Policyholder's office.

KPIC will provide notice to the Policyholder of the following actions no later than 60 days prior to the effective date of the action: termination of the Group Policy, increasing premiums, reducing or eliminating benefits, or restricting eligibility for coverage. The Policyholder will provide the notice to the Insured.

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

In this Certificate, Kaiser Permanente Insurance Company will be referred to as: "KPIC", "we", "us", or "our". The Insured Employee named in the attached Schedule of Coverage will be referred to as: "You", or "Your".

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

Language Assistance
SPANISH (Español): Para obtener asistencia en Español, llame al 1-(800)-788-0710.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog, tumawag sa 1-(800)-788-0710.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-(800)-788-0710.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-(800)-788-0710.

Some hospitals and other providers do not provide one or more of the following services that may be covered under Your policy and that You or Your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before You become a Policyholder or select a network provider. Call Your prospective doctor or clinic, or call the Kaiser Permanente Insurance Company at **1-800-788-0710 (TTY users call 711)** for assistance to ensure that You can obtain the health care services that You need.

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

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.

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) does not discriminate based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). We can provide no cost aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats; large print, audio, and accessible electronic formats. We also provide no cost language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages. To request these services, please call **1-800-464-4000** (TTY users call **711**).

If you believe that KPIC failed to provide these services or there is a concern of discrimination based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability you can file a complaint by phone or mail with the KPIC Civil Rights Coordinator. If you need help filing a grievance, the KPIC Civil Rights Coordinator is able to help you.

KPIC Civil Rights Coordinator
Grievance 1557
5855 Copley Drive, Suite 250
San Diego, CA 92111
1-888-251-7052

You may also contact the California Department of Insurance regarding your complaint.

By Phone:
California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

By Mail:
California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Electronically:
www.insurance.ca.gov

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

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INTRODUCTION

This Certificate describes the KPIC Participating (Preferred) Provider Organization (PPO).

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. The provider You select can affect the dollar amount You must pay in connection receiving Covered Services.

Please refer to the General Limitations and Exclusions section of this Certificate for a description of the plan's general limitations and exclusions. Likewise, the Schedule of Coverage contains specific cost sharing amounts when receiving care from Participating Providers and Non-participating Providers and limitations for specific benefits.

For information on how to make a complaint regarding timely access to care please refer to the ACCESS TO HEALTH CARE section in this Certificate.

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

Participating Provider Option (PPO): This Plan affords You the value of access to a Participating Provider network of Physicians and Hospitals. These providers have signed an agreement to provide care for Covered Persons at special rates. How You use this option is up to You. The decisions You make when You choose Your health care provider affect the dollar amount You must pay. In most cases, a greater portion of Your health care bill is covered and payable when You select a PPO provider.

Coverage under the Group Policy KPIC pays for Covered Services received from either Participating Providers or Non-Participating Providers.

To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory. You may visit KPIC's contracted provider network web site at: www.Multiplan.com/Kaiser to view KPIC's Participating Provider directory or to request a printed copy at no cost. Additionally, a current printed listing of KPIC's Participating Providers directory is available at no cost to You by calling the phone number listed on Your ID card or by writing to: KPIC Provider Relations Manager, 300 Lakeside Drive, Room 1335D, Oakland, CA 94612. If a Covered Person receives care from a Non-participating Provider, benefits under the Group Policy will be payable at the Non-participating Provider tier.

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 provided.

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

This Certificate includes a Schedule of Coverage that will give You a quick overview of Your coverage. It is very important, however, that You read Your entire Certificate of Insurance for a more complete description of Your coverage and the exclusions and limitations under this medical insurance plan.

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

Who Can Answer your Question?

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

For Coverage:	**1-800-788-0710 (TTY users call 711)**
Eligibility, name or address change:	**1-800-554-3099**

Or You may write to the Administrator:

NTT DATA Services PO Box 261155
Plano, TX 75026

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

PPO plans only - 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 Precertification of Covered Services or Utilization Review please call the number listed on Your ID card or: 1-800-448-9776.

You may contact the California Department of Insurance at the following telephone number, address, or website. The Department of Insurance should be contacted only after discussions with KPIC, or its agent or other representative:

California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

The Covered Person may write the California Department of Insurance at:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

SCHEDULE OF COVERAGE

PPO PLAN

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

You will be responsible for a larger portion of Your bill and Your out-of-pocket maximum may be more if You receive care from a Non-Participating Provider.

Payments under the Plan 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.)

COVERED PERSONS:	Employee and Dependents (if elected)
Dependent Child Age Limit:	26 unless disabled

	PARTICIPATING PROVIDER TIER	**NON-PARTICIPATING PROVIDER TIER**
MAXIMUM BENEFIT WHILE INSURED:	None	

Note: Charges in excess of the Maximum Allowable Charge or any charge over and beyond any benefit limit will not be applied toward satisfaction of the Deductible per Accumulation Period or the Out-of-Pocket Maximum.

Essential Health Benefits, as defined under the Policy are not subject to a Maximum Benefit While Insured or any dollar Benefit Maximum specified under the Policy. Benefits listed below are considered Essential Health Benefits, unless specifically noted otherwise.

ACCUMULATION PERIOD:	Calendar Year	
OUT-OF-POCKET MAXIMUMS per Accumulation Period:		
Individual Out-of-Pocket Maximum:	$6,000	$12,000
Family Out-of-Pocket Maximum:		
2 or more-Member Family	$12,000	$24,000

DEDUCTIBLES per Accumulation Period:
The Deductible per Accumulation Period applies to all Covered Charges incurred by a Covered Person during the Accumulation Period, unless otherwise indicated in this Schedule of Coverage.

Individual Deductible Maximum:	$1,500 [1]	$3,000
Family Deductible Maximum:		
2 or more-Member Family	$3,000 [1]	$6,000

You must pay Covered Charges for Services You received in a Calendar Year until You reach the Deductible amount shown here, unless "Deductible does not apply" is noted on the Service in this Schedule. This Policy will not begin to pay for your health care expenses until after Covered Charges exceed the Deductible amount. You will have to pay for all of your health care bills until these bills exceed your Deductible amount.

NOTE: Covered Charges applied to satisfy the Out-of-Pocket Maximum at the Participating Provider tier will not be applied towards satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider tier. Likewise, Covered Charges applied to satisfy the Out-of-Pocket Maximum at the Non-Participating Provider tier will not be applied towards satisfaction of the Deductibles or the Out-of-Pocket Maximum at the Participating Provider tier.

Covered Charges applied to satisfy Deductibles at the Participating Provider tier will not be applied towards satisfaction of Deductibles at the Non-Participating Provider tier. Likewise, Covered Charges applied to satisfy Deductibles at the Non-Participating Provider tier will not be applied towards satisfaction of the Deductibles at the Participating Provider Tier.

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

[1] Deductibles, Coinsurance and Copayments do not apply to Preventive Benefits required under the Affordable Care Act (ACA) at the Participating Provider tier. Preventive Benefits required under the Affordable Care Act (ACA) that are received at the Non-Participating Provider tier, however, are subject to Deductibles, Coinsurance and Copayments.

IMPORTANT: Read the section in Your Certificate regarding Precertification carefully. Benefits payable will be reduced by a $500 penalty, if You fail to obtain Precertification. Such Penalty or additional Deductible does not count toward satisfaction of the Out-of-Pocket Maximum.

	YOUR COST SHARE	
COVERED SERVICES	**PARTICIPATING PROVIDER TIER**	**NON-PARTICIPATING PROVIDER TIER**
Hospital Inpatient Care (including any Inpatient Hospital Care in connection with Birth Services)**:	30% (Subject to a per admission Copayment of $1,000)	50% (Subject to a per admission Copayment of $1,500)
Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification. Precertification is not required for emergency admissions, however, You or Your attending Physician must notify the Medical Review Program within 24 hours or as soon as reasonably possible.		
Skilled Nursing Facility Care:	30% (Subject to a per admission Copayment of $1,000)	50% (Subject to a per admission Copayment of $1,500)
	Combined Maximum of 60 days per Benefit Period	

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.		
Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.		
Urgent Care (including any Urgent Care in connection with Birth Services)**:	30%	50%
Provider Office Visits (including any Provider Office Visits in connection with Birth Services)**:		
Primary/Specialty Care Physician	$40 Copayment [1] Deductible does not apply	50% Deductible does not apply
Emergency Care or Emergency Services:	30% (subject to a $100 Copayment per visit, waived if admitted)	30% (subject to a $100 Copayment per visit, waived if admitted)
Cost Share for Emergency Care Services obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier and the Non-Participating Provider tier.		
Ambulance Services:		
Emergency Ambulance Services:	50%	50%
Cost Share for Emergency Care Services obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier and the Non-Participating Provider tier.		
Medically Necessary Non-Emergency Ambulance Services:	50%	50%
Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.		
Home Health Care Services:	20% Deductible does not apply Combined Maximum of 100 visits per Accumulation Period	20% Deductible does not apply
Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.		
Hospice Care:	30%	50%

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Outpatient Surgery:	30% (subject to a $100 Copayment per surgical encounter)	50% (subject to a $150 Copayment per surgical encounter)

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

Lab Tests (including any Lab Tests in connection with Birth Services)**:	30% [1]	50%

Some services require Precertification, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

X-Ray and Diagnostic Testing (including any X-Ray and Diagnostic Testing in connection with Birth Services)**:	30% [1]	50%

Some services require Precertification, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

Imaging (CT/PET scans and MRIs) (including any Imaging Testing in connection with Birth Services)**:	30% [1]	50%

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

Prosthetics and Orthotics:	30%	50%

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

Base Durable Medical Equipment and Special Footwear (including equipment and supplies, not listed below, for the management and treatment of diabetes) (Base Durable Medical Equipment includes, but is not limited to: canes, crutches; and tracheotomy tubing and supplies):	30%	50%

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

Supplemental Durable Medical Equipment (Supplemental Durable Medical Equipment includes, but is not limited to: oxygen; wheelchairs and hospital beds):	30% Deductible does not apply Combined Benefit Maximum of $2,000 per Accumulation Period	50% Deductible does not apply

This benefit is not considered an Essential Health Benefit. Your Cost Share for this benefit does not apply towards satisfaction of the Out of Pocket Maximum.

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.		
Diabetes equipment and supplies including: infusion set and syringe with needle for external insulin pump; testing strips; and lancets. (See General Benefits section of the Certificate of Insurance for a complete list of covered diabetes equipment and supplies):	30%	30% of Actual Billed Charges
Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.		
Diabetic Day-care Management Benefit:	No Charge Deductible does not apply	50%
Allergy Testing and Treatment (administered during an office visit):	30%	50%
Rehabilitation Services:		
Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.		
Rehabilitative Outpatient Therapy Services (physical therapy, occupational therapy, speech therapy, and pulmonary therapy)	30%	50%
Multidisciplinary Rehabilitation Care:		
Inpatient:	30% (Subject to a per admission Copayment of $1,000)	50% (Subject to a per admission Copayment of $1,500)
Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.		
Outpatient:	30%	50%

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Habilitation Services: *Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.*		
Habilitative Outpatient Therapy Services (physical therapy, occupational therapy, speech therapy and pulmonary/ respiratory therapy)	30%	50%
Outpatient Therapy Services (including Physical, Speech, Occupational, and Respiratory Therapy) in connection with the treatment of Pervasive Developmental Disorder or Autism:		
Individual Outpatient visits:	$40 Copayment Deductible does not apply	50% Deductible does not apply
Group Outpatient visits:	$20 Copayment Deductible does not apply	50% Deductible does not apply
Mental Health (including Severe Mental Illness of a person of any age and Serious Emotional Disturbances of a Child) and Care for Substance Use Disorder Benefits:		
Outpatient office visits:		
Mental Health or Substance Use Disorder Individual Outpatient visits:	$40 Copayment Deductible does not apply	50% Deductible does not apply
Mental Health or Substance Use Disorder Group Outpatient visits:	$20 Copayment Deductible does not apply	50% Deductible does not apply
Other Outpatient items and services (other than office visit services:		
Mental Health intensive outpatient programs:	30%, not to exceed $40 Deductible does not apply	50% Deductible does not apply
Mental Health partial hospitalization	30%, not to exceed $40 Deductible does not apply	50% Deductible does not apply
Outpatient reconstructive surgery and administered hormones for treating gender dysphoria	30%, not to exceed $40 Deductible does not apply	50% Deductible does not apply

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Substance Use Disorder intensive outpatient programs:	30%, not to exceed $40 Deductible does not apply	50% Deductible does not apply
Substance Use Disorder day treatment programs:	30%, not to exceed $40 Deductible does not apply	50% Deductible does not apply
Behavioral Health Treatment Program for Pervasive Development Disorder or Autism (including treatment provided in the home):	30%, not to exceed $40 Deductible does not apply	50% Deductible does not apply
Inpatient:	30% (Subject to a per admission Copayment of $1,000)	50% (Subject to a per admission Copayment of $1,500)

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification. Precertification is not required for emergency admissions, however, You or Your attending Physician must notify the Medical Review Program within 24 hours or as soon as reasonably possible.

Fertility Treatment (except in vitro):	30% Deductible does not apply Combined Maximum of $1,000 per Accumulation Period. Prescribed drugs filled at MedImpact pharmacy are not subject to the dollar maximum.	50% Deductible does not apply

This benefit is not considered an Essential Health Benefit. Your Cost Share for this benefit does not apply towards satisfaction of the Out of Pocket Maximum.

Screening and treatment of Phenylketonuria (PKU):	Same Cost Share as Covered Services for any other Sickness based upon setting and type of provider.	Same Cost Share as Covered Services for any other Sickness based upon setting and type of provider.

Some services require Precertification, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

Transplant Services:	30%	50%

Precertification is required, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

Second Medical Opinion:	$40 Copayment Deductible does not apply	50%

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Other Covered Services:	30%	50%

Some services require Precertification, please refer to the Precertification Section in Your Certificate of Insurance. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

PREVENTIVE CARE: [1]

Preventive Care Exams and Services (see Preventive section of the Certificate of Insurance for a complete list of these ACA Preventive Benefits)	No Charge Deductible does not apply	50% Deductible does not apply
Exams (including routine prenatal visits and first postnatal visit):	No Charge Deductible does not apply	50% Deductible does not apply
Screenings: Preventive Lab, X-ray and colorectal cancer screening and other screenings listed in the General Benefits section under Preventive Care Exams and Services.	No Charge Deductible does not apply	50% Deductible does not apply
Health Promotion:	No Charge Deductible does not apply	50% Deductible does not apply
Disease Prevention:	No Charge Deductible does not apply	50% Deductible does not apply
Family Planning including female sterilization, patient education and counseling:	No Charge Deductible does not apply	50% Deductible does not apply
Prescribed Contraceptive drugs (obtained at a Participating Pharmacy):	No Charge Deductible does not apply (must be obtained at a Participating Pharmacy)	
Prescribed Tobacco Cessation drugs (obtained at a Participating Pharmacy):	No Charge Deductible does not apply (must be obtained at a Participating Pharmacy)	

Other Covered Preventive Care:

Unless, otherwise indicated, the following Preventive Benefits may be subject to Deductible (see Preventive section of the Certificate of Insurance for a complete list of these Other Preventive Benefits)

Routine Nursery Care and Physician charges for a newborn while the mother is confined:	30%	50%

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Adult Preventive screening:	No Charge Deductible does not apply	50% Deductible does not apply
Adult Routine Physical Examinations:	No Charge Deductible does not apply Limited to one exam in any 12-month period of coverage	Not Covered
Other Hearing screenings:	No Charge Deductible does not apply	Not Covered
Other Family Planning, such as vasectomy, elective abortion and fertility testing and counseling:	$40 Copayment Deductible does not apply	50%
AIDS Vaccine:	No Charge Deductible does not apply	50% Deductible does not apply
Prenatal alpha-fetoprotein screening including services though participation in the California Prenatal Screening Program:	No Charge Deductible does not apply	No Charge Deductible does not apply
Health Education:	No Charge Deductible does not apply	50%
FDA approved tobacco cessation prescription or over-the-counter medications by a licensed health care professional authorized to prescribe drugs for women who are pregnant:	No Charge Deductible does not apply	50% Deductible does not apply
Iron deficiency anemia screening for pregnant women:	No Charge Deductible does not apply	50% Deductible does not apply
OPTIONAL BENEFITS:		
Chiropractic and Acupuncture Services: *Chiropractic Services are not considered an Essential Health Benefit. Your Cost Share for Chiropractic Services does not apply towards satisfaction of the Out of Pocket Maximum.*	Not Covered	Not Covered
Foreign Travel Immunization:	Not Covered	Not Covered
Vision Care: *Vision Care for Covered Person age 19 and over is not considered an Essential Health Benefit. Your Cost Share for this benefit does not apply towards satisfaction of the Out of Pocket Maximum.*	Not Covered	Not Covered

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER PARTICIPATING (MedImpact) PHARMACY TIER	NON-PARTICIPATING PROVIDER TIER NON-PARTICIPATING PHARMACY TIER
Outpatient Prescription Drug Benefit:		
Tier 0: Preventive Drugs: Required under the Affordable Care Act (ACA)	No Charge Deductible does not apply	Not Covered
Tier 1: Generic Drugs:	$15 Copayment per prescription Deductible does not apply	Not Covered
Tier 2: Brand Name Drugs:	$40 Copayment per prescription Deductible does not apply	Not Covered
Tier 3: Specialty Drugs:	30%, not to exceed $200 per prescription Deductible does not apply	Not Covered
DME Other pharmacy items: Disposable blood glucose and ketone urine test strips; blood glucose monitors; lancets and lancet puncture devices; pen delivery systems for the administration of insulin; visual aids excluding eyewear to assist in insulin dosing; and, peak flow meters.	30% Deductible does not apply	Not Covered
Maximum Daily Supply:	30 days*	

**FDA-approved self-administered hormonal contraceptive drugs are covered when obtained at a Participating Pharmacy or through the mail order program. If so prescribed by the prescribing provider, a maximum of a 12-month supply of the self-administered hormonal contraceptive drug may be obtained at one time.*

You or Your prescribing physician may request that the pharmacist dispense a partial quantity of the prescribed amount when filling a prescription for an oral, solid dosage Schedule II controlled substance. Your Cost Share will be prorated based on the partial amount that You obtain.

This Outpatient Prescription Drug Benefit uses an open formulary. Unless specifically excluded under the Plan, all FDA-approved drugs are part of this Plan's open formulary. The formulary consists of generic and preferred and non-preferred brand drugs including specialty drugs.

The Outpatient Prescription Drug benefit is considered an Essential Health Benefit. Copayments for outpatient prescription drugs covered under the Outpatient Prescription Drug benefit that are obtained at a Participating Pharmacy will accumulate to Your Out of Pocket Maximum. Outpatient Prescription Drug benefit that are obtained at a Participating Pharmacy are not subject to, nor do they contribute towards, satisfaction of the Deductible per Accumulation Period.

The Copayment or Coinsurance charged for covered prescribed orally administered anti-cancer drugs shall be, as applicable, the Brand Name or Generic drug Copayment or Specialty drug coinsurance. The Copayment or Coinsurance charged for such drugs shall not exceed $200 for a 30-day supply.

If the pharmacy's retail price for a covered Outpatient Prescription Drug is less than applicable Copayment, You are not required to pay more than the retail price at the point-of-sale, Your payment will apply to Deductible, if any, that applies to Outpatient Prescription Drugs and will contribute towards the satisfaction of the Out-of-Pocket Maximum.

Specialty drugs are limited to a 30-day maximum supply and are not available under the mail order service.

Mail Order Service
Copayments payable for Mail Order service is 2 times the corresponding single Copayment per prescription amount shown above for up to a 100-day supply.

[1] Deductibles, Coinsurance and Copayments do not apply to Preventive Benefits required under the Affordable Care Act (ACA) at the Participating Provider tier. Preventive Benefits required under the Affordable Care Act (ACA) that are received at the Non-Participating Provider tier, however, are subject to Deductibles, Coinsurance and Copayments.

**In accordance with California Insurance Code section 10119.5 other types of Birth Services not specifically listed in this SOC are covered at the same Cost Share as for any other covered medical condition. For example, a Medically Necessary non-preventive Lab test in connection with Birth Services is covered at the Cost Share listed for Lab Tests.

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: 1) a period of time of not less than twelve (12) months that is available to the Covered Person to satisfy the Deductible or Out-of-Pocket Maximum under the Group Policy; and 2) a period of time applicable to the Benefit Maximums, if any, under the Group Policy, such as visit, day and dollar limits. The Accumulation Period is set forth in the Schedule of Coverage.

Administrator means NTT DATA Services, PO Box 261155, Plano, TX 75026. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior notice. Neither KPIC nor its Administrator is the administrator of the Policyholder's employee benefit plan as that term is defined under Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA) as then constituted or later amended.

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

Alcohol or Substance Use Disorder means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the person's social, psychological, or physical adjustment to common problems on a recurring basis. Substance Use Disorder does not include addiction to foods.

Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:

(A) The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.

(B) The treatment is provided under a Treatment Plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:

- (i) A Qualified Autism Service Provider.
- (ii) A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
- (iii) A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.

(C) The Treatment Plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The Treatment Plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

- (i) Describes the patient's behavioral health impairments to be treated.
- (ii) Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
- (iii) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
- (iv) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

(D) The Treatment Plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The Treatment Plan shall be made available to KPIC upon request.

GENERAL DEFINITIONS

Benefit Maximum means a maximum amount of benefits that will be paid by KPIC for a specified type of Covered Charges incurred during a given period of time. The charges to which a Benefit Maximum applies are not considered Covered Charges after the Benefit Maximum has been reached. Covered Charges in excess of the Benefit Maximum will not be applied toward satisfaction of the Deductible and Out-of-Pocket Maximum.

Birth Center means an outpatient facility which:
1. complies with licensing and other legal requirements in the jurisdiction where it is located;
2. is engaged mainly in providing a comprehensive Birth Services program to pregnant individuals who are considered normal to low risk patients;
3. has organized facilities for Birth Services on its premises;
4. has Birth Services performed by a Physician specializing in obstetrics and gynecology, or at his or her direction, by a Licensed Midwife or Certified Nurse Midwife; and
5. has 24-hour-a-day Registered Nurse services.

Birth Services means professional and hospital services for monitoring and managing pregnancy before birth, during delivery and after birth. Birth Services includes prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures. Benefits payable for the treatment of complications of pregnancy will be covered on the same basis as Sickness.

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

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.

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

Coinsurance means a percentage of charges that You must pay when You receive a Covered Service as described under the **GENERAL BENEFITS** section and the Schedule of Coverage. Coinsurance amount is applied against the Covered Charge.

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

Complications of Pregnancy means any disease, disorder or conditions whose diagnoses are distinct from pregnancy, but are adversely affected by or are caused by pregnancy, and: (a) require Physician prescribed supervision; and (b) result in a loss or expense which, if not related to pregnancy, would be a Covered Service under the applicable provisions of this Group Policy.

Comprehensive Rehabilitation Facility means a facility primarily engaged in providing diagnostic, therapeutic, and restorative services through licensed health care professionals to injured, ill or disabled

individuals. The facility must be accredited for the provision of these services by the Commission on

Accreditation for Rehabilitation Facilities or the Professional Services Board of the American Speech-Language Hearing Association.

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

Copayment means the predetermined amount, as shown in the Schedule of Coverage, which is to be paid by the Insured for a Covered Service, usually at the time the health care is rendered. All Copayments applicable to the Covered Services are shown in the Schedule of Coverage.

Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.

Cost Share means: 1) Coinsurance; 2) Copayment; and 3) Deductible and 4) any benefit specific deductible incurred by a Covered Person.

Covered Charge or Covered Charges means the Maximum Allowable Charge(s) 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. Covered Person is sometimes referred to as "member".

Covered Services means those services which a Covered Person is entitled to receive pursuant to the Group Policy and are defined and listed under the section entitled General Benefits.

Creditable Coverage means

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

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

Deductible means the amount of Covered Charges a Covered Person must incur, while insured under the Group Policy, before any benefits will be payable during that Accumulation Period. The Deductible will apply to each Covered Person separately and must be met within each Accumulation Period. When Covered Charges equal to the individual Deductible are incurred during the Accumulation Period and are submitted to Us, the Deductible will have been met for that Covered Person. Once Covered Charges applied toward a family member's individual Deductible equal the family Deductible amount, the family.

Deductible will be satisfied for all family members for that Accumulation Period. Benefits will not be payable for Covered Charges applied to the Deductible. Covered Charges applied to satisfy the Deductible will not

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.

Dependent means only: a) Your spouse or Domestic Partner; and b) Your child who is of an age within the Age Limits for Dependent Children shown in the **ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE** section, or is a disabled child of any age. The word "**child**" includes: Your step- child; adopted child; child of Your Domestic Partner; or any other child for whom You or Your spouse or Domestic Partner are the court-appointed guardian.

Domestic Partner is an adult in a domestic partnership. A Domestic Partner may be regarded as Dependent if: a) the domestic partnership meets all of the domestic partnership requirements under California law, or was validly formed in another jurisdiction; or b) the domestic partnership is in accord with your Group's eligibility requirements, if any, that are less restrictive than California law.

Durable Medical Equipment means 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; and
4. approved for coverage under Medicare, except for apnea monitors; or
5. is otherwise required by law.

Supplies necessary for the effective use of Durable Medical Equipment are also considered Durable Medical Equipment, such as oxygen or drugs dispensed by Durable Medical Equipment vendors for use in Durable Medical Equipment items. However, drugs obtained at pharmacies are considered under the Outpatient Prescription Drug benefit even when obtained for use in a Durable Medical Equipment item.

Emergency Care or Emergency Services: All of the following with respect to an Emergency Medical Condition:

- 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 ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient

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

- Placing the person's health (or, with respect to a pregnant woman in active labor, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Essential Health Benefits means the general categories of benefits including the items and services covered within these categories of benefits that comprise an essential health benefit package as defined under California Insurance Code section 10112.27 and the Patient Protection and Affordable Care Act of 2010 (ACA) as then constituted or later amended.

Expense Incurred or Expenses Incurred means Expenses Incurred for Covered Services. An expense is deemed incurred as of the date of the service, treatment or purchase, giving rise to the charge or charges.

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

External Prosthetics and Orthotics means:
1. An External Prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Examples of external prosthetics includes artificial limbs, parental and enteral nutrition, urinary collection and retention systems, colostomy bags and other items and supplies directly related to ostomy care and eyewear after cataract surgery or eyewear to correct aphakia. Other examples are prosthetic devices incident to a mastectomy, including custom-made prostheses when medically necessary; adhesive skin support attachment for use with external breast prosthesis; and brassieres for breast prostheses and Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect. Supplies necessary for the effective use of prosthetic device are also considered prosthetics.
2. Orthotics that are rigid or semi rigid external devices. They must: a) support or correct a defective form or function of an inoperative or malfunctioning body part; or b) restrict motion in a diseased or injured part of the body. Orthotics do not include casts.

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

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

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

Home Health Care Agency means a public or private agency that is engaged in arranging and providing nursing services, Home Health Services and other therapeutic services in the home. The agency must be licensed as such (or if no license is required, approved as such) by a state department or agency having authority over Home Health Agencies. Home Health Services may consist of, but are not limited to the following:
1. part-time or intermittent skilled nursing services provided by a Registered Nurse or Licensed Vocational Nurse;
2. part-time or intermittent home health aide services which provide supportive services in the home under the supervision of a Registered Nurse or a physical, speech or occupational therapist;
3. physical, occupational or speech therapy; and
4. medical supplies, drugs and medicines prescribed by a Physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the Group

Policy if the Covered Person had remained in the Hospital.

Home Health Care means services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists when:

1. You are substantially confined to Your home (or a friend's or relative's home).
2. Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide).

A Physician determines that it is feasible to maintain effective supervision and control of your care in Your home and that the services can be safely and effectively provided in your home.

Hospice Care means a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of an insured experiencing the last phases of life due to a terminal illness. The care must be provided: 1) directly; or 2) on a consulting basis with the patient's Physician or another community agency, such as a visiting nurses' association. For purposes hereof, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 12 months.

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

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

The term **"Hospital"** will also include a psychiatric health facility which: a) is licensed by the California State Department of Health Services; and b) operates under a waiver of licensure granted by the California State Department of Mental Health.

Injury means bodily damage or harm of a Covered Person.

Insured Dependent means a Dependent family member of an Insured Employee who is enrolled as such under the Group Policy. An Insured Dependent may include but not limited to Your spouse, Domestic Partner, or children up to age 26, and disabled children of any age.

Insured Employee means a Covered Person who is an employee of the Policyholder or is one entitled to coverage under a welfare trust agreement.

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.

GENERAL DEFINITIONS

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

Maximum Allowable Charge means:

1. For Covered Services from a Participating Provider, the Negotiated Rate as defined under part 2 b below;
2. For Covered Services from a Non-Participating Provider, the lesser of:

   a) The Usual, Customary and Reasonable Charge (UCR):

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

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

   b) The Negotiated Rate:

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

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

   c) The Actual Billed Charges for the Covered Services:

   The charges 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

For Emergency Services rendered by Non-Participating Providers, the following rules apply:

If the amount payable by KPIC is less than the Actual Billed Charges by Non-Participating Providers for Emergency Service, KPIC will pay no less than the greater of the following:

1) The Negotiated Rate for the service. If there is more than one Negotiated Rate with a Participating Provider for a particular service, then such amount is the median of these Negotiated Rate, treating the Negotiated Rate with each provider as a separate Negotiated Rate, and using an average of the middle two Negotiated Rates if there is an even number of Negotiated Rates.

2) The amount it would pay for the service if it used the same method (for example, Usual and Customary charges) that it generally uses to determine payments for services rendered by Non- Participating Providers and if there were no cost sharing (for example, if it generally pays 80% of UCR and the cost sharing is 20%, this amount would be 100% of UCR).

3) The amount that Medicare (Part A or B) would pay for the service.

Under any of the above, KPIC may deduct, any Participating Provider Copayments and/or Coinsurance amount that would have been paid had the Emergency Service been rendered at a Participating Provider and/or any Non-Participating Provider deductible amount.

For Non-Emergency Covered Services obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility located in California:

In accordance with California law, if the Covered Person receives Non-Emergency Covered Services at a Participating Provider facility located in California at which, or as a result of which, the Covered Person receives Non-Emergency Covered Services from a Non-contracting Individual Health Professional, unless otherwise agreed to by the Non-contracting Individual Health Professional and KPIC the greater of:

a. The average contracted rate. For the purposes of this section, "average contracted rate" means the average of the contracted commercial rates paid by KPIC for the same or similar services in the geographic region; or,
b. 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered.

Notwithstanding the above, unless the Covered Person provides written consent that meets the requirements as described under the **ACCESS TO HEALTH CARE** section of this Certificate, the Covered Person will be responsible for paying only the “in-network cost sharing amount”. For purposes of this section, “in-network cost sharing amount means an amount no more than the same cost sharing the insured would pay for the same covered service received from a Participating Provider. The “in-network cost sharing amount” shall be based on the amount paid by KPIC as set forth above. Additionally, the “in- network cost sharing amount” paid by the insured shall satisfy the insured’s obligation to pay cost sharing for the health service. This constitutes the “applicable cost sharing amount owed by the insured”.

Under any of the above, KPIC may deduct, any Participating Provider Cost Sharing amount that would have been paid had the Covered Service been rendered by a Participating Provider at a Participating Provider facility**.**

Maximum Benefit While Insured means the dollar limitation of Covered Charges, if any, as shown in the Schedule of Coverage that will be paid for a Covered Person, while covered under the Group Policy. Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured.

Medical Review Program means the organization or program that: 1) evaluates proposed treatment or services; and 2) when appropriate, determines that KPIC will deny coverage on the grounds that the care is not Medically Necessary. The Medical Review Program may be contacted 24 hours per day, 7 days per week.

Medically Necessary means services that are:
1. Essential for the diagnosis or treatment of a Covered Person's Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;

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

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

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

Mental Disorder means a mental health condition identified as a "mental disorder" in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. It does not include services for conditions that the *DSM* identifies as something other than a "mental disorder."

Month means a period of time: 1) beginning with the date stated in the Group Policy; and 2) terminating on the same date of the succeeding calendar month. If the succeeding calendar month has no such date, the last day of the month will be used.

Necessary Services and Supplies means Medically Necessary Covered Services and supplies administered during any covered confinement or administered during other covered treatment, such as during a Physician office visit. Only drugs and materials that require supervision or administration by medical personnel during a covered confinement or other covered treatment are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to, surgically implanted prosthetic devices, oxygen, blood, blood products, and biological sera. 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. This does not include drugs and materials obtained from a pharmacy under the Optional Outpatient Prescription Drug benefit.

Non-contracting Individual Health Professional means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with KPIC. For this purpose, a “Non-contracting Individual Health Professional” shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a Non-contracting Individual Health Professional’s affiliation with a group.

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

Non-Participating Pharmacy means a pharmacy that does not have a Participating Pharmacy agreement with KPIC or its administrator in effect at the time services are rendered. Please consult with your group administrator for a list of Participating Pharmacies.

Non-Participating Provider means a Hospital, Physician or other duly licensed health care provider or facility that does not have a participation agreement with KPIC in effect at the time services are rendered. In most instances, You will be responsible for a larger portion of Your bill when You visit an Non-Participating Provider. Participating Providers are listed in the Participating Provider directory.

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.

GENERAL DEFINITIONS

Out-of-Pocket means a Covered Person's share of Covered Charges. This is normally the difference between the amount payable by KPIC and the Maximum Allowable Charge.

Out-of-Pocket Maximum means the maximum amount of Covered Charges a Covered Person will be responsible for in a given period of time (the Accumulation Period). The Accumulation Period is set forth in the Schedule of Coverage.

Participating Pharmacy means a pharmacy which has a Participating Pharmacy agreement in effect with KPIC at the time services are rendered. Please consult with your group administrator for a list of Participating Pharmacies.

Participating Provider means a provider duly licensed in the state where services are rendered and who is providing care under a written contract with KPIC or KPIC's contracted provider network.

Participating Provider Organization (PPO) means a KPIC indemnity plan type, in which Covered Persons have access to a network of contracted providers and facilities referred to as preferred providers. The Schedule of Coverage shows the plan type under which the Covered Person is insured.

Patient Protection and Affordable Care Act (PPACA) – means Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended. It is commonly referred to as the Affordable Care Act (ACA).

Percentage Payable means that percentage of Covered Charges to be paid by KPIC. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services.

Pervasive Developmental Disorder or Autism has the same meaning and interpretation as used in Section 10144.5 of the California Insurance Code.

Physician means a practitioner who is duly licensed as a Physician in the state in which the treatment is received. He or she must be practicing within the scope of that license. The term does not include a practitioner who is defined elsewhere in this General Definitions section.

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

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

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

PPO Service Area means the entire state of California.

Precertification means the required assessment of the necessity, efficiency and or appropriateness of specified health care services or treatment made by the Medical Review Program. Request for Precertification must be made by the Covered Person or the Covered Person's attending Physician prior to the commencement of any service or treatment. If Precertification is required, it must be obtained to avoid a reduction in benefits in a form of a penalty.

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

GENERAL DEFINITIONS

Preventive Care means measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care:

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

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

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

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

Qualified Autism Service Paraprofessional means an unlicensed and uncertified individual who meets all of the following criteria:

(A) Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
(B) Provides treatment and implements services pursuant to a Treatment Plan developed and approved by the Qualified Autism Service Provider.
(C) Meets the education and training qualifications described in Section 54342 of Title 17of the California Code of Regulations.
(D) Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers.
(E) Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism Treatment Plan.

Qualified Autism Service Professional means an individual who meets all of the following criteria:

(A) Provides Behavioral Health Treatment which may include clinical case management and case supervision of a Qualified Autism Service Provider.
(B) Is supervised by a Qualified Autism Service Provider.
(C) Provides treatment pursuant to a Treatment Plan developed and approved by the Qualified Autism Service Provider.
(D) Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
(E) Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
(F) Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism Treatment Plan.

Qualified Autism Service Provider means either of the following:

(A) A person who is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive developmental disorder or Autism, provided the services are within the experience and competence of the person who is nationally certified; or
(B) A person licensed as a physician and surgeon, physical therapist, occupational therapist,

psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for Pervasive developmental disorder or Autism, provided the services are within the experience and competence of the licensee.

Reconstructive Surgery means a surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function; or 2) to create a normal appearance to the extent possible. Reconstructive Surgery includes, but is not limited to, incidental surgery to a covered mastectomy and Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

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.

Residential Treatment means Medically Necessary services provided in a licensed residential treatment facility that provides 24-hour individualized Substance Use Disorder or mental health treatment. Services must be above the level of custodial care and include:

1. Room and board;
2. Individual and group Substance Use Disorder therapy and counseling;
3. Individual and group mental health therapy and counseling;
4. Physician services;
5. Medication monitoring;
6. Social services; and
7. Drugs prescribed by a physician and administered during confinement in the residential facility.

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

Routine Patient Care Costs means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:

1. Health care services typically provided absent a clinical trial.
2. Health care services required solely for the provision of the investigational drug, item, device, or service.
3. Health care services required for the clinically appropriate monitoring of the investigational item or service.
4. Health care services provided for the prevention of complications arising from the provision of the investigational drug item, device, or service.
5. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine Patient Care Costs do not include the costs associated with the provision of any of the following:

1. Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
2. Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses, that a Covered Person may require as a result of the treatment being provided for purposes of the clinical trial.
3. Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
4. Health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded from coverage under the Group Policy.

5. Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Serious Emotional Disturbances of a Child means those minors under the age 18, who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which result in behavior inappropriate to the child's age according to expected developmental norms, and who meets one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
   a) The child is at risk of removal from home or has already been removed from the home.
   b) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
2. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
3. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness means a category of Mental Disorder which includes:
1. Schizophrenia
2. Schizoaffective disorder
3. Bipolar disorder (manic-depressive illness)
4. Major depressive disorders
5. Panic disorder
6. Obsessive-compulsive disorder
7. Pervasive developmental disorder or autism
8. Anorexia Nervosa
9. Bulimia Nervosa

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

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

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

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

Specialty Drugs means high-cost drugs that are listed on KPIC's specialty drug list.

Stabilize means to provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Treatment Plan means a written document developed and approved by a Qualified Autism Service Provider for the specific patient being treated for Pervasive Developmental Disorder or Autism. The

Treatment Plan must have measurable goals over a specific timeline and shall be reviewed at least once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the Qualified Autism Service Provider does all of the following:

1. Describes the patient's behavioral health impairments to be treated.
2. Designs an intervention plan that includes:
   a. the service type,
   b. number of hours, and
   c. parent participation needed to achieve the plan' s goal and objectives, and
   d. the frequency at which the patient's progress is evaluated and reported.
3. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
4. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

The Treatment Plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The Treatment Plan shall be made available to KPIC upon request.

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

Urgent Care Center means a facility legally operated to provide health care services in emergencies or after hours. It is not part of a Hospital.

Urgent Care Facility means a facility legally operated to provide health care services requiring immediate medical attention but which do not meet the definition of an emergency.

You/ Your refers to the Insured Employee who is enrolled for benefits under This Plan.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Eligibility for Insurance

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

Eligible Employee

An **"Eligible Employee"** is a person who, at the time of original enrollment: a) resides in an area specified by the plan type as listed below; b) is working for a Policyholder as a permanent full-time employee as shown below or is entitled to coverage under a trust agreement or employment contract; c) by virtue of such employment enrolls for the Group Policy and d) reached an eligibility date. Eligible Employee includes sole proprietors and partners of a partnership 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 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.

Full-Time Work

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

Permanent Employee

A **"permanent employee"** is a person scheduled to work full-time and is not a seasonal, temporary or substitute employee.

Plan Service Area Enrollment Requirement

PPO Plan - An eligible Employee must live or work within the PPO Service Area as defined under the General Definitions section of this Certificate. For purposes of this provision, "work within the PPO Service Area" means working for a Policyholder whose situs is within the PPO Service Area."

Eligibility Date

Your eligibility date is the date Your employer becomes a Policyholder if You are an eligible employee on that date, or the Policyholder's Application for coverage indicates that the eligibility waiting period does not apply to initial employees. 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 elected by the Policyholder.

Effective Date of Your Insurance

Your effective date of insurance is subject to the Enrollment Rules that follow.

Enrollment Rules

1. **Early Enrollment**. If You enroll on or before Your eligibility date, Your effective date is Your eligibility date.
2. **Timely 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.
3. **Late Enrollment**. If you enroll for coverage more than 31 days after Your initial eligibility Date, You will be considered a Late Enrollee. Late enrollees are eligible for enrollment only during the annual Open Enrollment period set by the Policyholder. If You enroll during this period, Your effective date is the date agreed upon between the Policyholder and KPIC.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

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

"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 the regular duties of his or her employment.

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

The term **"Dependent"** means only: a) Your spouse or Domestic Partner; and b) Your child who is of an age within the Age Limits for Dependent Children shown below. The word "child" includes: a) Your step-child; b) adopted child; c) child of Your Domestic Partner; and d) any other child for whom You or Your spouse or Domestic Partner are the court-appointed guardian.

An Insured Dependent is not required to live with the parent or within an applicable service area. Coverage outside the United States is limited to Emergency Services.

Age Limits for Dependent Children

The age limit for Dependent children is under **26** years, except for a full-time student who is on medical leave of absence as described below in this subsection, and for Disabled Dependent children, as described below under the "Age Limits for Disabled Dependent Children" subsection. If Your employer elected to make coverage available under Your Plan beyond this age limit for Dependent children who are full-time students, then a Dependent child beyond this age limit who is a full-time student may be covered. The Dependent child must be of an age within the Student Age Limit as shown in Your Schedule of Coverage. A **"full-time student"** is a Dependent child who is enrolled at a high school, college, university, technical school, trade school, or vocational school on a full-time basis. A **"full-time student"** may also include, those who are on medical leave of absence from the school or those who have any other change in enrollment in school) due to a Medically Necessary condition as certified by the attending Physician. Such student coverage shall commence on the earlier of: the first day of the medical leave of absence; or on the date certified by the Physician. Coverage for students on medical leave of absence is subject to a maximum of 12 months and shall not continue beyond the effective date of the termination of the Group Policy.

Proof of status as a **"full-time student"** must be furnished to KPIC at time of enrollment or within 31 days after attaining such status and subsequently as may be required by KPIC.

The age limit for Dependent children does not apply to a **"full-time student"** who is on medical leave of absence as described above, if, as a result of the nature of the sickness, injury, or condition, would render the dependent child incapable of self-sustaining employment and is chiefly dependent upon You for support and maintenance.

Age Limits for Disabled Dependent Children

A Disabled Dependent child means Your child of any age who is both: 1) incapable of self-sustaining employment by reason of a physically or mentally disabling sickness, injury or condition and 2) chiefly dependent upon 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 physically or mentally disabling sickness, injury or condition; or b) the date the child no longer chiefly depends on You for support and maintenance.

<u>Initial enrollment of a Disabled Dependent child age 26 or over</u>

If You are requesting coverage for a Disabled Dependent child age 26 or over who is not currently covered under the plan You must provide us documentation of the Dependent's incapacity and dependency within 60 days after we request it so that we can determine if the Dependent is eligible for coverage as a disabled

Dependent.

Initial enrollment of a Dependent child under age 26 will be the same as any other Dependent child.

Continued Enrollment for Disabled Dependents age 26 and over

Such child will continue to qualify as a Dependent until the earlier of the following dates: a) the date the child recovers from the physically or mentally disabling sickness, injury or condition; or b) the date the child no longer chiefly depends on You for support and maintenance.

KPIC shall send a notice to the Insured Employee at least 90 days prior to the date of the Dependent child's attainment of limiting age of the termination of the Dependent child's coverage on such date. In the said notice, KPIC shall require the Insured Employee's submission of the proof of such incapacity and dependency within 60 days of the receipt of KPIC's notification and subsequently, as may be required by KPIC, but not more frequently than annually after the two-year period following the Dependent child's attainment of the limiting age. KPIC shall determine whether the Dependent child meets that criteria before the child attains the limiting age. If KPIC fails to make the determination by that date, coverage of the child will continue pending our determination.

Subsequently, proof of continued incapacity may be required by KPIC, but not more frequently than annually after the two-year period following the Dependent child's attainment of the limiting age. Proof of such incapacity and dependency must be submitted to KPIC within 60 days of KPIC's request.

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 a Qualified Medical Child Support Order qualifies as Your Dependent on the date specified in the court order. An adopted child qualifies as Your Dependent on the earlier of: the date of adoption or the date of placement for adoption.

Effective Date of Dependent Coverage

A Dependent's effective date of insurance is subject to the Enrollment Rules that follow.

Enrollment Rules

1. **Early Enrollment**. If You enroll a Dependent on or before his eligibility date, his effective date is the later of: a) Your effective date of insurance; or b) the Dependent's eligibility date.
2. **Timely 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.
3. **Late Enrollment**. If you enroll a Dependent for coverage more than 31 days after Your initial eligibility date, the Dependent will be considered a Late Enrollee. Late enrollees are eligible for enrollment only during the annual Open Enrollment period set by the Policyholder. If You enroll a Dependent during this period, his effective date is the date agreed upon between the Policyholder and KPIC.

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 a family plan, the Covered Person, employee, employer or group administrator may enroll the eligible child under family coverage by sending KPIC a written application and paying KPIC any additional amounts due as a result of the change in coverage. Enrollment period restrictions will not apply in these circumstances. However, the child should be enrolled within 31 days of the court or administrative order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

If the Covered Person, employee, administrator or employer fails to apply for coverage for the Dependent child pursuant to the Order, the custodial parent, district attorney, child's legal custodian or the State

Department of Health Services may submit the application for insurance for the eligible child. Enrollment period restrictions will not apply in these circumstances. However, the child must be enrolled within 31 days of the Order to avoid any delays in the processing of any claim that may be submitted on behalf of the 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 Group Policy;
3. All family coverage is eliminated for members of the employer group; or
4. Nonpayment of premium.

Effective Date for Future Dependents

The effective date of insurance for a Dependent will be the date You acquire the Dependent in the case of birth, adoption, or placement for adoption. In the case of marriage, the effective date for the new spouse is on the first day of the month following the date of marriage. You must notify KPIC that You have a new Dependent within 31 days so that the Dependent can be added to Your coverage. This will also help avoid delays on any claim You might file on the Dependent.

Exception for Newborns

A newborn Dependent child is insured from the moment of birth for the first 31 days. You must enroll the newborn Dependent for insurance within 31 days of that Dependent's birth in order for insurance to extend beyond the 31-day period. If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next annual Open Enrollment period to enroll the child for coverage.

Exception for Adopted Children

An adopted child is insured from the earlier of the date of adoption or the date of placement for adoption. You must enroll the adopted child for insurance within 31 days of his eligibility date in order for insurance to extend beyond the 31-day period. If coverage terminates at the expiration of the 31-day period, the child will be considered a Late Enrollee and You must wait until the next annual Open Enrollment period to enroll the child for coverage.

Exception to the Late Enrollment Rules

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.

Late Enrollment Exception

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

A. The person meets all of the following requirements:
   1. At the time of initial enrollment, the person was covered under another employer's medical plan or no share-of-cost Medi-Cal coverage, or the state Children's Health Insurance Program (CHIP) or Access for Infants and Mothers (AIM) Program and certified, at the time of initial enrollment, that coverage under the other employer medical plan or Medi-Cal, CHIP or AIM was the reason for declining coverage; and
   2. The person has lost or will lose coverage under:
      a. 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

b. the no share-of-cost Medi-Cal plan, CHIP or AIM; or
c. the state Exchange (Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
i. A qualified individual was not enrolled in a qualified health plan.
ii. A qualified individual was not enrolled in the qualified health plan that the individual selected.
iii. A qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost sharing reductions; and

3. The person is enrolled for the employee's medical coverage within 30 days after termination of the other medical coverage (60 days if the other coverage was Medi-Cal, CHIP or AIM), or within 30 days after cessation of the other employer's contributions toward the other medical coverage.

B. The employee is employed by an employer who offers multiple health benefit plans and the individual elects coverage under a different plan during an Open Enrollment period.
C. A court has ordered that coverage be provided for a spouse, Domestic Partner or minor child under a covered employee's health benefit plan.
D. 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.
E. The person meets the criteria described in paragraph "A" of this provision and was under a COBRA continuation provision and the coverage under that provision has been exhausted.
F. The person is a Dependent of an Insured Employee who has lost or will lose his or her no share-of-cost Medi-Cal, CHIP or AIM coverage and requests enrollment within 60 days after notification of this loss of coverage.
G. The person becomes eligible for a premium assistance subsidy under Medi-Cal, CHIP or AIM and requests enrollment within 60 days of when eligibility for the premium assistance subsidy is determined.

If You declined enrollment for yourself or Your Dependents (including Your spouse or Domestic Partner) because of other health insurance coverage, You may, in the future be able to enroll yourself or Your Dependents under the Group Policy, provided that You request enrollment within 30 days after Your other coverage ends, or 60 days if the other coverage was Medi-Cal, CHIP or AIM. 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 any or all of Your Dependents (if You are already enrolled, You may be able to enroll any or all of your dependents), provided that You request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Termination of an Insured Employee's Insurance

Your insurance will automatically terminate on the earlier of:

1. the date You cease to be covered by KPIC;
2. the date the Group Policy is terminated;
3. the date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. the end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion. (The period that the Policyholder has in which to pay the premium then due is the later of 31 days from each premium due date (except the first) or 31 days from the date KPIC provides notice of non renewal due to non-payment of premium to the Policyholder.)
5. the last day of the month You cease to qualify as an Eligible Employee; or

6. the date You relocate to a place outside of the geographic service area of a provider network, if applicable. (See the eligibility section for information about the Plan Service Areas.) If You cease to qualify as an Eligible Employee because You no longer live in an area specified for the Plan in which You are enrolled, Your insurance will end on the last day of the Policy Year in which You change residence.

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.

If Your or Your Dependent's Policy is rescinded or cancelled, You have the right to appeal the rescission or cancellation. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Termination of an Insured Dependent Coverage

An Insured Dependent's coverage will end on the earliest date shown below:

1. the date the Eligible Employee 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 Your insurance ends, unless continuation of coverage is available to the Dependent under the provisions of the Group Policy;
4. the end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion;
5. the date the Group Policy is terminated;
6. the date the Dependent, or the Dependent's representative, commits an act of fraud or makes an intentional misrepresentation of a material fact
7. the date the Dependent relocates to a place outside of the geographic service area of a provider network, if applicable, unless specifically provided otherwise in the Group Policy;
8. The date You cease to be covered by KPIC.

Continuation of Coverage during Layoff or Leave of Absence

If Your full-time work ends because of a disability, an approved leave of absence or layoff, You may be eligible to continue insurance for Yourself and Your Dependents up to a maximum of three months if full-time work ends because of disability or two months if work ends because of layoff or leave of absence other than family care leave of absence. These provisions apply as long as You continue to meet Your Groups written eligibility requirements and This Plan has not terminated. You may be required to pay the full cost of the continued insurance during any such leave.

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

Rescission for Fraud or Intentional Misrepresentation

Subject to any applicable state or federal law, if You performed an act or practice constituting fraud or made an intentional misrepresentation of material fact under the terms of the Group Policy, KPIC may rescind Your coverage under the Group Policy by giving You no less than 31 days advance written notice. The rescission will be effective, on:

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

After 24 months following the Group Policy Effective Date, Your coverage under the Group Policy will not be rescinded or cancelled for any reason.

If KPIC rescinds the Group Policy, we will send a notice to the Insured via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended rescission and notifying the Insured of his or her right to appeal that decision to the California Insurance Commissioner.

If Your or Your Dependent's Policy is rescinded, you have the right to appeal the rescission. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

ACCESS TO HEALTH CARE

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
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. Normally, benefits payable under the Group Policy are greater for Covered Services received from Participating Providers than those benefits payable for Non-Participating Providers. Except as otherwise provided under federal or state law, in order for benefits to be payable at the Participating Provider tier, the Covered Person must receive care from a Participating Provider.

You may visit KPIC's contracted provider network web site at: www.Multiplan.com/Kaiser to view the provider directory or to request a printed copy at no cost. Additionally, a current printed listing of KPIC's Participating Providers directory is available at no cost to You by calling the phone number listed on Your ID card or by writing to: KPIC Provider Relations Manager, 300 Lakeside Drive, Room 1335D, Oakland, CA 94612. To verify the current participation status of any provider, please call the toll-free number listed in the provider directory. If the Covered Person receives care from a Non-Participating Provider, benefits under the Group Policy are payable at the Non-Participating Provider tier.

If you require interpreter services or require the provider directory to be translated in another language other than English, please call 1-800-788-0710. The English version of this document is the official version. The foreign language version is for informational purposes only.

If medically appropriate care cannot be provided by a Participating Provider within the required distance or travel time from the Covered Person's residence or place of work of:

1. 15 miles or 30 minutes for Primary Care Physician, including mental health providers; and
2. 30 miles or 60 minutes for Specialty Care Provider including Qualified Autism Providers;

KPIC shall arrange for the required care with an available and accessible licensed provider. The Covered Person shall be responsible for paying only the applicable Participating Provider Cost Sharing for the service and will not be liable for the payment of any amount in excess of the Usual, Customary and Reasonable Charge or the Actual Billed Charges. The Cost Share for this service will apply to the satisfaction of the Deductible and the Out of Pocket Maximum at the Participating Provider tier.

Non-Emergency Services Obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility located in California
This provision does not apply to Emergency Care Services.

Except as provided under the exception below, in accordance with California law, if the Covered Person receives Non-Emergency Covered Services at a Participating Provider facility located in California at which, or as a result of which, the Covered Person receives Covered Services from a Non-contracting Individual Health Professional, the Covered Person will be responsible for paying no more than the same Cost Sharing that the Covered Person would pay for the same Covered Services received from a Participating Provider (the in-network cost-sharing amount) and will not be liable for the payment of any additional amounts that would generally apply to services rendered by a non-contracting provider. The Cost Share incurred for the non-emergency service described above will apply to the Deductible and the Out of Pocket Maximum accumulation at the Participating Provider tier. No Deductible will apply if the Participating Provider Deductible has already been met. The Covered Person will not pay any amount if the Out-of-Pocket Maximum at the Participating Provider tier has already been reached.

Exception to the above rule. For services subject to this section, the above rule does not apply and a Non-contracting Individual Health Professional may bill or collect from the Covered Person the out-of-network cost sharing, if applicable, if the Covered Person gave his or her written consent to the Non-contracting Individual Health Professional rendering the service and that written consent demonstrates satisfaction of all the following criteria:

(1) At least 24 hours in advance of care, the Covered Person consents in writing to receive services from the identified Non-contracting Individual Health Professional.
(2) The consent obtained by the Non-contracting Individual Health Professional is in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent must not be obtained by the facility or any representative of the facility. The consent must not be obtained at the time of admission or at any time when the Covered Person is being prepared for surgery or any other procedure.
(3) At the time consent is provided, the Non-contracting Individual Health Professional must give the Covered Person a written estimate of the Covered Person's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The Non-contracting Individual Health Professional must not attempt to collect more than the estimated amount without receiving separate written consent from the Covered Person or their authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.
(4) The consent must advise the Covered Person that he or she may elect to seek care from a contracted provider or may contact the Covered Person's insurer in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.
(5) The consent and estimate must be provided to the Covered Person in the language spoken by the Covered Person, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552 of the Health and Safety Code.
(6) The consent shall also advise the Covered Person that any costs incurred as a result of the Covered Person's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

Access to Care

Covered Services under the Out-of-Area Indemnity (OOA) insurance plan can be received from any licensed provider. Subject to the Maximum Allowable Charge definition under the General Definitions section of this Certificate, You may be responsible for payment to any licensed provider of any amount in excess of the Usual, Customary and Reasonable Charge (UCR) when the UCR is less than the Actual Billed Charges.

When You're Not Sure What Kind of Care You Need

Sometimes it's difficult to know what kind of care You need, so we have licensed health care professionals available to assist You by phone 24 hours a day, seven days a week. Here are some of the ways they can help You:

- They can answer questions about a health concern, and instruct You on self-care at home if appropriate
- They can advise You about whether You should get medical care, and how and where to get care (for example, if You are not sure whether Your condition is an Emergency Medical Condition, they can help You decide whether You need Emergency Care or Urgent Care, and how and where to get that care)
- They can tell You what to do if You need care and a health care provider's office is closed

You can reach one of these licensed health care professionals by calling 1-888-251-7052. When You call, a trained support person may ask You questions to help determine how to direct Your call.

ACCESS TO HEALTH CARE

If You have a complaint regarding Your ability to access needed health care in a timely manner you may contact KPIC at:

Kaiser Permanente Insurance Company (KPIC)

Attn: KPIC Operations
Grievance and Appeals Coordinator
1800 Harrison Street, 20th Floor Oakland, CA 94612

You may also fax this information to: KPIC Attn: KPIC Operations Grievance and Appeals Coordinator at (877) 727-9664

You may also contact the California Department of Insurance regarding Your complaint at:

California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

The Covered Person may write the California Department of Insurance at:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

TIMELY ACCESS TO CARE

Your coverage provided under the Group Policy may include coverage for Covered Services that are received from either Participating Providers or Non-Participating Providers. See Your Schedule of Coverage to determine if Your coverage includes Participating Providers.

This section describes standards for appointment wait times and the availability of interpreter services when health care is obtained from Participating Providers. Please refer to the **ACCESS TO HEALTH CARE SECTION** of this Certificate for further information about obtaining health care under this Policy.

Appointment Wait Times

In accordance with the provisions of state law, access to health care from a Participating Provider will meet the following appointment availability standards:

1) Urgent care appointments for services that do not require precertification shall be available within 48 hours of the request for appointment;
2) Urgent care appointments for services that require precertification as shown in the **PRECERTIFICATION** section of this Certificate shall be available within 96 hours of the request for appointment;
3) Non-urgent appointments for primary care shall be available within ten business days of the request for appointment;
4) Non-urgent appointments with specialist physicians shall be available within fifteen business days of the request for appointment;
5) Non-urgent appointments with a non-physician mental health care provider shall be available within ten business days of the request for appointment;
6) Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition shall be available within fifteen business days of the request for appointment; and,
7) Telephone triage or screening services shall be provided in a timely manner appropriate for the Covered Person's condition. The triage or screening waiting time shall not exceed 30 minutes.

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the Covered Person's health.

Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Notice of the Availability of Interpreter Services from a Participating Provider

Language interpretation services in languages other than English are available to limited-English- proficient Covered Persons at no cost and shall be coordinated with scheduled appointments for health care services from a Participating Provider in a manner that ensures the provision of interpreter services at the time of the appointment without imposing an undue delay on the scheduling of the appointment. If You require interpreter services for Your health care appointment, please request such services at the time You call to schedule Your appointment.

PRECERTIFICATION

This section describes:
1. How failure to obtain Precertification affects coverage;
2. Precertification administrative procedures; and
3. Which clinical procedures require Precertification.

If Precertification is not obtained, benefits will be reduced through the application of a penalty as described herein 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 inpatient care is extended beyond the number of days first precertified without further Precertification, benefits for the extra days: 1) similarly will be penalized; or 2) will not be covered at all if deemed not to be Medically Necessary.

If Precertification is not obtained, benefits payable for all Covered Charges incurred in connection with any of these services will be reduced by a penalty of $500 each time Precertification is required. However, the penalty will not result in a reduction greater than 50% of the Covered expenses or $500 whichever is less per occurrence or per claim. This $500 penalty will not count toward the satisfaction of any Deductible, coinsurance or Out-of-Pocket Maximum applicable under the Group Policy.

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

Medical Review Program means the organization or program that: 1) evaluates proposed treatment or services; and 2) when appropriate, determines that KPIC will not deny coverage on the grounds that the care is not Medically Necessary. The Medical Review Program may be contacted 24 hours per day, 7 days per week.

Precertification Through the Medical Review Program

The following treatment or services must be precertified by the Medical Review Program:

1. Hospital Confinements*.
2. Inpatient Mental Health admissions and services*.
3. Inpatient Substance Use Disorder admissions and services*.
4. Inpatient care at a Skilled Nursing Facility or any other licensed medical facility.
5. Home Health Care Services, including Home Infusion and Home Therapy.
6. Inpatient Rehabilitation Therapy admissions, services and programs.
7. Inpatient Residential Treatment
8. Outpatient surgery at a Hospital, Free-Standing Surgical Facility or other licensed medical facility.
9. The following specific treatments and procedures:
    a) Blepharoplasty, Pitosis Repair
    b) Breast Augmentation/Implants
    c) Breast Reduction
    d) Clinical Trials
    e) Cosmetic Procedures
    f) Craniofacial Reconstruction
    g) Dental and Endoscopic Anesthesia
    h) Durable Medical Equipment (DME):
        i. Airway Clearance Vest
        ii. Bone stimulator
        iii. Cardioverter Defibrillator Vest
        iv. Cough Stimulator Device
        v. Communicators

vi. CPAP/BIPAP
vii. External Vacuum Erection Devices
viii. Hospital-grade electric breast pump
ix. Insulin pump
x. Neuromuscular Stimulators
xi. Oxygen
xii. Patient Lifts
xiii. Specialty beds
xiv. TENS Units
xv. Wheelchair Cushions/Seating Systems
xvi. Woundvac

i) Enteral Solutions
j) Genetic Testing
k) Habilitative Services (outpatient physical therapy, occupational therapy, speech therapy and pulmonary therapy)
l) Injectable medications
m) Imaging Services: MRI, MRA, CT, CTA, PET, EBCT
n) Implantable Prosthetics (includes breast, bone conduction, cochlear, and ocular)
o) Medical Food Products for treatment of Phenylketonuria (PKU)
p) Non-Emergency Air or Ground Ambulance Transport
q) Orthognathic Surgery (non-dental jaw bone surgery)
r) Orthotics/Prosthetics
s) The following outpatient Procedures:
    i. Outpatient sleep studies (lab or home)
    ii. Outpatient vein procedures (office or outpatient); includes sclerosing, ablations, stripping
    iii. Cosmetic procedures (office or outpatient)
    iv. Dermatology procedures (office or outpatient); includes injection of fillers, photopheresis, laser, tattooing, phototherapy
    v. Outpatient hyperbaric treatment
    vi. Pill or wireless endoscopy (office or outpatient)
    vii. Oral procedures (office or outpatient); includes palate, tongue, floor of mouth, prosthesis
    viii. External counterpulsation
    ix. Complex wound care (office or outpatient); includes wound vacuum, cultured or biomechanical skin graft
    x. Insertion or removal of Neurostimulator
t) Pain Management:
    i. Epidural Injections
    ii. Use of Neurolytic agent
    iii. Decompression Procedure
    iv. Epidural or Intrathecal Implant procedures
    v. Epidural or Intratheacal Pump use.
    vi. Injection of anesthetic agent
    vii. Insertion or removal of Neurostimulator
    viii. Paravertebral or Transforaminal injections
    ix. Sacroiliac Injection.
u) Radiation Therapy Services
v) Reconstruction Surgery (including all procedures by plastic surgeon)
w) Rehabilitative Services (outpatient physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation)
x) Spinal surgery
y) Temporomandibular Joint Surgery
z) Transplants

* Precertification is not required for emergency admissions. You or Your attending Physician should notify

the Medical Review Program of the admission as soon as reasonably possible and not later than 24 hours following an emergency admission.

Precertification Administrative Procedures - For All Plans

1. The Covered Person or his or her attending Physician must notify the Medical Review Program as follows:
    a) Planned Hospital Confinement - at least 3 days prior to admission for such Hospital Confinement.
    b) Extension of a Hospital Confinement - As soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond: i) the number of days originally precertified; or
    c) ii) the date on which coverage of the Hospital Confinement by KPIC under This Plan terminates.
    d) Other treatments or procedures requiring Precertification - At least 3 days prior to performance of any other treatment or service requiring Precertification or as soon as reasonably possible.
    e) Emergency Hospital Confinement - within 24 hours after care has commenced. This requirement is not applied if notice is given as soon as reasonably possible.
2. The Medical Review Program will:
    a) precertify the requested treatment or service, however, in no event will the Medical Review Program require a treating Physician to request or obtain prior approval for the purpose of determining the length of hospital stay following a covered mastectomy or lymph node dissection; or
    b) deny Precertification entirely; or
    c) deny the requested treatment or service but precertify an alternative treatment or service; and
3. Under the Medical Review Program, a Covered Person may be required to:
    a) obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Covered Person is required to obtain a second surgical opinion, it will be provided at no charge to the Covered Person.
    b) 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.

The Medical Review Program may request Your agreement to participate in the following voluntary case management programs: a) case management; b) Hospital discharge planning; and or c) long-term case management programs.

Pregnancy Precertification: When a Covered Person is admitted to a Hospital for the delivery of a child, the Covered Person is entitled to stay in the hospital without any Precertification for a minimum of:

Forty-eight (48) hours for a normal vaginal delivery; and 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 Precertification requirements as any other Sickness.

Length of Stay for Mastectomy and Lymph Node Surgical Services
The length of a hospital stay associated with mastectomy or lymph node surgical procedures will be determined by the attending Physician in consultation with the patient, post-surgery, consistent with sound clinical principles and processes. The treating physician and surgeon is not required to receive prior approval from KPIC in determining the length of hospital stay following these procedures.

PRECERTIFICATION

Review Process

If a request for Precertification is denied, in whole or in part, the Covered Person, or the individual legally responsible for the Covered Person, will be: 1) notified in writing; and 2) given an opportunity for review. A copy of the procedures by which the Covered Person may seek review will be provided to the Covered Person or the individual legally responsible for the Covered Person at the time of denial.

Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Failure to Comply with the Precertification Procedures

Failure to comply with any of the Precertification procedures set forth above will result in a penalty as previously described.

The dollar amount of any penalty applied will not count toward satisfaction of any Deductible, coinsurance, or Out-of-Pocket Maximum.

DEDUCTIBLES AND MAXIMUMS

Individual Deductible

Unless otherwise indicated in the Schedule of Coverage or elsewhere in the Policy, the Deductible as shown in the Schedule of Coverage applies to all Covered Charges incurred by a Covered Person during the Accumulation Period. The Deductible applies separately to each Covered Person during each Accumulation Period. When Covered Charges equal to the individual Deductible Maximum are incurred during the Accumulation Period and are submitted to Us, the Deductible will have been met for that Covered Person. Benefits will not be payable for Covered Charges applied to the Deductible. The Accumulation Period is set forth in the Schedule of Coverage.

Family Deductible Maximum

When Covered Charges equal to the individual Deductible Maximum are incurred during the Accumulation Period and are submitted to Us, the Deductible will have been met for that Covered Person. All remaining family members must continue paying for Covered Charges for services that are subject to the Deductible until they either meet their individual Deductible Maximum or until the family collectively reaches the family Deductible Maximum. Once the family Deductible Maximum is satisfied, benefits begin for the rest of the family for that Accumulation Period whether or not each of their individual Deductible maximum has been met. The Individual Deductible will not be further applied to any other Covered Charges incurred during the remainder of that Accumulation Period by any other person in Your family. The Accumulation Period is set forth in the Schedule of Coverage.

Some Covered Services may be subject to additional or separate deductible amounts as shown in the Schedule of Coverage.

NOTE: Please refer to the Schedule of Coverage for the actual amount of Your Individual and Family Deductible.

Doctor Office Visit Copayment Exception - Not subject to Calendar Year Deductible 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 Copayment for each visit to a Participating Provider. The Covered Person will be responsible for any charge that is not a covered medical charge as defined by the Plan. The office visit Copayment and waiver of the Deductible described in this paragraph do not apply to charges incurred for certain services as noted in the Schedule of Coverage.

Percentage Payable

The Percentage Payable by KPIC is applied to Covered Charges after any applicable Deductible has been met.

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 incurred under the following apply to the Out-of- Pocket Maximum unless otherwise indicated in the Schedule of Coverage.

<u>For PPO Plans:</u>

Covered Charges incurred under the following apply to the Out-of-Pocket Maximum:

1. Cost Sharing incurred for all covered Essential Health Benefits under the Participating Provider tier will be applied towards the Out-of-Pocket Maximum under the Participating Provider tier;
2. Cost Sharing incurred for all covered Essential Health Benefits under the Non-Participating Provider tier will be applied towards the Out-of-Pocket Maximum under the Non-Participating Provider tier; except that
    a. Cost Sharing for Emergency Care Services, including emergency hospital care and emergency medical transportation, obtained from a Non-Participating Provider will be applied

towards the Out-of-Pocket Maximum at the Participating Provider tier and the Non-Participating Provider tier; and,

b. Cost Sharing for Non-Emergency Covered Services obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility will be applied towards the Out-of-Pocket Maximum under the Participating Provider tier. Refer to the "Non-Emergency Services Obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility" provision under the **ACCESS TO HEALTH CARE** section of this Certificate for additional information.

Individual Out-of-Pocket Maximums When the Covered Person's Cost Share applicable to the Out- of-Pocket Maximum amount equals the Out-of-Pocket Maximum amount shown in the Schedule of Coverage during the Accumulation Period, the Covered Person is not required to pay a Cost Share for any further Covered Charges incurred by that same Covered Person for the remainder of that Accumulation Period. The Accumulation Period is set forth in the Schedule of Coverage.

Family Out-of-Pocket Maximums: Once a family member reaches their Individual Out-of-Pocket Maximum, no further Cost Share will apply for Covered Services for that individual during the Accumulation Period. All remaining family members must continue paying Cost Share for Cover Services until they either satisfy their individual Out-of-Pocket Maximum or until the family collectively satisfies the family Out-of-Pocket Maximum. When the family's Cost Share applicable to the Out-of- Pocket Maximum amount equals the family Out-of-Pocket Maximum amount shown in the Schedule of Coverage during the Accumulation Period, all family members are not required to pay a Cost Share for any further Covered Charges incurred by all family members for the remainder of that Accumulation Period. The Accumulation Period is set forth in the Schedule of Coverage.

Maximum Allowable Charge

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

Other Maximums

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

GENERAL BENEFITS

This section describes the general benefits provisions. General Limitations and Exclusions are listed in the General Limitations and Exclusions section. Optional Benefits are set forth under the Sections entitled “Optional Outpatient Drug Benefits” and “Optional Benefits”. Please refer to the Schedule of Coverage to determine which, if any, optional benefits Your employer elected.

Insuring Clause

Upon receipt of a satisfactory notice of claim and proof of loss, KPIC will pay the Percentage Payable for Expenses Incurred up to the Maximum Allowable Charge for the treatment of a Covered Service, 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 the attending Physician or those prescribed or ordered by Non-Participating Provider who are duly licensed by the state 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 any benefit maximum shown in the Schedule of Coverage.

Payments under this 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
3. May be subject to Precertification.

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 services of an Acute Care Hospital, Skilled Nursing Facility or other licensed medical facility
4. Skilled Nursing Care Services provided in a Skilled Nursing Facility or other licensed medical facility include:
    a) Physician and nursing services;
    b) Room and board;
    c) Drugs prescribed by a physician as part of the plan of care in the plan skilled nursing facility in accord with the plan's drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel;
    d) Durable medical equipment in accord with the plan's durable medical equipment formulary if skilled nursing facilities ordinarily furnish the equipment;
    e) Imaging and laboratory services that skilled nursing facilities ordinarily provide;
    f) Medical social services; Blood, blood products, and their administration;
    g) Medical supplies;
    h) Physical, occupational, and speech therapy;
    i) Behavioral health treatment for pervasive developmental disorder or autism; and
    j) Respiratory therapy.

    Care in a Skilled Nursing Facility is limited to: a) the maximum number of covered days shown in the Schedule of Coverage; b) care in a licensed Skilled Nursing Facility or other licensed medical facility; c) care under the active medical supervision of a Physician; and d) services consistent with medical needs. 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 60 consecutive days.
5. Necessary Services and Supplies, including medication dispensed while confined in a Hospital or administered during other covered treatment, such as a Physician office visit.
6. Treatment in an Emergency Department of a Hospital or an Urgent Care Center. Please refer to the

subsection, “Benefits for Emergency Services” in this General Benefits section for further information

7. Physicians' services, including office visits.
8. Transportation of a Covered Person to or from Covered Services, by licensed ambulance or licensed psychiatric transport van service, when a Physician determines that the use of other means of transportation may endanger the Covered Person’s health.
9. Emergency medical transportation without Precertification provided through the 911 emergency response system in the following situations:
   a. the request was made for an emergency medical condition and ambulance transport services were required;
   b. the Covered Person reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.
10. Nursing care by an RN, or, an LVN, 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 in the absence of these nursing services.
11. Services by a Certified Nurse Practitioner; Certified Clinical Nurse Specialist; Licensed Midwife; 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.
13. X-ray, other imaging including diagnostic mammogram and lab tests.
14. Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.
15. Genetic testing, limited to genetic testing used to diagnose, treat, or determine predisposition to breast cancer and prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures.
16. Home Health Care Services except:
    a) meals;
    b) personal comfort items; and
    c) housekeeping services.

    Covered Home Health Care Services are limited to part-time or intermittent home health care consisting of up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide. Up to three visits per day (counting all home health visits) are covered. Up to 100 visits per Accumulation Period (counting all home health visits) are covered. They must be provided in the Covered Person's home and according to a prescribed treatment plan. If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to Your home for three hours and then leaves, that counts as two visits. Also, each person providing services counts toward these visit limits. For example, if a home health aide and a nurse are both at Your home during the same two hours, that counts as two visits.
17. Outpatient surgery in a Free-Standing Surgical Facility or other licensed medical facility.
18. Hospital charges for use of a surgical room on an outpatient basis.
19. Hospice Care limited to:
    a) Interdisciplinary team care with development and maintenance of an appropriate plan of care.
    b) Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse.
    c) Bereavement Services.
    d) Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
    e) Medical direction with the medical director being also responsible for meeting the general medical needs of the enrollees to the extent that these needs are not met by the attending physician.
    f) Volunteer services.
    g) Short-term inpatient care arrangements.

h) The following shall be provided to the extent reasonable and necessary for the palliation and management of terminal illness and related conditions: pharmaceuticals, medical equipment and supplies.
i) Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
j) Ostomy and urological supplies, incontinence supplies.
k) The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
    i. nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home.
    ii. respite care (short-term inpatient care) required at a level that cannot be provided at home.

Members who elect to receive Hospice Care are not entitled to any other benefits under the Plan for the terminal illness.

20. 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.
21. Birth Services, including those performed in a Birth Center. For information regarding the length of stay for inpatient maternity care, please refer to the subsection “Length of Stay for Inpatient Maternity Care” in this General Benefits section.
22. External Prosthetic and Orthotic Devices that are Medically Necessary including prosthetics and orthotics needed following surgery, such as removal of a tumor mastectomy or laryngectomy. Coverage for external breast prostheses after a full or partial mastectomy, or lumpectomy will include up to three bras each Accumulation Period designed for the exclusive use with the prosthetic. Coverage for prosthetic and orthotic devices is limited to standard mode or item that adequately meets the medical needs of the Covered Person. Convenience and luxury items and features are not covered. Repair or replacement of prosthetic and orthotic devices is limited to: a) that needed because of growth; b) Prosthetics needed following surgical removal of a tumor.
23. Prosthetics (internally implanted).
24. Rental of Durable Medical Equipment. However, purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental. Repair or replacement of Durable Medical Equipment is covered if such repair or replacement is necessary as a result of ordinary wear and tear, subject to any limitation specified in the Schedule of Coverage; Repair or replacement of Durable Medical Equipment is not covered if it is needed due to negligence, misuse or disuse of the equipment. Replacement of lost or stolen Durable Medical Equipment is not covered. Durable Medical Equipment is limited to the standard item of Durable Medical Equipment that adequately meets the medical need of the Covered Person. Durable Medical Equipment includes special footwear for individuals who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or developmental disability.

    Durable Medical Equipment includes but is not limited to
    a. the following Base Durable Medical Equipment items:
        i. Diabetic Shoes and Inserts: off-the-shelf depth-inlay shoes; custom-molded shoes; custom-molded multiple density inserts; fitting, modification, and follow-up care for podiatric devices; repair or replacement of podiatric devices.
        ii. Glucose Monitors, Infusion Pumps, and Related Supplies: external single or multiple channel electric or battery-operated ambulatory infusion pumps; home blood glucose monitors; blood glucose test or reagent strips for home blood glucose monitors; interstitial glucose monitors; programmable and non- programmable implantable infusion pumps; infusion pump used for uninterrupted parenteral administration of medication; infusion sets for external insulin pumps; infusion supplies for external drug infusion pumps; lancets; calibrator solution/chips; single or multi-channel stationary parenteral infusion pumps; replacement batteries for home blood glucose monitors and infusion pumps; spring-

powered device for lancet; syringe with needle for insulin pump.

iii. Respiratory Drug Delivery Devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; water collection device for nebulizer; spacer for use with metered dose inhaler.

iv. Tracheostomy Equipment: artificial larynx; replacement battery for artificial larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits.

v. Canes and Crutches: adjustable and fixed canes, including standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips, and underarm pads.

vi. Dry pressure pad for a mattress.

vii. Cervical traction equipment (over door).

viii. Osteogenesis Stimulation Devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low-density ultrasound osteogenesis stimulator.

ix. IV pole.

x. Phototherapy (bilirubin) light with photometer.

xi. Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage.

xii. Non-segmental home model pneumatic compressor for the lower extremities; and

b. Supplemental Durable Medical Equipment not described under bulleted item “a” above that is approved by Medicare, such as oxygen, wheelchairs, and hospital beds.

Coverage of enteral and parenteral nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections is included under the prosthetic and orthotic benefit. Please refer to the Schedule of Coverage for the specific prosthetic and orthotic benefit coverage.

Please refer to Preventive Care Exams and Services in this General Benefits section for coverage of breast pumps.

25. Management and treatment of diabetes which includes equipment, supplies and medications as follows:

a) Blood glucose monitors and blood glucose testing strips.
b) Blood glucose monitors designed to assist the visually impaired.
c) Insulin pumps and all related necessary supplies.
d) Ketone urine testing.
e) Lancet and lancet puncture devices.
f) Pen delivery systems for the administration of insulin.
g) Podiatric devices to prevent or treat diabetes-related complications.
h) Insulin syringes.
i) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Coverage also includes diabetic day-care self-management program, training, education and medical nutrition therapy services, which shall be provided by appropriately licensed or registered health care professionals and diabetic day-care management programs. For the purposes of this provision, "diabetic day-care self-management program" means an educational program of instruction which will enable diabetic patients and their families to gain an understanding of the diabetic process, and the daily management of diabetic therapy in order to avoid frequent hospitalizations and complications.

26. Inpatient and Outpatient dialysis services related to acute renal failure and end-stage renal disease. Equipment, training, and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

27. Special footwear for individuals who suffer from foot disfigurement. Foot disfigurement includes, but is not limited to, disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes, and foot disfigurement caused by accident or development disability.
28. Vision, including routine exams, eye refractions, orthoptics, glasses, contact lenses of the fitting of glasses or contact lenses.
29. Rehabilitative Services. The following Services are covered:
    a) Physical therapy rendered by a certified physical therapist. Therapy must be attended as prescribed by the attending Physician.
    b) Speech therapy rendered by a certified speech therapist or certified speech pathologist.
    c) Occupational therapy rendered by a certified occupational therapist. Therapy must be attended as prescribed by the attending Physician.
    d) Pulmonary therapy.
30. Multidisciplinary services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program.
31. Respiratory therapy rendered by a certified respiratory therapist.
32. Mental Health Services for diagnosis and treatment of a Mental Disorder, including Severe Mental Illness and Serious Emotional Disturbances of a Child, limited to:
    a) Outpatient office visit mental health services, including the following:
        i. Individual and group mental health evaluation and treatment, including repetitive Transcranial Magnetic Stimulation (rTMS);
        ii. Psychological testing when necessary to evaluate a Mental Disorder;
        iii. Outpatient Services for the purpose of monitoring drug therapy; and
        iv. Gender dysphoria treatment, including diagnostic assessment, psychotherapy, and medication management.
    b) Outpatient other items and services (other than office visit services) for mental health care, defined as other outpatient intermediate services that fall between inpatient care and regular outpatient office visits, including but not limited to the following:
        i. Intensive psychiatric treatment programs, including the following:
            1) Short-term hospital-based intensive outpatient care;
            2) Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program;
            3) Mental health partial hospitalization;
            4) Electroconvulsive Therapy (ECT); and
            5) Psychiatric observation for an acute psychiatric crisis.
        ii. Mental Health partial hospitalization;
        iii. Services that are Medically Necessary for treating gender dysphoria, including outpatient reconstructive surgery and administered hormones; and
        iv. Behavioral Health Treatment Program for Pervasive Development Disorder or Autism (including treatment provided in the home).
    c) Inpatient mental health care, including the following:
        i. Inpatient hospitalization, including coverage for room and board, prescription drugs, and services of physicians and providers who are licensed health care professionals acting within the scope of their license; and
        ii. Treatment in a residential care facility, including short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis.
33. Treatment, services, or supplies covered under the Group Policy if received as an inpatient or outpatient in a Hospital or other licensed medical facility according to a prescribed treatment plan in connection with substance abuse. For purposes hereof, "substance abuse" means: a) alcoholism; and b) drug dependency. Treatment is limited to a program of therapy in: i) a facility established primarily for the treatment of substance abuse; ii) treatment in a residential care facility; or iii) a part of a Hospital used primarily for such treatment. 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.
34. Transplant services in connection with an organ or tissue transplant procedure, including charges

incurred by a donor or prospective donor who is not insured under the plan will be paid as though they were incurred by the insured provided that the services are directly related to the transplant. Coverage for transplant services shall not be denied based upon the Covered Person being infected with the human immunodeficiency virus (HIV)

35. Allergy testing and treatment, services, material and serums.
36. Fertility Services, except in vitro fertilization. Treatment of infertility is limited to treatment by artificial means for the purpose of causing pregnancy, such as: a) drugs; b) medicines; c) artificial insemination; d) gamete intrafallopian transfer; e) ovum transplants; f) donor eggs; or g) donor sperm. Treatment must be consistent with prevailing standards for efficacy. Benefits payable for diagnosis of infertility will be covered on the same basis as a Sickness.
37. Diagnosis and treatment of covered conditions directly affecting the upper or lower jawbone, or associated bone joints, including craniomandibular and temporomandibular joint disorders limited to Medically Necessary non-dental diagnostic and non-dental surgical treatment only.
38. Reconstructive Surgery. Coverage is limited to a surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function; or 2) to create a normal appearance to the extent possible. Reconstructive Surgery includes, but is not limited to, non-dental jaw bone surgery, incidental surgery to a covered mastectomy and Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Reconstructive breast surgery following a mastectomy including reconstruction of the healthy breast to produce a symmetrical appearance; prostheses; and treatment of complication at all stages of the mastectomy, including lymphedemas. Please refer to 'Prosthetic and Orthotic Devices that are Medically Necessary' in this **GENERAL BENEFITS** section for coverage of breast prostheses needed after a covered mastectomy.
39. External breast prosthesis after full or partial mastectomy, or lumpectomy, upon the order of a Physician. Coverage includes up to three bras each Accumulation Period designed for the exclusive use with the prosthetic.
40. General anesthesia and associated facility charges for dental procedures rendered in a Hospital or surgery center setting, when the clinical status or underlying medical condition of the Covered Person requires that the dental procedure be performed while the Covered Person is under general anesthesia in a Hospital or surgery center setting. Coverage shall not be provided unless the Covered Person is: under seven years of age; or
    a) developmentally disabled; or
    b) one whose health is compromised and for whom general anesthesia is medically necessary.

    This provision does not apply to treatment rendered for temporal mandibular joint disorders nor does it provide coverage for any dental procedure or the professional fees or services of the dentist.
41. Screening and treatment of Phenylketonuria (PKU), including coverage for medical food products, such as formula that are medically necessary for the treatment of PKU. Such coverage for formula and special food products are limited to the extent that the cost of such formulas or special food products exceed the cost of a normal diet.
42. Coverage for a second medical opinion, limited to charges for Physician consultation, and charges for any additional x-rays, laboratory tests and other diagnostic studies. Benefits will not be payable for x-ray, laboratory tests, or diagnostic studies that are repetitive of those obtained as part of the original medical opinion and/or those for which KPIC paid benefits.
43. Behavioral Health Treatment for Pervasive Developmental Disorder or Autism. The treatment must be prescribed by a physician or surgeon; or is developed by a psychologist and provided under the Treatment Plan prescribed by a Qualified Autism Service Provider and administered by one of the following:
    a) Qualified Autism Service Provider.
    b) Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
    c) Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.
44. Habilitative Services. The following Services are covered:
    a) Physical therapy rendered by a certified physical therapist.
    b) Occupational therapy performed by a licensed occupational therapist.

c) Speech therapy rendered by a certified speech therapist or certified speech pathologist.
d) Pulmonary therapy.
e) Multidisciplinary habilitation services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program.

45. Covered Services in connection with the diagnosis of Obesity. These include Covered Services to diagnose the causes of obesity, for treatment of diseases causing obesity, or resulting from obesity including screening, diagnostic testing and lab services.
46. Telehealth when used as a mode of delivering otherwise Covered Services via interactive and non-interactive communications methods, including, email or the transmission of data via online technology, telephone and fax. Coverage is limited to services obtained from a Participating Provider.
47. Diagnosis, treatment and management of osteoporosis, including but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.
48. Covered Services associated with clinical trials, including Routine Patient Care Costs, if all of the following requirements are met:
    a) You are a ”qualified insured” eligible to participate in the approved clinical trial, as defined below, according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
        i. A Participating Provider makes this determination; or
        ii. A Non-Participating provider makes this determination, including a Non-Participating provider located outside this state, if the clinical trial is not offered or available through a Participating Provider. If any Participating Provider participates in the clinical trial and will accept You as a participant in the clinical trial, You must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where You live; and
    b) The services would be covered under this Policy if they were not provided in connection with a clinical trial.

    For Covered Services related to a clinical trial, You will pay the Cost Sharing You would pay if the Covered Services were not related to a clinical trial. If You participate in the clinical trial offered by a Non-Participating Provider because the clinical trial is not offered or available through a Participating Provider, then the Participating Provider Cost Sharing and Out-of-Pocket Maximum applies.

    "Qualified insured" means an insured who meets both of the following conditions:
    (A) The Insured is eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition; and
    (B) Either of the following applies:
        (i) The referring health care professional is a Participating Provider and has concluded that the Insured's participation in the clinical trial would be appropriate because the Insured meets the conditions of subparagraph (A); or
        (ii) The Insured provides medical and scientific information establishing that the Insured's participation in the clinical trial would be appropriate because the Insured meets the conditions of subparagraph (A).

    “Approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition that meets at least one of the following:
    (A) The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
        (i) The National Institutes of Health.
        (ii) The federal Centers for Disease Control and Prevention.
        (iii) The Agency for Healthcare Research and Quality.
        (iv) The federal Centers for Medicare and Medicaid Services.

(v) A cooperative group or center of any of the entities described in clauses (i) to (iv), inclusive, the Department of Defense, or the United States Department of Veterans Affairs.
(vi) A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
(vii) One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
(I) The United States Department of Veterans Affairs.
(II) The United States Department of Defense.
(III) The United States Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
(C) The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Preventive Care

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

Preventive Care Exams and Services

As shown in the Schedule of Coverage, the following preventive services are not subject to Deductibles, Copayments or Coinsurance if received at the Participating Provider tier. 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 routine prenatal care office visits, according to the Health Resources and Services Administration (HRSA) guidelines.

Screening:

1) Abdominal aortic aneurysm screening
2) Asymptomatic bacteriuria screening
3) Breast cancer mammography screening
4) Cervical dysplasia screening including Human Papilloma Virus (HPV) screening and Pap test,
5) Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy. This includes anesthesia required for colonoscopies, pathology for biopsies resulting from a screening colonoscopy, over the counter and prescriptions drugs necessary to prepare the bowel for the procedure and a specialist consultation visit prior to the procedure.
6) Depression screening
7) Diabetes screening for non-pregnant women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus
8) Gestational diabetes screening
9) Hepatitis B and Hepatitis C virus infection screening
10) Hematocrit or Hemoglobin screening in children
11) High blood pressure screening
12) Lead Screening
13) Lipid disorders screening
14) Lung cancer screening with low-dose computed tomography, including a counseling visit to discuss the screening

15) Newborn congenital hypothyroidism screening
16) Newborn hearing loss screening
17) Newborn metabolic/hemoglobin screening
18) Newborn sickle cell disease screening
19) Newborn Phenylketonuria screening
20) Obesity screening
21) Osteoporosis screening
22) Rh (D) incompatibility screening
23) Sexually transmitted infection screening such as chlamydia, gonorrhea, syphilis and HIV screening
24) Type 2 diabetes mellitus screening
25) Tuberculin (TB)Testing
26) Urinary incontinence screening in women
27) Visual impairment in children screening

Health Promotion:

1) Unhealthy alcohol use and drug misuse assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse.
2) Healthy diet behavioral counseling.
3) Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children.
4) Referral for testing for breast and ovarian cancer susceptibility, genetic counseling and BRCA mutation testing.
5) Sexually transmitted infections counseling.
6) Tobacco use and tobacco-caused disease counseling and interventions, including all FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs.
7) Discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention and when prescribed by a physician for asymptomatic women with an increased risk of breast cancer and no history of breast cancer, risk reducing medication such as tamoxifen and raloxifene.
8) When prescribed by a licensed health care professional authorized to prescribe drugs:
   a) aspirin in the prevention of cardiovascular disease and preeclampsia in pregnant women and colorectal cancer.
   b) iron supplementation for children from 6 months to 12 months of age.
   c) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
   d) topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.
   e) folic acid supplementation for women planning or capable of pregnancy.
9) Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and consulting by a trained provider during pregnancy and/or in the post-partum period, purchase of a breast pump (including a hospital-grade double breast pump kit). In lieu of purchase of a breast pump, rental of a hospital-grade electric breast pump, including any equipment that is required for pump functionality, when prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.
10) All prescribed FDA-approved contraceptive drugs and all prescribed FDA-approved contraceptive methods for all women with reproductive capacity, including but not limited to cervical caps, vaginal rings, continuous extended oral contraceptives and patches. This includes the following 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, and 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. In addition, fertility awareness-based methods, including the lactation amenorrhea method,

although less effective, is covered for women desiring an alternative method.

11) Screening and counseling for interpersonal and domestic violence.
12) Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls.
13) Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.
14) Counseling of parents of children, adolescents, and young adults aged 6 months to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce their risk for skin cancer.

Disease prevention:

1) Immunizations as recommended by the Centers for Disease Control and HRSA. Coverage includes flu shots administered at a Participating Pharmacy.
2) Prophylactic gonorrhea medication for newborns to protect against gonococcal ophthalmia neonatorum
3) Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met: a) individuals are aged 40-75 years; b) they have one or more cardiovascular risk factors; and c) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.
4) Pre exposure Prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition

Covered Services under the Affordable Care Act (ACA) have been determined by recommendations and comprehensive guidelines of governmental scientific committees and organizations as listed below:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including:
    a) The American Academy of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care, and
    b) The Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children.
4. For women, to the extent not described in paragraph (a), evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration Women's Preventive Services Guidelines.

The preventive services listed above may change according to federal guidelines in effect as of January 1 of each year, however, such changes, unless we notify You otherwise, will not be effective until your Group Policy renews in that Calendar Year. You will be notified at least sixty (60) days in advance, if any item or service is removed from the list of covered services.

For a complete list of current preventive services required under the Patient Protection Affordable Care Act for which cost share does not apply, please call: 1-800-464-4000. You may also visit:

- U.S. Centers for Medicare & Medicaid Services Preventive Care Benefits. www.healthcare.gov/center/regulations/prevention.html.
- U.S. Preventive Services Task Force Grade A & B recommendations. www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention. www.cdc.gov/vaccines/acip/index.html
- Guidelines for women's preventive health care as supported by the Health Resources and Services

Administration (HRSA).
www.hrsa.gov/womensguidelines/

- Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.
www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

Please note, however, for recommendations that have been in effect for less than one year, KPIC will have one year from the effective date to comply.

Note: Screening colonoscopies or sigmoidoscopies are covered under this section as a preventive benefit. This includes polyp removal during a colonoscopy performed as a screening procedure. However, sigmoidoscopies or colonoscopies that are not screening are not Covered Services under the Preventive Exams and services benefit but may be Covered Services as Outpatient care and may affect Your out of pocket costs.

Other Preventive Care

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

1. Routine nursery care and Physician charges for a newborn while the mother is confined.
2. Adult preventive screening. Services must meet the prevailing standards. The care will include:
   a) Screening and diagnosis of prostate cancer, including but not limited to prostate- specific antigen testing and digital rectal examination when Medically Necessary and consistent with good professional practice. 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; and
   b) All other cancer screening tests not covered under ACA including any cervical cancer screening test approved by the Federal Food and Drug Administration.
3. Adult routine physical examinations. Services must meet prevailing standards. The care shall include: a) examination; b) history; and c) x-ray and laboratory tests limited to: EKG, chest x- rays, CBC, comprehensive metabolic panel, urinalysis (when performed in conjunction with a routine adult physical examination)
4. Other hearing screenings limited to services to determine the need for a hearing correction
5. Family planning limited to:
   a) The charge of a Physician for consultation concerning the family planning alternatives available to You and Your spouse or Domestic Partner (except those considered preventive benefits under ACA), including any related diagnostic tests;
   b) Charges for the following procedures:
      i) vasectomy;
      ii) elective abortion; and
      iii) fertility testing and counseling.

   Family planning charges do not include any charges for the following:
   a) artificial insemination;
   b) in vitro fertilization and other procedures involving the eggs; and
   c) implantation of an embryo developed in vitro.

   Please refer to Health Promotion under Preventive Care Exams and Services in this General Benefits section for coverage of contraceptive methods.
6. AIDS vaccine limited to those approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service
7. Prenatal alpha-fetoprotein screening
8. Health education counseling programs and programs for stress management and chronic conditions

such as diabetes and asthma.
9. FDA approved tobacco cessation prescription or over-the-counter medications by a licensed health care professional authorized to prescribe drugs for women who are pregnant.
10. Iron deficiency anemia screening for pregnant women.
11. Health Education including diabetic day care management.
12. Iron deficiency anemia screening for pregnant women.
13. Vitamin D to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.

Length of Stay for Inpatient Maternity Care

Hospital Confinements in connection with childbirth for the mother or newborn child will not be limited to less than 48 hours following normal vaginal delivery and not less than 96 hours following a Caesarean section, unless, after consultation with the mother, the attending provider discharges the mother or newborn earlier. Your Physician may order a follow-up visit for You and Your newborn to take place within 48 hours after discharge.

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

Length of Stay for Mastectomy and Lymph Node Surgical Services

The length of a hospital stay associated with mastectomy or lymph node surgical procedures will be determined by the attending Physician in consultation with the patient, post-surgery, consistent with sound clinical principles and processes. The treating physician and surgeon is not required to receive prior approval from KPIC in determining the length of hospital stay following these procedures.

Benefits for Emergency Services

Emergency Services are covered 24 hours a day, 7 days a week, anywhere in the world. If You have an Emergency Medical Condition, call 911 or go to the nearest emergency room.

If You receive Emergency Care/Services and cannot, at the time of emergency, reasonably reach a Participating Provider, that emergency care rendered during the course of the emergency will be paid for in accordance with the terms of the Group Policy, at benefit levels at least equal to those applicable to treatment by a Participating Providers for emergency care in an amount based on the Usual, Customary, and Reasonable charges in the area where the treatment is provided.

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

Extension of Benefits

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

GENERAL BENEFITS

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

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

GENERAL LIMITATIONS AND EXCLUSIONS

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

1. Charges in excess of the Maximum Allowable Charge.
2. Confinement, treatment, services or supplies not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically covered under the plan.
3. Services or supplies other than Emergency Services received outside the United States.
4. Treatment, services, or supplies provided by the Covered Person; his or her spouse or Domestic Partner; a child, sibling, or parent of the Covered Person or of the Covered Person's spouse or Domestic Partner; or a person who resides in the Covered Person's home.
5. 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.
6. Dental care including dental x-rays; dental appliances; orthodontia; and dental services resulting from medical treatment. This exclusion does not include: a) visits for repairs or treatment of accidental injury to a jaw or sound natural teeth when performed or rendered within 12 months following an accident, when the accident is sustained while covered under the Group Policy; b) service that is for an Insured Dependent child because of congenital disease or anomaly; or c) the removal of impacted wisdom teeth when imbedded in bone; or d) Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures.
7. Cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance. This exclusion does not apply to covered Reconstructive services including services related to mastectomy or testicular implants, or prosthetics to replace all or part of an external facial body part or to covered reconstructive surgery services for treating gender dysphoria that are described under the **GENERAL BENEFITS** section.
8. Nonprescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician, except as listed under Preventive Care in the **GENERAL BENEFITS** section.
9. Any treatment, procedure, drug or equipment, or device which is experimental or investigational. This means that one of the following is true:
    - 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
    - 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.
    - As described under the Outpatient Prescription Drug Benefits section, this exclusion will not apply to experimental drugs and medicines that are used to treat cancer if one or more of the following conditions is met:
    - the drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information publication; or
    - the drug is recommended for treatment of the Covered Person's particular type of cancer and has been found to be safe and effective in formal clinical studies, the result of which have been published in either the United States or Great Britain.
10. Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems, except as otherwise provided for the treatment of Severe Mental Illness of a person of any age and/or Serious Emotional Disturbances of a Child or Mental Disorders described in the DSM IV.
11. Services, supplies or drugs rendered for the treatment of obesity or weight management, including bariatric surgery, weight loss programs (such as Weight Watchers and OPTIFAST), fitness programs and gym memberships. However, Covered Charges made to diagnose the causes of obesity or Covered Charges made for treatment of diseases causing obesity or resulting from obesity, including screening, diagnostic testing and lab services are covered.
12. Recreational therapy.
13. Testing for ability, aptitude, intelligence or interest.

14. Items and services that are not health care items and services, including the following:
    a. Teaching manners and etiquette
    b. Teaching and support services to develop planning skills such as daily activity planning and project or task planning
    c. Items and services that increase academic knowledge or skills
    d. Teaching and support services to increase intelligence
    e. Academic coaching or tutoring for skills such as grammar, math, and time management
    f. Teaching you how to read, whether or not you have dyslexia
    g. Educational testing
    h. Teaching art, dance, horse riding, music, play or swimming, except that this exclusion for "teaching play" does not apply to Covered Services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the **GENERAL BENEFITS** section
    i. Teaching skills for employment or vocational purposes
    j. Vocational training or teaching vocational skills
    k. Professional growth courses
    l. Training for a specific job or employment counseling
    m. Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to covered physical therapy services that are part of a physical therapy treatment plan and covered under the **GENERAL BENEFITS** section.
15. Non-surgical treatment of craniomandibular and temporomandibular joint disorders.
16. Confinement, treatment, services or supplies that are required: a) by a court of law; or b) for insurance, travel, employment, school, camp, government licensing, or similar purposes.
17. Personal comfort items such as telephone, radio, television, or grooming services.
18. Custodial care. Custodial Care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse. This exclusion does not apply to custodial care that is provided as part of covered home health care or hospice care.
19. Care in an intermediate care facility. This is a level of care for which a Physician determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.
20. Routine foot care such as trimming of corns and calluses
21. Confinement or services that are not Medically Necessary or treatment that is not completed in accordance with the attending Physician's orders.
22. Services of a private duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility.
23. Medical social services except those services related to discharge planning in connection with: a) a covered Hospital Confinement; b) covered Home Health Care Services; or c) covered Hospice Care.
24. Living expenses or transportation, except as provided under Covered Services.
25. Reversal of sterilization.
26. Services provided in the home other than Covered Services provided through a Home Health Agency.
27. The following Home Health Care Services:
    a) meals,
    b) personal comfort items,
    c) housekeeping services.
28. Services received in connection with a surrogacy arrangement, except for otherwise Covered Services provided to a Covered Person who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Please refer to the “Surrogacy Arrangement” provision under the **GENERAL PROVISIONS** section for information about Your obligations to Us in connection with a surrogacy arrangement, including Your obligation to reimburse Us for any services We cover and to provide information about anyone who may be financially responsible for Covered Services the baby (or babies) receive.
29. 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.

30. Computed tomographic colonography screening (virtual colonoscopy) except when endoscopic colonoscopy screening cannot be safely performed, such as in anatomical blockage of the colon.
31. Biofeedback or hypnotherapy.
32. Foreign travel Immunizations, regardless of age.
33. Health education, including but not limited to: a) stress reduction; b) weight reduction; or d) the services of a dietitian. This exclusion does not apply to services including tobacco use and tobacco- caused disease counseling and intervention
34. Hearing exams; hearing therapy; or hearing aids.
35. Radial keratotomy to treat a refractive error of the eye.
36. Vision services, including routine exams, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses.
37. Services for which no charge is normally made in the absence of insurance.
38. Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases.
39. Fertility preservation services when a covered treatment may directly or indirectly cause Iatrogenic Infertility in accordance with the provisions of California Senate Bill 600 of 2019 and any subsequent implementing regulations and guidance, California Insurance Code section 10112.27, and any other applicable laws as then constituted or later amended in connection with its coverage.

OPTIONAL OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

To determine if You are covered for the Optional Outpatient Prescription Drug Benefit You must refer to the Schedule of Coverage. If the Prescription Drug Benefit is not listed as covered under Your Schedule of Coverage, then the benefit is excluded from coverage.

Prescribed drugs, medicines and supplies purchased from a licensed pharmacy 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 require administration by medical personnel; and e) 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.

Open drug formulary

This Outpatient Prescription Drug Benefit uses an open formulary. Unless specifically excluded under the Plan, all FDA-approved drugs are part of this Plan's open formulary The formulary consists of generic and preferred and non-preferred brand drugs including specialty drugs. To access the Outpatient Prescription Drug Formulary online, please visit http://info.kaiserpermanente.org/html/kpic/formulary.html

All Medically Necessary outpatient prescription drugs are covered, including disposable devices for the administration of a covered outpatient prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs, and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. Please see the "Exception Requests for a drug not on the formulary" subsection below for information on the exception process.

Prior Authorization

Outpatient Prescription Drug Prior authorization is a procedure that is used to encourage safe and cost-effective medication use. Prior authorization is generally applied to drugs that have multiple indications, are high in cost, or have a significant safety concern.

The purpose of prior authorization is to ensure that a Covered Person gets the right medication. This means that when Your licensed prescribing provider prescribes a drug that has been identified as subject to prior authorization, the medication needs to be reviewed by Us to determine Medical Necessity before the prescription is filled. Prior authorization edits address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.

If a drug requires prior authorization, your licensed prescribing provider will need to work with Us to pre-approve the drug. Prior authorized drugs have specific clinical criteria that You must meet in order to obtain coverage. Refer to the formulary for a complete list of medications requiring prior authorization. The most current formulary can be obtained by visiting kp.org/kpic/ppo. If you have questions about prior authorization or about drugs covered You can call 24 hours a day, 7 days a week (closed holidays), at 1-800-788-2949 or 711 (TTY).

The Covered Person or the licensed prescribing provider must notify the Prescription Drug Review Program as follows:

1. The Covered Person or the licensed prescribing provider can obtain a copy of the request form by calling 1-800-788-2949. Prior authorization requests not made on the prescribed request form shall not be accepted;
2. We will accept the request form through any reasonable means of transmission, including, but not limited to, paper, electronic, or any other mutually accessible method of transmission;
3. Upon receipt of a completed request form, We will notify the licensed prescribing provider within 72 hours for non-urgent requests and within 24 hours if exigent circumstances exist from receipt of a request

form, that:

a. The request is approved; or
b. The request is disapproved due to:
    i. Not Medically Necessary; or
    ii. Missing material information necessary to determine Medical Necessity; or
    iii. The patient is no longer eligible for coverage; or
    iv. The request is not submitted on the prescribed Request Form and must be resubmitted using the prescribed request form.

4. If We fail to respond within 72 hours for non-urgent requests and within 24 hours if exigent circumstances exist from receipt of a request form from a licensed prescribing provider; the request shall; be deemed to have been approved.
5. In the event, the licensed prescribing provider's prior authorization request is disapproved:
6. The notice of disapproval must contain an accurate and clear written explanation of the specific reasons for disapproving the request.
7. If the request is disapproved due to missing material information necessary to determine Medical Necessity, the notice of disapproval must contain an accurate and clear explanation that specifically identifies the missing material information.
8. The prescription drug prior authorization request shall be deemed approved in the event that:
9. The notice of disapproval is not sent to the licensed prescribing provider within 72 hours of receipt of a non-urgent request and within 24 hours for exigent circumstances; or
10. We accept any prescription drug prior authorization form other than the prescribed request form and We did not send timely disapproval.
11. Notices required to be sent to the Covered Person or to his/her designee or the licensed prescribing provider shall be delivered by Us in the same manner as the request form was submitted to Us, or any other mutually agreeable accessible method of notification.
12. Prescription drug prior authorization procedures conducted electronically through a web portal, or any other manner of transmission mutually agreeable, shall not require the licensed prescribing provider to provide more information than is required by the request form.

Step therapy process

Selected prescription drugs require step therapy. The step therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain high-cost medications. Refer to the formulary for a complete list of medications requiring step therapy. This means that to receive coverage You may first need to try a proven, cost-effective medication before using a more costly treatment. Treatment decisions are always between You and Your Provider.

The step therapy program is a process that defines how and when a particular drug can be dispensed by requiring the use of one or more prerequisite drugs (1st line agents), as identified through the Covered Person's drug history, prior to the use of another drug (2nd line agent).

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

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

Exigent circumstances *exists when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when a Covered Person is using a drug while undergoing a current course of treatment.*

Request form *means the prescription drug prior authorization form prescribed by KPIC as set forth under applicable California state law.*

Licensed prescribing provider *shall include a provider authorized to write a prescription pursuant to*

subdivision (a) of the Business and Professional Code section 4040, to treat a medical condition of a Covered Person.

There are no precertification requirements for outpatient prescription drugs under the open formulary. As such, there are no prior authorization or exception request processes for outpatient prescription drugs under this coverage.

Exception Requests

You or Your designated assignee or the licensed prescribing provider may request an exception to the Outpatient Prior Authorization Request and Step Therapy process described above if You are already being treated for a medical condition and currently under medication of a drug subject to prior authorization or step therapy, provided the drug is appropriately prescribed and is considered safe and effective for your condition.

However, further prior authorization may be required for the continued coverage of a prescription drug prescribed pursuant to a prior authorization or step therapy process imposed from a prior insurance policy.

To request a waiver please call: 1-800-788-2949 (MedImpact).

If Your request for a waiver of Outpatient Prescription Drug Prior Authorization or of the step therapy process is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Exception Requests for a drug not on the Formulary

You can request an exception to obtain coverage of a drug that is not listed on the formulary by calling MedImpact, KPIC's Pharmacy Benefit Manager ("PBM") at **1-800-788-2949.** Upon receipt of Your request, MedImpact will notify You within 72 hours for non-urgent requests and within 24 hours if urgent circumstances exist, of the request approval or other outcome. (Urgent circumstances exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health or ability to regain maximum function or when an insured is using a drug while undergoing a current course of treatment.) If a standard exception request is granted, coverage of the requested drug, including refills, will be granted for the duration of the prescription. If an exception based on urgent circumstances is granted, coverage of the drug will be granted for the duration of the urgency.

If Your request for an exception for coverage of a drug not listed on the formulary is denied, altered, or delayed, You have the right to appeal the denial, alteration or delay. Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

Outpatient Prescription Drug Benefits

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

1. Legend Drugs. Legend Drugs means drugs that are approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state law to be dispensed to the public only by prescription from a licensed Physician or other licensed provider;
2. Experimental drugs and Medicines used to treat cancer if one or more of the following conditions is met:
   a) the drug is recognized for treatment of the Covered Person's particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information publication: or
   b) the drug is recommended for treatment of the Covered Person's particular type of cancer and has been found to be safe and effective in formal clinical studies, the result of which have been

published in either the United States or Great Britain;

3. Off-label use of covered prescription drugs;
4. Insulin, including needles and syringes used for insulin;
5. Prescriptive medications for the treatment of diabetes;
6. Glucagon;
7. Disposable devices that are Medically Necessary for the use of covered outpatient prescription drugs, including disposable needles and syringes needed for injecting covered drugs and supplements, and inhaler spacers needed to inhale covered drugs;
8. The following other pharmacy items:
   a) Disposable blood glucose and ketone urine test strips;
   b) Blood glucose monitors;
   c) Lancets and lancet puncture devices;
   d) Pen delivery systems for the administration of insulin;
   e) Visual aids excluding eyewear to assist in insulin dosing; and,
   f) Peak flow meters

Please refer to "Management and treatment of diabetes" under the **GENERAL BENEFITS** section of this Certificate for a list of diabetic equipment and supplies covered under the medical benefit portion of this Plan.

9. Contraceptive drugs and devices. These drugs and devices are covered as preventive services under the Preventive Care and Services header in the General Benefits section;
10. Drugs or devices that do not require a prescription by law (over the counter drugs). These drugs are limited to over the counter contraceptive and other oral over the counter drugs which are covered as preventive services under the Preventive Care and Services header in the General Benefits section;
11. Continuity drugs. If this Plan is amended to exclude a drug that we had previously been covering and providing to You under this Plan we will continue to be provided if a Your Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.
12. Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells.
13. Pain management medications prescribed for a terminally ill patient when Medically Necessary and in accordance with our formulary guidelines. For purposes hereof, a terminally ill patient is any patient whose life expectancy, as determined by a Physician, is not greater than 12 months.

If a Physician prescribes a Brand Name, Generic or over the counter Prescription Drug and the pharmacy's retail price for the prescription drug is less than the applicable copayment, the insured is not required to pay any more than the retail price.

Limitations:

Mail Order Service

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

The prescription drug mail order service is administered by the Mail Order Pharmacy ("Pharmacy") contracted by KPIC's Pharmacy Benefit Manager ("PBM").

The contracted mail order service can give You more information about obtaining refills. For example, not all drugs can be mailed through our mail-order service. Some drugs (for example, drugs that are extremely high cost or require special handling) may not be eligible for mailing. Drugs cannot be mailed outside the United States. Please check with the contracted mail order service if You have a question about whether or not Your prescription is available to be mailed. Items available through our mail-order service are subject to change at any time without notice.

OPTIONAL OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

Any prescriptions that are delayed greater than 4 days in facility have upgraded/expedited shipping placed on them at Pharmacy's expense. If at any point the patient states that they are out of medication or running out of medication, Pharmacy may upgrade shipping to Overnight, arrange for short term supply at a local store, or both. Some exclusions may apply depending on medication type (ex. Controlled medications).

2. Episodic drugs prescribed for the treatment of sexual dysfunction disorders are limited to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period

Brand Name Prescription Drug and Generic Prescription Drug Rules (These rules do not apply to FDA-approved contraceptive drugs.)

1. If the drug prescribed by the Physician is a Generic Prescription Drug – Copayment due for the prescription is that of the Generic Prescription Drug, as shown in the Schedule of Coverage.
2. If the drug prescribed by the Physician is a Generic Drug and the Covered Person prefers a Brand Name Prescription Drug – Copayment due for the prescription is the Brand Name Prescription Drug Copayment as shown in the Schedule of Coverage, plus the cost difference between the Brand Name Prescription Drug and the Generic Prescription Drug.
3. If a Physician prescribes a Brand Name Prescription Drug and orders such prescription as "DISPENSED AS WRITTEN", the copayment due for such prescription is the applicable copayment for a Brand Name Prescription Drug, as shown in the Schedule of Coverage.
4. If a Physician prescribes a Brand Name Prescription Drug and did not order such prescription as "DISPENSED AS WRITTEN", and a Generic Prescription Drug is available, but the Covered Person prefers a Generic Prescription Drug, the copayment due for such prescription is the applicable copayment for a Generic Prescription Drug, as shown in the Schedule of Coverage.
5. If a Physician prescribes a Brand Name Prescription Drug and did not order such prescription as "DISPENSED AS WRITTEN", and a Generic Prescription Drug is available, but the Covered Person prefers a Brand Name Prescription Drug, the copayment due for such prescription is the applicable copayment for a Brand Name Prescription Drug, as shown in the Schedule of Coverage, plus the cost difference between the Brand Name Prescription Drug and the Generic Prescription Drug.
6. If a Physician prescribes a Brand Name Prescription Drug and did not order such prescription as "DISPENSED AS WRITTEN", and a Generic Prescription Drug is not available, the copayment due for such prescription is the applicable copayment for a Brand Name Prescription Drug, as shown in the Schedule of Coverage.

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. Experimental Drugs and Medicines not listed as covered.
2. Drugs or devices that do not require a prescription by law except when over the counter drug coverage is required by law.
3. Weight loss drugs.
4. Charges for the administration of any drug when the drug does not require administration by medical personnel.
5. Any drug 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.

OPTIONAL BENEFITS, LIMITATIONS, AND EXCLUSIONS

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

1. Foreign travel Immunizations, regardless of age.
2. Vision services:
   a) Coverage for adults (age 19 and older) is limited to an allowance every 24 months towards the cost of routine exams, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses.
   b) Coverage for children (up to age 19) is provided to a Covered Person until the last day of the month in which the Covered Person turns nineteen years of age and includes the following:
      i) one routine eye exam every 24 months, including refractive exams to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses; and
      ii) either one pair of lenses (single vision, conventional, or lenticular), and one pair of eyeglass frames (limited to standard frames, not including designer or deluxe frames; or safety frames that requires prescription safely lenses) every 24 months; or, a 24-month supply of contact lenses every 24 months (elective or Medically Necessary).

   Please see Your Schedule of Coverage
3. Musculoskeletal therapy involving manual manipulation of the spine to correct subluxation demonstrable by x-ray.
4. Chiropractic and Acupuncture services. Coverage for office visits is limited to Medically Necessary chiropractic and acupuncture services authorized and provided by a Participating or Non-Participating Provider. Except for the initial examination, chiropractic benefits are limited to chiropractic services for the treatment or diagnosis of neuromusculoskeletal disorders that are due to subluxation and are treatable by manual manipulation of the spine. Please note that you may receive care or treatment from your Chiropractor that is not covered under your optional Chiropractic benefits. Please refer to the General Benefits section in this Certificate for an explanation of your benefits and coverage.

FEDERAL CONTINUATION OF HEALTH INSURANCE

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

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

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

Qualifying Events

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

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

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

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

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

Continuation of Coverage Period

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

1. 18 months following qualifying event (A) except if a qualifying event (B) occurs during this 18 months, the continuation of coverage period will be extended an additional 18 months for a total period of 36 months.
2. 36 months following qualifying event (B);
3. for a qualifying event (C):
   a) the date of Your death, at which time Your dependents (other than Your surviving spouse in (i) below) will be entitled to continue coverage on the same basis as if a qualifying event (B) had occurred.
   b) if You died before the occurrence of a qualifying event (C), Your surviving spouse is entitled to lifetime coverage.
4. the end of a 36-month period following an event described in qualifying event (D), without regard to whether that occurrence is a qualifying event, or for any subsequent qualifying event;
5. the date You or Your dependents become covered under any other group coverage providing hospital, surgical or medical benefits, insured or self-insured, which does not contain any limitation with respect to any preexisting condition;
6. the date a Covered Person, other than those provided continuation of coverage under qualifying event

(C) becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
7. the date the employer ceases to provide any group health coverage for its employees; or
8. the date any premium for continuation of coverage is not timely paid.

Requirements

You or Your Dependent must notify the employer within 60-days of the following qualifying events:
1. the date You and Your spouse were legally divorced or legally separated; or
2. the date the coverage for Your Dependent child ceases due to reaching the limiting age.

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

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

In any event, KPIC will not be required to provide a continuation of coverage under this provision unless KPIC has received:
1. a written request for continuation, signed by You or Your Dependent; and
2. the premium for the period from the termination date to the end of the last month for which Your employer has paid the group premium.

If Your Employer Group's size changes to 19 or fewer employees and Your employer is required to comply with Cal-COBRA, this will not affect You and Your coverage if You were already enrolled in Federal COBRA.

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 11 months for a total period of 29 months. To obtain that extension, the Covered Person must notify the employer of Social Security's determination before the initial 18- month maximum period ends.

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

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

Extension of Coverage After Exhaustion of COBRA

If a Covered Person has exhausted continuation of coverage under COBRA and or Cal COBRA (if applicable) and the Covered Person was entitled to less than 36 months of COBRA and or Cal COBRA

(if applicable) coverage, such continuation of coverage may be extended to a maximum of 36 months from the effective date of the COBRA coverage.

FEDERAL CONTINUATION OF HEALTH INSURANCE

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.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

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

CALIFORNIA REPLACEMENT AND DISCONTINUANCE

Insurance Continued from a Replaced Plan

Replaced Plan as used in this section means a Policyholder's health benefit plan which the Policyholder has replaced, not more than 60 days after its termination with This Plan.

Continued Insurance means the insurance of a Covered Person whose medical coverage under a Replaced Plan has ceased:

1. due to the Replaced Plan's termination; or
2. due to a Policyholder's termination of medical coverage under a Replaced Plan.

Continued Insurance

The effective date of a Covered Person's continued insurance will not be deferred because:

1. an Insured Employee is not actively at work on that date; or
2. a Dependent is confined in a health care facility on that date;

The Insured Employee's insurance under the plan will be the same as they would have had under the Replaced Plan until the date on which that Covered Person is: a) an Insured Employee who is actively at work; or b) a Dependent who is not confined in a health care facility.

Termination of Continued Insurance during Total Disability

The Continued Insurance of a Covered Person who became totally disabled while covered under a Replaced Plan will terminate on the earlier of these dates:

1. the date the Covered Person is no longer totally disabled; or
2. the last date of the 12-month period that follows the last day for which premiums were paid for the Covered Person's medical coverage under the replaced plan;

Unless the Covered Person is insured as otherwise provided under This Plan.

Limitations and Reductions

1. No benefits will be paid under the plan for Expenses Incurred due to an Injury or Sickness for which a Covered Person is entitled to an extension of benefits under the Replaced Plan.
2. Benefits paid under this provision will not be more than the benefits of the Replaced Plan as they would be paid if the plan had not been replaced.
3. The Continued Insurance benefits will be reduced by the amounts that are paid under a Replaced Plan for the same loss or expense.

Policy Termination during Total Disability - Extension of Benefits

The insurance 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 or on the date the Covered Group ceases to be a Policyholder.

A Covered Person other than a Dependent minor is **"totally disabled"** only if in the judgment of a Physician, an illness or injury is:

1. expected to result in: death or has lasted or is expected to last for a continuous period of at least 12 months; and
2. 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, an illness or injury:

1. is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and
2. makes the person unable to engage in most of the normal activities of persons in good health of like age.

COORDINATION OF BENEFITS

Application

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

The benefits of this Plan:

1. will not be reduced when this Plan is primary;
2. may be reduced when another Plan is primary and This Plan is secondary. The benefits of This Plan are reduced so that they and the benefits payable under all other Plans do not total more than 100% 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.
    c) if the other Plan does not have the birthday rule, but has the male\female rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
4. Dependent Child: Separated or Divorced Parents: If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined as follows:
    a) first, the Plan of the parent with custody of the child;
    b) then, the Plan of the spouse or the Domestic Partner of the parent with custody of the child; and
    c) finally, the Plan of the parent without custody of the child.

    However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the primary Plan. This paragraph does not apply with respect to any 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 or retired (or as that employee's Dependent). The secondary Plan is the Plan which covers that person as a laid off or retired Covered Person (or as that Covered Person’s Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
6. Longer\Shorter Length Of Coverage: If none of the above rules determines the order of benefits. the primary Plan is the Plan which covered a Covered Person, or subscriber the longer time. The secondary Plan is the Plan which covered that person the shorter time.

Effect of Medicare

This Plan will be primary to Medicare for an active employee and Dependent spouse or Domestic Partner 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 or Domestic Partner of a retiree age 65 or over; this applies whether or not the retiree or spouse or Domestic Partner is enrolled in Medicare.

Members with Medicare and Retirees

This plan is not intended for retirees and most Medicare beneficiaries. If, during the term of this Group Policy, You are or become eligible for Medicare or You retire, the following will apply:

- If You are the Insured Employee and You retire, Your coverage under this Policy will be terminated and You may be eligible to continue membership as described in Your Group Policy or in the Termination of Membership section of This Plan.
- If federal law requires that Your Group's health care plan be primary and Medicare coverage be secondary, Your coverage under this Policy will be the same as it would be if You had not become eligible for Medicare.
- If none of the above applies to You and You are eligible for Medicare, please ask Your Group's benefits administrator about Your membership options.

Reduction in this Plan's Benefits

When the benefits of This Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable Benefit Maximum of This Plan.
Any benefit amount not paid under This Plan because of coordinating benefits becomes a benefit credit under This Plan. This amount can be used to pay any added Allowable Expenses the Covered Person may incur during the remainder of the Calendar Year, including any coinsurance payable under This Plan.

Right to Receive and Release Information

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

Facility of Payment

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

Right of Recovery

If the amount of the payments made by KPIC is more than it should have paid, KPIC may recover the excess from one or more of the following:
1. the persons KPIC has paid or for whom it has paid.
2. insurance companies.
3. other organizations.

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

When a Covered Person’s Injury appears to be someone else's fault, benefits otherwise payable under the policy for Covered Expense incurred as a result of that Injury will not be paid unless the Covered Person or his legal representative agrees:

a) to repay KPIC for such benefits to the extent they are for losses for which compensation is paid to the Covered Person by or on behalf of the person at fault;
b) to allow KPIC a lien on such compensation and to hold such compensation in trust for KPIC; and
c) to execute and give to KPIC any instruments needed to secure the rights under a) and b).

COORDINATION OF BENEFITS

Definitions Related to Coordination of Benefits

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

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

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

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

1. This Plan.
2. any group, blanket, or franchise health insurance.
3. a group contractual prepayment or indemnity plan.
4. a health maintenance organization (HMO), whether a group practice or individual practice association.
5. a labor-management trustee plan or a union welfare plan.
6. an employer or multi-employer plan or employee benefit plan.
7. any government program, including Medicare, as long as benefits under such program are not, by law, excess to this Plan; and they do expand the definition of "Allowable Expenses, as set forth above.
8. insurance required or provided by statute.

Plan does not include any:

1. individual or family policies or contracts.
2. public medical assistance programs, including Medicare, as long as benefits under such program are not, by law, excess to this Plan; and they do expand the definition of "Allowable Expenses, as set forth above.
3. group or group-type Hospital indemnity benefits of $100 per day or less.
4. school accident-type coverages.
5. traditional fault automobile or no-fault automobile policies.

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

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

CLAIM AND APPEALS PROCEDURES

This section contains the following:

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

A. Definitions Related to Claims and Appeals Procedures

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

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

1. deny Your Claim, in whole or in part, including but not limited to, reduction of benefits or a failure or refusal to cover an item or service resulting from a determination that an expense is:
    a) experimental or investigational;
    b) not Medically Necessary or appropriate.
2. terminate Your coverage retroactively except as the result of non-payment of premiums (also known as rescission), or
3. continue to delay, deny or modify Your Claim when You Appeal.

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

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

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

Language and Translation Assistance

If We send You an Adverse Benefit Determination at an address in a county where a federally mandated

threshold language applies, then Your notice of Adverse Benefit Determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least 10% of the population is literate only in the same federally mandated non-English language. You may request language assistance with Your Claim and/or Appeal by calling **1-800-464-4000**.

If We send You an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then You may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10% of the population is literate only in the same federally mandated non-English language. You may request translation of the notice by calling **1-800-464-4000**.

Appoint a Representative

If You would like someone to act on Your behalf regarding Your Claim or Appeal, You may appoint an authorized representative. You must make this appointment in writing. Please send Your representative's name, address and telephone contact information to the address below. You must pay the cost of anyone You hire to represent or help You.

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

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

Reviewing Information Regarding Your Claim

If You want to review the information that We have collected regarding Your Claim, You may request, and We will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of Your Claim. To make a request, You should contact NTT DATA Services by calling 1- 800-392-8649.

A. The Claims Process

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

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

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

In addition, there are separate Appeals procedures for Adverse Benefit Determinations due to a retroactive termination of coverage (rescission). Please refer to the subsection **6. Appeals of retroactive coverage termination (rescission)** provision under this section for a detailed explanation.

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

All Claims under this Policy will be administered by:

NTT DATA Services
P.O. Box 261130
Plano, TX 75026

CLAIM AND APPEALS PROCEDURES

1. Post-service Claims

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

The following procedures apply for filing a Post-Service Claim:

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

    NTT DATA Services
    P.O. Box 261130
    Plano, TX 75026

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

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

  - If We deny Your Claim, please refer to subsection **C. The Internal Appeals Process** provision under this section for details regarding Your mandatory appeal process and other rights. Likewise, Our Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding Your available appeal rights, including external review.

Notice of Claims

You must give Us written notice of claim within 20 days after the occurrence or commencement of any loss covered by the Policy, or as soon as reasonably possible. You may give notice or may have someone do it for You. The notice should give Your name and Your policy number. Notice given by or on behalf of You to Us at the address listed below, or to any KPIC authorized agent, with information sufficient to identify the Covered Person, shall be deemed notice to KPIC.

NTT DATA Services
P.O. Box 261130
Plano, TX 75026

CLAIM AND APPEALS PROCEDURES

Claim Forms

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

Proof of Loss

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

Time for Payment of Claims

Subject to due written Proof of Loss, all indemnities for loss for which this policy provides payment will be paid to the Covered Person as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Insured Employee immediately, but no later than 30 days upon receipt of due written proof.

Payment of Claims

Subject to any written direction of the Covered Person in an application or otherwise all or a portion of any indemnities provided by this Policy on account of hospital, nursing, medical or surgical service may, at the Covered Person's option, and unless the Covered Person requests otherwise in writing not later than the time for filing Proof of Loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

Contested Claims

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

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

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

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

Legal Action

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No action may be brought more than three (3) years after the date written Proof of Loss is given to Us.

Time Limitations

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

Overpayment

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

1. KPIC's files contain clear, documented evidence of an overpayment and written authorization from the

claimant or assignee, if applicable, permitting such withholding procedure; or

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

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

NTT DATA Services
P.O. Box 261130
Plano, TX 75026

Participating Provider Claims

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

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

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

Pre-service Claims

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

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

Following are the procedures for filing a Pre-service Claim.

- **Pre-service Claim**
  - Send Your request in writing to Us that You want to make a Claim for Us to Pre-certify a benefit or treatment You have not yet received. Your request and any related documents You give Us constitute Your Claim. You must either mail Your Claim to Us at the address below or, fax Your Claim to Us at 1-866-338-0266.

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

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

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

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

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

2. Concurrent Care Claims

Concurrent care Claims means request for authorization that We continue to cover or pay for an ongoing course of treatment for a Covered Service to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. Failure to receive authorization before continuing to receive treatment beyond the number of days or number of treatments initially authorized may be the basis of reduction of Your benefits. If You receive any of the Covered Services You are requesting before We make Our decision, Your Concurrent Care Claim will become a Post-service Claim with respect to those Services. If You have any general questions about Concurrent Care Claims, please call 1-888-567-6847. Concurrent claims can be either Urgent Care Claims or non-Urgent Care Claims.

If We either (a) deny Your request to extend Your current authorized ongoing care (Your concurrent care Claim) or (b) inform You that authorized care that You are currently receiving is going to end early and You

Appeal Our Adverse Benefit Determination at least 24 hours before Your ongoing course of covered treatment will end, then during the time that We are considering Your Appeal, You may continue to receive the authorized Covered Services. If You continue to receive these Covered Services while We consider Your Appeal and Your Appeal does not result in Our approval of Your concurrent care Claim, then You will have to pay for the services that We decide are not covered.

Please refer to the **PRE-CERTIFICATION** section of this Certificate for details regarding the Pre-certification of Concurrent Care Claims.

Here are the procedures for filing a Concurrent Care Claim.

- **Concurrent Care Claim**

  - Tell Us in writing that You want to make a concurrent care Claim for an ongoing course of covered treatment. Inform Us in detail of the reasons that Your authorized ongoing care should be continued or extended. Your request and any related documents You give Us constitute Your Claim. You must either mail Your Claim to Us at the address below, or fax Your Claim to Us at 1-866-338-0266.

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

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

  - We will review Your Claim, and if We have all the information We need We will make a decision within a reasonable period of time. If You submitted Your Claim 24 hours or more before Your care is ending, We will make Our decision before Your authorized care actually ends. If Your authorized care ended before You submitted Your Claim, We will make Our decision but no later than 15 days after We receive Your Claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond Our control delay Our decision, if We send You notice before the initial 15-day decision period ends. If We tell You We need more information, We will ask You for the information before the initial decision period ends, and We will give You until Your care is ending or, if Your care has ended, 45 days to send Us the information. We will make Our decision as soon as possible, if Your care has not ended, or within 15 days after We first receive any information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within the stated timeframe after We send Our request, We will make a decision based on the information We have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe We gave You for sending the additional information.

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

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

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

B. The Internal Appeals Process

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

As a member of a group with health coverage insured by KPIC, Your internal review process includes two mandatory levels of appeal for medical Claims and one level of appeal for claims arising from the optional prescription drug benefit.

First Level of Appeal

If We deny Your Claim (Post Service, Pre-service or Concurrent Claims), in whole or in part you have the right to request an Appeal of such decision. Our Adverse Benefit Determination notice will tell You

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

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

NTT DATA Services
P.O. Box 261130
Plano, TX 75026

With respect to medical Claims, if You disagree with Our decision on Your first level appeal, Your first level adverse appeal decision notice will tell You how to submit a second level appeal. We must receive Your first level review request within 180 days of Your receiving this notice of Our initial Adverse Benefit Determination. Please note that We will count the 180 days starting 5 business days from the date of the notice to allow for delivery time, unless You can prove that You received the notice after that 5-business day period.

With respect to claims arising from the optional prescription drug benefit, Our decision of Your one level of appeal is the final decision and You may be deemed to have exhausted all Your internal appeals. If You disagree with Our decision, You may have the right to request for an external review. For a detailed provision of the external review process, please refer to D: External Review under this section.

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

You may also fax this information to: KPIC Attn: KPIC Operations
Grievance and Appeals Coordinator at (877) 727-9664

Second Level of Appeal (applicable to Medical Claims only)

If Your first level appeal decision is not wholly in Your favor, You are entitled to a second level of review. We must receive Your second level appeal request within 180 days of Your receiving this notice of Our first level appeal decision. Please note that We will count the 180 days starting 5 business days from the date of the

first level appeal notice to allow for delivery time unless You can prove that You received the notice after that 5-business day period. Contact Us at 877-847-7572 with any questions about Your appeal rights.

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

You may also fax this information to: KPIC Attn: KPIC Operations
Grievance and Appeals Coordinator at (877) 727-9664

Providing Additional Information Regarding Your Claim
When You Appeal, You may send Us additional information including comments, documents, and additional medical records that You believe support Your Claim. If We asked for additional information and You did not provide it before We made Our initial decision about Your Claim, then

You may still send Us the additional information so that We may include it as part of Our review of Your Appeal. Please send all additional information to Kaiser Permanente Insurance Company Grievance and Appeals Coordinator at the address above. You may also fax this information to **(877) 727-9664.**

When You Appeal, You may give testimony in writing or by telephone. Please send Your written testimony to the address set forth above. To arrange to give testimony by telephone, You should contact KPIC Grievance and Appeals Coordinator at 877-847-7572.

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

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

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

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

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

1. Post-service Appeal

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

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

You may also fax this information to: KPIC Attn: KPIC Operations
Grievance and Appeals Coordinator at (877) 727-9664

- We will review Your appeal as follows:

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

- For appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive Your request for our review unless we inform You otherwise in advance.

- If We deny Your Appeal, Our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.

2. Non-urgent Pre-service Appeal

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

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

You may also fax this information to: KPIC Attn: KPIC Operations
Grievance and Appeals Coordinator at (877) 727-9664

We will review Your appeal as follows:

- For Appeals involving medical claims - Because You have not yet received the services or equipment that You requested, we will review Your Appeal and send You a written decision of each level of Your two level appeal process within a reasonable period of time appropriate to the circumstances, but in no event later than 15 days from the date that we receive Your request for our review at that level unless we inform You otherwise in advance.

- For appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive Your request for our review unless we inform You otherwise in advance.

- If We deny Your Appeal, Our Adverse Benefit Determination notice will tell You why We denied Your

Appeal and will include information regarding any further process, including external review, that may be available to You.

3. Urgent Pre-service Appeal

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

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

- When You send Your Appeal, (whether First Level or Second Level of Appeal) You may also request simultaneous external review of Our Adverse Benefit Determination. If You want simultaneous external review, Your Appeal must tell Us this. You will be eligible for the simultaneous external review only if Your pre-service Claim qualifies as urgent. If You do not request simultaneous external review in Your Appeal, then You may be able to request external review after We make Our decision regarding Your Appeal (see **D. External Review** provision under this section), if Our internal appeal decision is not in Your favor.

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

- We will review Your Appeal and notify You of Our decision orally or in writing as soon as Your clinical condition requires, but not later than 72 hours after We received Your Appeal. If We notify You of Our decision orally, We will send You a written confirmation within 3 days after that.

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

4. Non-urgent Concurrent Care Appeal

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

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

You may also fax this information to: KPIC Attn: KPIC Operations Grievance and Appeals Coordinator at (877) 727-9664

We will review Your appeal as follows:

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

- For appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive Your request for our review unless we inform You otherwise in advance.

- If We deny Your Appeal, Our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.

5. Urgent Concurrent Care Appeal

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

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

- When You send Your Appeal, (whether First Level or Second Level of Appeal) You may also request simultaneous external review of Our Adverse Benefit Determination. If You want simultaneous external review, Your Appeal must tell Us this. You will be eligible for the simultaneous external review only if Your concurrent care Appeal qualifies as urgent. If You do not request simultaneous external review in Your Appeal, then You may be able to request external review after We make Our decision regarding Your Appeal (see **D. External Review** provision under this section), if Our internal appeal decision is not in Your favor.

- We will decide whether Your Appeal is urgent or non-urgent unless Your attending health care provider tells Us Your Appeal is urgent. If We determine that Your Appeal is not urgent, We will treat Your Appeal as non-urgent. Generally, an Appeal is urgent only if using the procedure for non-urgent Appeals (a) could seriously jeopardize Your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without continuing Your course of covered treatment.

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

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

Determination notice will tell You why We denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.

6. Appeals of retroactive coverage termination (rescission)

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

Kaiser Permanente
P.O Box 41912
Los Angeles, CA 90041-1912

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

Appeal of retroactive coverage termination

- Within 180 days after You receive Our Adverse Benefit Determination that Your coverage will be terminated retroactively, You must tell Us in writing that You want to Appeal Our termination of Your coverage retroactively. Please include the following: (1) Your name and Medical Record Number, (2) all of the reasons why You disagree with Our retroactive coverage termination, and (3) all supporting documents. Your request and the supporting documents constitute Your Appeal. You must mail Your Appeal to **Kaiser Permanente P.O. Box 41912 Los Angeles, CA 90041-1912.**

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

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

Help With Your Appeal

You may contact the state ombudsman:

California Department of Insurance Office of the Ombudsman
300 Capitol Mall, Suite 1600
Sacramento, CA 95814
Consumer Phone: (916) 492-3545
E-mail: ombudsman@insurance.ca.gov

C. External Review

If You are dissatisfied with Our final Adverse Benefit Determination, You may have a right to request an external review. For more information about how to obtain this review, please call KPIC toll free number at: **1-800-464-4000** or call the:

California Department of Insurance
1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

The Covered Person may write the California Department of Insurance at:

California Department of Insurance
Consumer Communications Bureau

300 S. Spring Street
Los Angeles, CA 90013

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

Except when external review is permitted to occur simultaneously with Your urgent pre-service Appeal or urgent concurrent care Appeal, You must exhaust Our internal claims and Appeals procedure for Your Claim before You may request external review unless We have failed to comply with federal requirements regarding Our Claims and Appeals procedures.

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

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

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

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

CLAIMS DISPUTE IMPORTANT NOTICE

If a Covered Person believes a claim has been wrongfully denied or rejected, the Covered Person may have the matter reviewed by the California Department of Insurance. However, the Covered Person should first contact KPIC to try and resolve the dispute. If the dispute is not resolved, the Covered Person may contact the California Department of Insurance.

The Covered Person may call KPIC to make a complaint concerning a claim at the following number:

(800) 392-8649

The Covered Person may also write to KPIC at:

Kaiser Permanente Insurance Company
P.O. Box 261155
Plano, TX. 75026

The Covered Person may contact the California Department of Insurance to obtain information on companies, coverage, rights or complaints at:

1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

The Covered Person may write the California Department of Insurance at:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW

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 toll free number at 1-800-392-8649 or call the California Department of Insurance at:

1-800-927-HELP
(1-800-927-4357)
TDD: 1-800-482-4TDD
(1-800-482-4833)

The Covered Person may write the California Department of Insurance at:

California Department of Insurance
Consumer Communications Bureau
300 S. Spring Street
Los Angeles, CA 90013

Or You can log in to the California Department of Insurance website at:

www.insurance.ca.gov

You have the right to an independent medical review upon the concurrence of the following:

1. You believe that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers;
2. You have a Life-threatening or Seriously Debilitating Condition;
   a) Duly certified by Your Physician, for which:
      I. standard therapies have not been effective in improving Your condition; or
      II. standard therapies would not be Medically Necessary; or
      III. there is other beneficial therapy covered under this Group Policy other than the proposed experimental or investigational therapy; and

   b) Your contracting Physician has recommended a drug, device, procedure or therapy duly certified by him in writing that it is likely to be more beneficial than any available standard therapy; or You or Your Physician duly licensed and board certified to practice in the area of practice appropriate for Your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial to You than any other available therapy.

   c) The Physician's certification shall contain a statement of the evidence relied upon by him in making the above recommendation;

   d) Such recommendation or request as stated in item number 3 above has been denied, delayed or modified by us based on Medical Necessity;

   e) The therapy, drug, device or procedure would otherwise be covered under the Group Policy were it not determined by us that such therapy, drug, device or procedure is experimental or investigational.

   f) Upon denial of coverage as stated in item c) above, a notice shall be sent to You, explaining in detail Your rights under this process.
3. Your membership was terminated retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.
4. If we continue to deny the payment, coverage or service requested or You do not receive a timely decision.

The external independent review is conducted by an independent third party which may be one of the following:

1. An independent review organization (IRO) selected from a list of randomly assigned Independent Review Organizations (IROs) provided by the California Department of Insurance; or
2. An entity contracted directly with the California Department of Insurance to conduct external reviews.

YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW

If Your coverage is through an employer group subject to the Employee Retirement Security Income Act of 1974 (ERISA), You may also have the right to bring a civil action under section 502(a) of ERISA, as then constituted or later amended. To determine if Your plan is covered by ERISA, please check with Your employer.

Definitions

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

"**Life-threatening**" means either or both of the following:

1. Sickness or Injury where the likelihood of death is high unless the course of the Sickness is interrupted.
2. Sickness or Injury with potentially fatal outcomes, where the end point of clinical intervention is survival.

"**Seriously Debilitating Condition**" means Sickness or Injury that causes major irreversible morbidity.

NOTE: Notwithstanding the foregoing, the effective date of implementation by KPIC of the above requirements are subject to the provisions under ACA, as then constituted or later amended, or subject to the provisions under any interim final regulations promulgated by any government agency in the implementation of the provisions of the ACA.

GENERAL PROVISIONS

Time Effective

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

Time Limit on Certain Defenses

After two years from the date of issue of this Group Policy, no misstatements, made by the Policyholder in the application for the Group Policy shall be used to void the Group Policy, or to deny, contest or reduce a claim.

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.

Assignment

Payment of benefits under this Group Policy for treatment or services that are not provided, prescribed or directed by Participating Providers are not assignable and thereby not binding on KPIC, unless previously approved by KPIC in writing.

Payment of benefits shall be made by KPIC directly to the provider, including medical transportation providers (ambulance), certified nurse-midwives, nurse practitioners and licensed midwives, or to the Insured or Dependent or, in the case of the Insured's death, to his or her executor, administrator, provider, spouse, Domestic Partner or relative.

Surrogacy Arrangement

If You enter into a surrogacy arrangement and You or any other payee are entitled to receive payments or other compensation under the surrogacy arrangement, You must reimburse Us for Covered Services You receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. A "surrogacy arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.

Note: This "Surrogacy Arrangements" provision does not affect Your obligation to pay Your Cost Share for these Covered Services. After You surrender a baby to the legal parents, You are not obligated to reimburse Us for any Covered Services that the baby receives after the date of surrender (the legal parents are financially responsible for any services that the baby receives).

By accepting Surrogacy Health Services, You automatically assign to Us Your right to receive payments that are payable to You or any other payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure Our rights, We will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy Our lien. The assignment and Our lien will not exceed the total amount of Your obligation to Us under the preceding paragraph.

Within 30 days after entering into a surrogacy arrangement, You must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information We request in order to satisfy our rights

You must send this information to:
Kaiser Permanente Insurance Company
P.O. Box 261155
Plano, TX. 75026

You must complete and send Us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Us to determine the existence of any rights we may have under this "Surrogacy Arrangements" provision and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy Arrangements" section without Our prior, written consent.

If Your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, Your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if You had asserted the claim against the third party. We may assign Our rights to enforce Our liens and other rights.

If You have questions about Your obligations under this provision, please contact Us by calling the phone number listed on Your ID card.

Money Payable

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

Notice of Termination of Provider

KPIC will provide written notice to the Group Policyholder of any termination, permanent breach of contract by, or permanent inability to perform of any Participating Provider, if the termination, breach or inability would materially and adversely affect the Covered Person. The Group Policyholder shall distribute to the Insured Employee the substance of such notice within 30 days of receipt.

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:
A. provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Policy;
B. accept claim forms and requests for claim payment from the custodial parent; and
C. 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:

A. the Order is no longer valid;
B. the Dependent child has become covered under other health insurance or health coverage;
C. in the case of employer-provided coverage, the employer has stopped providing family coverage for all employees; or
D. 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.

Completion of Covered Services by Terminated Provider

If You or Your Dependent are currently receiving Covered Services with a Terminated Participating Provider, You or Your Dependent may be eligible to continue receiving benefits at the Participating Provider tier, if You or Your Dependent is undergoing a course of treatment for any of the following conditions:

1. Acute Condition;
2. Serious Chronic Condition;
3. Pregnancy and immediate postpartum care;
4. Terminal illness;
5. Maternal Mental Health;
6. Care of children under age 3; or
7. Surgery or other procedure duly recommended and documented by the Terminated Participating Provider to occur within 180 days of the termination of the contract with the Participating Provider.

Duration of completion of Covered Services shall be provided as follows:

1. For Acute Condition – completion of Covered Services shall be provided until the Acute Condition ends.
2. For Serious Chronic condition – completion of Covered Services shall be provided until the earlier of:
    a. twelve (12) months from the contract termination date with the Participating Provider; or
    b. the first day when it would be safe to transfer Your care to a Participating Provider.
3. For Pregnancy and immediate postpartum care – completion of Covered Services shall be provided until the duration of the pregnancy and immediate postpartum care.
4. For Maternal Mental Health Condition - completion of covered services for the maternal mental health condition shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
5. For Terminal illness – completion of Covered Services shall be provided until the duration of the illness
6. For Care of children under age 3 – completion of Covered Services shall be provided until the earlier of:
    a. twelve months from the termination date of the Terminated Participating Provider; or
    b. the child's third birthday

To continue receiving benefits at the Participating Provider tier, all the following requirements must be met:

1. You must make the request for completion of a Covered Service within a reasonable time from the termination date of the Terminated Provider;
2. You or Your Dependent must be undergoing treatment with a Terminated Participating Provider under any of the above conditions;
3. The treatment must be for Medically Necessary Covered Services;
4. You or Your Dependent are eligible to receive benefits under the Group Policy at the time of receipt of the service; and
5. The terminated Participating Provider agrees in writing to the same contractual terms and conditions that were imposed upon the Terminated Participating Provider by KPIC or KPIC's provider network prior to the termination of the contract.

GENERAL PROVISIONS

For purposes of this subsection, the following definitions apply:

Acute Condition means medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration.

Maternal Mental Health Condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

Pregnancy means the three trimesters of pregnancy.

Serious Chronic Condition means an illness or other medical condition that is serious, if one of the following is applicable about the condition:
1) it persists without full cure;
2) it worsens over an extended period of time; or
3) it requires ongoing treatment to maintain remission or prevent deterioration.

Terminal Illness means an incurable or irreversible illness that has a high probability of causing death within a year or less.

Terminated Participating Provider means a provider whose written contract with KPIC or KPIC's contracted provider network has been terminated. A Terminated Participating Provider is not a provider who voluntarily leaves KPIC or KPIC's contracted provider network.

Continuity of Care for New Covered Persons by Non-Participating Providers

If You are a new Covered Person and currently receiving Covered Services from a Non-Participating Provider, benefits under the Group Policy are payable at the Non-Participating Provider tier. In order for benefits to be payable at the Participating Provider tier, You must receive care from a Participating Provider.

A current copy of KPIC's directory of Participating Providers is available from Your employer. To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory.

Kaiser Permanente Insurance Company One Kaiser Plaza
Oakland, California 94612

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Additional Information and Forms Applicable to Your Insurance Coverage

Please note the following pages are not part of the employer group insurance policy.

The following pages contain information we are required to provide you.

HIPAA Notice of Privacy Practices

KAISER PERMANENTE INSURANCE COMPANY ("KPIC")

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

In this Notice we use the terms "we," "us" and "our" to describe KPIC.

I. WHAT IS "PROTECTED HEALTH INFORMATION"?

Your protected health information ("PHI") is individually identifiable health information, including demographic information, about your past, present or future physical or mental health or condition, health care services you receive, and past, present or future payment for your health care. Demographic information means information such as your name, social security number, address, and date of birth.

PHI may be in oral, written or electronic form. Examples of PHI include your medical record, claims record, enrollment or disenrollment information, and communications between you and your health care provider about your care.

With the exception of those insured in California, your individually identifiable health information ceases to be PHI 50 years after your death.

II. ABOUT OUR RESPONSIBILITY TO PROTECT YOUR PHI

By law, we must

1. protect the privacy of your PHI;
2. tell you about your rights and our legal duties with respect to your PHI;
3. notify you if there is a breach of your unsecured PHI; and
4. tell you about our privacy practices and follow our Notice currently in effect.

We take these responsibilities seriously, and have put in place administrative safeguards (such as security awareness training and policies and procedures), technical safeguards (such as encryption and passwords), and physical safeguards (such as locked areas and requiring badges) to protect your PHI and, as in the past, we will continue to take appropriate steps to safeguard the privacy of your PHI.

III. YOUR RIGHTS REGARDING YOUR PHI

This section tells you about your rights regarding your PHI, and describes how you can exercise these rights.

Your right to access and amend your PHI
Subject to certain exceptions, you have the right to view or get a copy of your PHI that we maintain in records relating to your care or decisions about your care or payment for your care. Requests must be in writing.

After we receive your written request, we will let you know when and how you can see or obtain a copy of your record. If you agree, we will give you a summary or explanation of your PHI instead of providing copies. We may charge you a fee for the copies, summary or explanation.

If we do not have the record you asked for but we know who does, we will tell you who to contact to request it. In limited situations, we may deny some or all of your request to see or receive copies of your records, but if we do, we will tell you why in writing and explain your right, if any, to have our denial reviewed.

If you believe there is a mistake in your PHI or that important information is missing, you may request that we correct or add to the record. Requests must be in writing, telling us what corrections or additions you are requesting, and why the corrections or additions should be made. We will respond in writing after reviewing your request. If we approve your request, we will make the correction or addition to your PHI. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement.

Submit all written requests to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

Your right to choose how we send PHI to you or someone else
You may ask us to send your PHI to you at a different address (for example, your work address) or by different means (for example, fax instead of regular mail).

If your PHI is stored electronically, you may request a copy of the records in an electronic format offered by KPIC. You may also make a specific written request to KPIC to transmit the electronic copy to a designated third party.

If the cost of meeting your request involves more than a reasonable amount, we are permitted to charge you our costs that exceeds that amount.

Your right to an accounting of disclosures of PHI
You may ask us for a list of our disclosures of your PHI. Write to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

You are entitled to one disclosure accounting in any 12-month period at no charge. If you request any additional accountings less than 12 months later, we may charge a fee.

An accounting does not include certain disclosures, for example, disclosures:

- to carry out treatment, payment and health care operations;
- for which KPIC had a signed authorization;
- of your PHI to you;
- for notifications for disaster relief purposes;
- to persons involved in your care and persons acting on your behalf; or
- not covered by the right to an accounting.

Your right to request limits on uses and disclosures of your PHI
You may request that we limit our uses and disclosures of your PHI for treatment, payment and health

care operations purposes. We will review and consider your request. You may write to us at:

Kaiser Permanente Insurance Company
Attention Privacy Director
One Kaiser Plaza (25 B)
Oakland, CA 94612

Your right to receive a paper copy of this Notice
You have a right to receive a paper copy of this Notice upon request.

IV. HOW WE MAY USE AND DISCLOSE YOUR PHI

Your confidentiality is important to us. Our employees are required to maintain the confidentiality of the PHI of our insureds and we have policies and procedures and other safeguards to help protect your PHI from improper use and disclosure. Sometimes we are allowed by law to use and disclose certain PHI without your written permission. We briefly describe these uses and disclosures below and give you some examples.

How much PHI is used or disclosed without your written permission will vary depending, for example, on the intended purpose of the use or disclosure. Sometimes we may only need to use or disclose a limited amount of PHI, such as to confirm that you are KPIC-insured. At other times, we may need to use or disclose more PHI such as when we assist in resolving an appeal or grievance.

- **Payment**: Your PHI may be needed to determine our responsibility to pay for, or to permit us to bill and collect payment for, treatment and health-related services that you receive. When you or a provider sends us the bill for health care services, we use and disclose your PHI to determine how much, if any, of the bill we are responsible for paying.

- **Health care operations**: We may use and disclose your PHI for certain health care operations, for example, quality assessment and improvement, licensing, accreditation, activities relating to the creation, renewal or replacement of health insurance or health benefits; conducting medical review; legal services; auditing functions, including fraud and abuse detection and compliance programs; customer service, underwriting, and determining premiums and other costs of providing health care.

- **Business associates**: We may contract with business associates to perform certain functions or activities on our behalf, such as payment and health care operations. These business associates must agree to safeguard your PHI.

- **Specific types of PHI**: There are stricter requirements for use and disclosure of some types of PHI, for example, mental health and drug and alcohol abuse patient information, mental health records, and HIV tests, and genetic testing information. However, there are still circumstances in which these types of information may be used or disclosed without your authorization.

- **Underwriting**: We may use and disclose your PHI, to the extent permitted under applicable law, for underwriting purposes, including the determination of benefit eligibility and costs of coverage and to perform other activities related to issuing a benefit policy. However, we are prohibited from using or disclosing your genetic information for underwriting purposes. Your genetic information includes information about your genetic tests, your family members' genetic tests, and requests for or receipt of genetic services by you or any family members.

- **Communications with family and others when you are present**: Sometimes a family member or other person involved in your care will be present when we are discussing your PHI with you. If you object, please tell us and we won't discuss your PHI or we will ask the person to leave.

- **Communications with family and others when you are not present**: There may be times when it is necessary to disclose your PHI to a family member or other person involved in your care because there is an emergency, you are not present, or you lack the decision-making capacity to agree or object. In those instances, we will use our professional judgment to determine if it's in your best interest to disclose your PHI. If so, we will limit the disclosure to the PHI that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.

- **Disclosure in case of disaster relief**: We may disclose your name, city of residence, age, gender, and general condition to a public or private disaster relief organization to assist disaster relief efforts, unless you object at the time.

- **Disclosures to parents as personal representatives of minors**: In most cases, we may disclose your minor child's PHI to you. In some situations, however, we are permitted or even required by law to deny your access to your minor child's PHI. Examples of when we must deny such access include your minor child's PHI regarding drug or addiction, certain mental health services, and venereal disease.

- **Public health activities**: Public health activities cover many functions performed or authorized by government agencies to promote and protect the public's health and may require us to disclose your PHI.

  - For example, we may disclose your PHI as part of our obligation to report to public health authorities certain diseases, injuries, conditions, and vital events such as births. Sometimes we may disclose your PHI to someone you may have exposed to a communicable disease or who may otherwise be at risk of getting or spreading the disease.
  - The Food and Drug Administration (FDA) is responsible for tracking and monitoring certain medical products, such as pacemakers and hip replacements, to identify product problems and failures and injuries they may have caused. If you have received one of these products, we may use and disclose your PHI to the FDA or other authorized persons or organizations, such as the maker of the product.
  - We may use and disclose your PHI as necessary to comply with federal and state laws that govern workplace safety.

- **Health oversight**: As a health insurer, we are subject to oversight conducted by federal and state agencies. These agencies may conduct audits of our operations and activities and in that process, they may review your PHI.

- **Disclosures to your employer or your employee organization**: If you are enrolled in a KPIC health insurance plan through your employer or employee organization, we may share certain PHI with them without your authorization, but only when allowed by law. For example, we may disclose your PHI for a workers' compensation claim or to determine whether you are enrolled in the plan or whether premiums have been paid on your behalf. For other purposes, such as for inquiries by your employer or employee organization on your behalf, we will obtain your authorization when necessary under applicable law.

- **Workers' compensation**: We may use and disclose your PHI in order to comply with workers' compensation laws. For example, we may communicate your medical information regarding a work-related injury or illness to claims administrators, insurance carriers, and others responsible for evaluating your claim for workers' compensation benefits.

- **Military activity and national security**: We may sometimes use or disclose the PHI of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your PHI to authorized federal

officials as necessary for national security and intelligence activities or for protection of the President and other government officials and dignitaries.

- **Required by law**: In some circumstances federal or state law requires that we disclose your PHI to others. For example, the Secretary of the Department of Health and Human Services may review our compliance efforts, which may include seeing your PHI.

- **Lawsuits and other legal disputes**: We may use and disclose PHI in responding to a court or administrative order, a subpoena, or a discovery request. We may also use and disclose PHI to the extent permitted by law without your authorization, for example, to defend a lawsuit or arbitration.

- **Law enforcemen**t: We may disclose PHI to authorized officials for law enforcement purposes, for example, to respond to a search warrant, report a crime on our premises, or help identify or locate someone.

- **Abuse or neglect**: By law, we may disclose PHI to the appropriate authority to report suspected child abuse or neglect or to identify suspected victims of abuse, neglect, or domestic violence.

- **Coroners and funeral directors**: We may disclose PHI to a coroner or medical examiner to permit identification of a body, determine cause of death, or for other official duties. We may also disclose PHI to funeral directors.

- **Inmates**: Under the federal law that requires us to give you this Notice, inmates do not have the same rights to control their PHI as other individuals. If you are an inmate of a correctional institution or in the custody of a law enforcement official, we may disclose your PHI to the correctional institution or the law enforcement official for certain purposes, for example, to protect your health or safety or someone else's.

V. ALL OTHER USES AND DISCLOSURES OF YOUR PHI REQUIRE YOUR PRIOR WRITTEN AUTHORIZATION

Except for those uses and disclosures described above, we will not use or disclose your PHI without your written authorization. Some instances in which we may request your authorization for use or disclosure of PHI are:

- **Marketing**: We may ask for your authorization in order to provide information about products and services that you may be interested in purchasing or using. Note that marketing communications do not include our contacting you with information about treatment alternatives, prescription drugs you are taking or health-related products or services that we offer or that are available only to our health plan enrollees. Marketing also does not include any face-to-face discussions you may have with your providers about products or services.
- **Sale of PHI**: We may only sell your PHI if we received your prior written authorization to do so.

When your authorization is required and you authorize us to use or disclose your PHI for some purpose, you may revoke that authorization by notifying us in writing at any time. Please note that the revocation will not apply to any authorized use or disclosure of your PHI that took place before we received your revocation. Also, if you gave your authorization to secure a policy of insurance, including health insurance from us, you may not be permitted to revoke it until the insurer can no longer contest the policy issued to you or a claim under the policy.

VI. HOW TO CONTACT US ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you have any questions about this Notice, or want to lodge a complaint about our privacy practices, please let us know by calling or writing to:

Kaiser Permanente Insurance
Company Attention Privacy
Director
One Kaiser Plaza
(25 B) Oakland,
CA 94612

You also may notify the Secretary of the Department of Health and Human Services

(HHS). We will not take retaliatory action against you if you file a complaint about our

privacy practices.

VII. CHANGES TO THIS NOTICE

We may change this Notice and our privacy practices at any time, as long as the change is consistent with state and federal law. Any revised notice will apply both to the PHI we already have about you at the time of the change, and any PHI created or received after the change takes effect. If we make an important change to our privacy practices, we will promptly change this Notice and notify you via the
U.S. Postal Service that the change has been made along with instructions for obtaining the new notice.

Except for changes required by law, we will not implement an important change to our privacy practices before we revise this Notice.

VIII. EFFECTIVE DATE OF THIS NOTICE

This Notice is effective on September 23, 2013

KAISER PERMANENTE
KAISER PERMANENTE INSURANCE COMPANY

PRIVACY NOTICE

Privacy Policy and Practices

This notice describes the privacy policy and practices regarding non-public personal information followed by Kaiser Permanente Insurance Company (herein referred to as "KPIC', "we", "us", and "our"). This notice is provided to you in compliance with the Gramm-Leach-Bliley Financial Services Modernization Act.

Collection of Non-public Personal Information

The types of non-public personal information that we may collect includes, but are not limited to:

- Information we receive from you as part of application forms, enrollment forms, claims forms, pre-certification/utilization reviews, etc, including, but not limited to, your name, address, sex, date of birth, Social Security number, martial status, dependents, and the identity of your employer.

- Information otherwise legally obtained by us, including information you authorize us to receive and/or resulting from your transactions with us, our affiliates, or non-affiliated third parties, including, but not limited to, medical information and claims history.

Disclosure of Non-public Personal Information

Unless otherwise authorized by you, KPIC will not disclose your non-public personal information except to affiliates and non-affiliates third parties as necessary to administer, underwrite, process, service, reinsure or market its own insurance products, or as necessary to effect, administer, or enforce a transaction authorized by you. When KPIC must release non-public personal information to non-affiliated third parties, as noted above, such third parties will subject to contractual agreements that require the third parties to maintain the confidentiality of such non-public personal information. If, at a future date, KPIC determines there is a need to share your non-public personal information with a non-affiliated third party, other than as described above, we will provide you with an advance opportunity to direct us not share such information.

KPIC may also disclose non-public personal information to authorized persons or entities to comply with: federal, state, or local laws, including any properly authorized civil, criminal, or regulatory investigation or subpoena or summons; or respond to judicial process or government regulatory authorities having jurisdiction over us for examination, compliance, or other purposes as authorized by law

Non-public Personal Information Regarding Former Customers

Any non-public personal information KPIC maintains on former customers will be maintained on a confidential and secure basis. Any discosure of that information will only be made in keeping with the privacy policy and practices described in this notice or as otherwise permitted or required by law.

Confidentiality and Security of Non-public Personal Information

KPIC is committed to protecting the confidentiality and security of non-public personal information. In collaboration with our affiliates, we maintain physical, electronic, and procedural safeguards that comply with federal and state standards regarding the protection of such information. To insure that your information is not misused and is properly protected, KPIC has instituted the following:

- Employees are required to comply with our policies and procedures that exist to protect the confidentiality of customer information. Any employee who violates our privacy policy and practices is subject to a disciplinary process. Our policy requires medical records to be maintained in secure areas not accessible to the public.

- Employee access to information is provided on a business need-to- know basis such as: to facilitate administration, make benefit determinations, pay claims, managed care, underwrite coverage, or provide customer service.

- Mail and electronic security procedures to maintain confidentiality of the information we collect and to guard against its unauthorized access. Such methods include locked files, user authentication, encryption, and firewall technology.

- Contractual agreements with its non-affiliated third parties that require such third parties to maintain the confidentiality of non-public personal information.

Where to Write For More Information

If you have any questions about KPIC's privacy policy and practices, please write to the address listed below:

Kaiser Permanente Insurance Company
Attention: President
One Kaiser Plaza, 25 B
Oakland, California 946

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

***Employers**: Please provide a copy of this notice to all certificate holders*

IMPORTANT NOTICE REGARDING YOUR HEALTH INSURANCE COVERAGE

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (the Act) was passed into law on October 21, 1998. The law requires group and individual health plans that provide mastectomy coverage, such as your plan coverage, to also provide coverage for:

1. reconstruction of both the diseased and non-diseased breast to produce symmetrical appearance; and
2. prostheses and treatment of physical complications at all stages of the mastectomy, including lypmhademas.

The Kaiser Permanente Insurance Company plan under which you are insured provides coverage for mastectomy and includes the services listed above when performed following a covered mastectomy.

If you have any questions about the coverage provided under the Act and your plan of insurance, please do not hesitate to contact us at the number listed on your insurance card.