KAISER PERMANENTE

Kaiser Permanente Insurance Company

California Comprehensive Major Medical (PPO) for Small Business

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.

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

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 **1-800-788-0710** (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

P.O. Box 1809 Pleasanton, CA 94566

1-800-788-0710 (TTY: 711)

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

MEDICAL INFORMATION CONFIDENTIALITY NOTICE

An insured who is a protected individual is not required to obtain the Certificateholder's authorization to receive certain medical services ("sensitive services") or to submit a claim for sensitive services if the protected individual has the right to consent to care. Under California law, insureds also have the right to request confidential communication of medical information related to sensitive services that they receive.

"**Protected individual**" means any adult insured covered under a health insurance policy or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code.

"**Sensitive services**" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the California Family Code, and Sections 121020 and 124260 of the California Health and Safety Code, obtained by a patient of any age at or above the minimum age specified for consenting to the service specified in the section.

"**Medical information**" means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health insurer, pharmaceutical company, or contractor regarding a patient's medical history, reproductive or sexual health application information, mental or physical condition, or treatment. "Individually identifiable" means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity.

Requests for confidential communications. A request for confidential communication will apply to all communications that disclose medical information or provider name and address related to medical services that you have received. Your request will be valid until you submit a revocation of your request or if you submit a new confidential communication request. To protect the confidentiality of the information, a KPIC representative will call you upon receipt

of your request to verify and acknowledge your request. The KPIC representative will send you a form relative to your request.

You may request a confidential communication of medical information related to medical services that you have received to:

KAISER PERMANENTE INSURANCE COMPANY

ATTN: KPIC OPERATIONS

P.O. BOX 1809

Pleasanton, CA 94566

1-800-788-0710

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)-686-7100.
TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 1-(800)-686-7100.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码1-(800)-686-7100.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-(800)-686-7100

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.

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INTRODUCTION

This Certificate describes the KPIC Participating (Preferred) Provider Organization (PPO) and Indemnity (OOA) Medical Insurance Plans. It is important that You reference the Schedule of Coverage to determine the type of plan under which You are covered.

Please read the following information carefully. It will help You understand how the provider You select can affect the dollar amount You must pay in connection with receiving Covered Services. Your coverage under the Group Policy includes coverage for Covered Services received from Participating Providers as well as Non-participating Providers. 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.

To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory. To view KPIC's Participating Provider directory or to request a printed copy at no cost, You may visit KPIC's contracted provider network web site at www.Multiplan.com/Kaiser for providers in CA, CO, GA, HI, MD, OR, VA, WA and the District of Columbia (hereafter referred to as KP states) and kp.org/CignaPPONetworkDirectory for providers for all other states. 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 under this coverage.

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 Questions?

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

For coverage: **1-800-788-0710 (TTY users call 711)**

Eligibility, name or address change: **1-800-554-3099**

Or You may write to the Administrator:

For Southern California:
KFHP Claims Department
P.O. Box 7004
Downey, CA 90242-7004
Member Services
1-800-788-0710

INTRODUCTION

For Northern California:
KFHP Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
Member Services
1-800-788-0710

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.

If you have complaints regarding Your coverage under this Plan, You may contact KPIC at:

Kaiser Permanente Insurance Company (KPIC)

Attn: KPIC Operations

Grievance and Appeals Coordinator

P.O. BOX 1809

Pleasanton, CA 94566

1-800-788-0710

or 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 FOR SMALL BUSINESS

Metal Plan Designation: GOLD

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, in connection with receiving Covered Services.

You will be responsible for a larger portion of Your bill including higher deductibles 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

ACCUMULATION PERIOD: Calendar Year

	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
OUT-OF-POCKET MAXIMUMS per ACCUMULATION PERIOD:		
Individual Out-of-Pocket Maximum:	$7,800	$15,600
Family Out-of-Pocket Maximum:	$15,600	$31,200

DEDUCTIBLES per ACCUMULATION PERIOD:

You must pay Covered Charges for Services You received in the Accumulation Period 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: *Preventive Care Exams and Services required under the Affordable Care Act (ACA) that are received at the participating Provider tier are not subject to Deductible.*

Individual Deductible Maximum:	$350 [1]	$1,000 [1]
Family Deductible Maximum:	$700 [1]	$2,000 [1]

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER

NOTE: Covered Charges applied to satisfy the Deductible, including per admission deductible, if any, apply to satisfy the Out-of-Pocket Maximum. Cost Shares applied to satisfy the Out-of-Pocket Maximums at the Participating Provider tier will not be applied towards satisfaction of the Out-of-Pocket Maximums at the Non-Participating Provider tier. Likewise, Cost Shares applied to satisfy the Out-of-Pocket Maximum at the Non-Participating Provider tier will not apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier, except when Emergency Care Services are obtained from a Non-Participating Provider the Covered Charges will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier.

Covered Charges will apply towards satisfaction of the Deductible, if any, at the Participating Provider tier for the following Covered Services obtained from a Non-Participating Provider: 1) Emergency Care Services; 2) Emergency Ambulance Services; 3) Air Ambulance Services; and 4) Non-emergency services rendered by a Non-Participating Provider in a Participating Provider facility.

Deductibles including any benefit-specific deductibles, Copayments and Coinsurance for Covered Charges contribute toward satisfaction of the Out-of-Pocket Maximum.

Quantitative treatment limits, such as annual or lifetime day visits do not apply to Medically Necessary Treatment of Mental Health and Substance Use Disorders.

[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 ACA that are received at the Non-Participating Provider tier, however, may be subject to Deductibles, Coinsurance and Copayments.

IMPORTANT: Read the section in Your Certificate of Insurance regarding Precertification carefully. Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification.

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Hospital Inpatient Care Facility Fee (e.g. Hospital room) for inpatient):	20%	40%
Physician, Surgeon or Surgical services:	20%	40%
	Inpatient Hospital Ancillary Care/Services are not subject to a deductible per hospital admission for both participating and non-participating provider tiers.	

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Precertification is required for hospital inpatient care (except for emergency admissions, admissions for delivery of a child, and admissions for mastectomy and lymph node surgical procedures). Benefits payable may be reduced by a $500 penalty if You fail to obtain Precertification. Please refer to the Precertification Section in Your Certificate of Insurance for details, including the exceptions to the Precertification requirement for emergency admissions; hospital stays related to a maternity admission for a minimum of 48 hours for a vaginal delivery and 96 hours for a caesarean delivery; and length of hospital stay following mastectomy and lymph node dissection.		
Skilled Nursing Facility Care:	20%	40%
	Combined Maximum of 100 days per Benefit Period [1] (The day maximum does not apply to Medically Necessary Treatment of Mental Health and Substance Use Disorders.)	
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, 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:	$25 Copayment Deductible does not apply	40%
Provider Office Visits:		
Primary Care Physician	$25 Copayment Deductible does not apply	40%
Other Practitioner office visits (includes other visits not provided by either Primary Care or Specialty Care Physicians or not specified in another benefit category, such as acupuncture visits):	$25 Copayment Deductible does not apply	40%
Specialty Care Physician	$50 Copayment Deductible does not apply	40%
Emergency Care or Emergency Services:		
Facility Charges:	20% (waived if admitted)	20% (waived if admitted)

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
Physician Services:	No Charge	No Charge

Cost Share for Emergency Care or 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. The Participating Provider Deductible, if any, for these benefits will otherwise apply towards satisfaction of the Deductible at the Participating Provider tier.

Emergency Ambulance Services:	20%	20%

Cost Share for Emergency Ambulance 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. The Participating Provider Deductible, if any, for these benefits will likewise apply towards satisfaction of the Deductible at the Participating Provider tier.
The cost-sharing amount for covered services received from non-contracting ground ambulance provider would be the same as the cost-sharing amount for the same covered services received from a contracting ground ambulance provider. Cost-sharing arising pursuant to the covered services received from a non-contracting ground ambulance provider is to count toward any deductible in the same manner as cost-sharing would be attributed to a contracting provider. Additionally, cost-sharing arising pursuant to the covered services received from a non-contracting ground ambulance provider is to count toward the limit on annual out of-pocket expenses.

Medically Necessary Non-Emergency Ambulance Services:	20%	20%

Cost Share for Medically Necessary ground and water Non-Emergency Ambulance Services obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Non-Participating Provider tier. For Non-Emergency Ambulance Services obtained from a Non-Participating Provider, the Non-Participating Provider Deductible, if any, will apply. However, Cost Share for non-emergency Air Ambulance Services obtained from a Non-Participating Provider will apply towards satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier and the Participating Provider Deductible, if any, for these benefits likewise apply towards satisfaction of the Deductible at the Participating Provider tier.

The cost-sharing amount for covered services received from non-contracting ground ambulance provider would be the same as the cost-sharing amount for the same covered services received from a contracting ground ambulance provider. Cost-sharing arising pursuant to the covered services received from a non-contracting ground ambulance provider is to count toward any deductible in the same manner as cost-sharing would be attributed to a contracting provider. Additionally, cost-sharing arising pursuant to the covered services received from a non-contracting ground ambulance provider is to count toward the limit on annual out of-pocket expenses.

Precertification is required for non-emergency ambulance, 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	40%

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
	Combined Benefit Maximum of 100 visits per Accumulation Period (limit does not apply to physical, occupational, and speech therapists visits in the home). (The day maximum does not apply to Medically Necessary Treatment of Mental Health and Substances Use Disorders.)	
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:	No Charge Deductible does not apply	40%
Outpatient Surgery:	20% Deductible does not apply	40%
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:	$25 Copayment [1] Deductible does not apply	40%
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.		
COVID-19 home antigen tests and molecular tests:	No Charge *Combined Benefit Maximum of 8-test limit for home antigen tests per month per member*	40%
X-Ray and Diagnostic Testing:	$65 Copayment [1] Deductible does not apply	40%
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):	20% [1] Deductible does not apply	40%
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:	20% Deductible does not apply	40%
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.		

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Base Durable Medical Equipment (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):	20% Deductible does not apply	40%
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):	20% Deductible does not apply Combined Benefit Maximum of $2,000 per Accumulation Period	40%
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 limited to: infusion set and syringe with needle for external insulin pump; testing strips; lancets; skin barrier; adhesive remover wipes and transparent film (See also, "Other Covered Preventive Care" in this Schedule of Coverage.):	20% Deductible does not apply	20%
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	40% Deductible does not apply
Allergy Testing and Treatment (administered during an office visit):	20% Deductible does not apply	40%
Abortion services	No charge Deductible does not apply	No charge Deductible does not apply.

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
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 rehabilitation):	$25 Copayment Deductible does not apply	40%
Multidisciplinary Rehabilitation Care:		
Inpatient:	20%	40%
Outpatient:	$25 Copayment Deductible does not apply	40%
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):	$25 Copayment Deductible does not apply	40%
Outpatient Therapy Services (including Physical, Speech, Occupational, and Respiratory Therapy) in connection with the treatment of Pervasive Developmental Disorder or Autism):		
Individual Outpatient visits:	$25 Copayment Deductible does not apply	40%
Group Outpatient visits:	$12 Copayment Deductible does not apply	40%

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Mental Health and Substance Use Disorder Treatment Benefits:		
Outpatient office visits:		
Mental Health or Substance Use Disorder Treatment Individual Outpatient visits:	$25 Copayment Deductible does not apply	40%
Mental Health or Substance Use Disorder Treatment Group Outpatient visits:	$12 Copayment Deductible does not apply	40%
Outpatient items and services (other than office visit services):		
Mental health intensive outpatient programs:	No Charge Deductible does not apply	40%
Mental health partial hospitalization:	No Charge Deductible does not apply	40%
Outpatient reconstructive surgery and administered hormones for treating gender dysphoria:	No Charge Deductible does not apply	40%
Substance Use Disorder Treatment intensive outpatient programs:	No Charge Deductible does not apply	40%
Substance Use Disorder day treatment programs:	No Charge Deductible does not apply	40%
Behavioral Health Treatment Program for Pervasive Development Disorder or Autism, (including treatment provided in the home):	No Charge Deductible does not apply	40%

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Inpatient:	20%	40%

Except in an emergency, 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 and Assisted Reproductive Technologies (ART) Services:	Cost share is the same as medical services - subject to deductible and out-of-pocket maximum. (1 oocyte retrieval and 1 embryo transfer – per lifetime) Benefit Maximum of $1,000 per Accumulation Period	Not Covered
Transplant Services:	20%	40%

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.

Birth Services (except routine prenatal care. Please see ACA Preventive benefits in this SOC):	20%	40%
Second Medical Opinion:	$25 Copayment Deductible does not apply	40%
Medically Necessary Contact Lenses (including fitting and dispensing) for:		
Treatment of Aniridia (missing iris)	No Charge Deductible does not apply	0% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge

Limited to 2 lenses per eye, subject to Benefit Maximum of 4 lenses per Accumulation Period

Pediatric Dental (children under age 19):

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Diagnostic & Preventive (D&P): X-rays, Exams, Cleanings, Sealants, Including Pulp Vitality Tests	No Charge Deductible does not apply	No Charge up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge. Deductible does not apply
Basic Services: Basic Restorative:	20% Deductible does not apply	20% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge. Deductible does not apply
Major Services: Crowns & Casts, Prosthodontics, Endodontics, Periodontics, Oral Surgery:	50% Deductible does not apply	50% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge. Deductible does not apply
Orthodontics (Medically Necessary):	50% Deductible does not apply	50% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge. Deductible does not apply
Pediatric Vision (children under age 19): Exams:	No Charge Deductible does not apply	0% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge Combined limit of one visit per Accumulation Period

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Lenses (including optional Lenses and Treatments):	No Charge Deductible does not apply	20% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge
	Combined limit of one set of lenses per Accumulation Period	
Frames:	No Charge Deductible does not apply	20%
	Combined limit of one pair of standard frames per Accumulation Period	
Contact Lenses (in lieu of eyeglasses):	No Charge Deductible does not apply	20%
	Limited to 12-month supply of contact lenses for each eye every Accumulation Period	
Medically Necessary Contact Lenses:	No Charge Deductible does not apply	0% up to the Maximum Allowable Charge. You are responsible for any amounts charged that exceed the Maximum Allowable Charge
	Limited to 12-month supply of contact lenses for each eye every Accumulation Period	

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.

Low Vision services:	
Exams:	$50 Copayment per visit Deductible does not apply Limited to one visit every 5 years
Follow up care:	$50 Copayment per visit Deductible does not apply Limited to four visits every 5 years

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Low Vision Aids	20%	40%

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.

Other Covered Services:	20% [1]	40%

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 Preventive Benefits)

Exams (including routine prenatal visits and first postnatal visit):	No Charge Deductible does not apply	40% 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	40% Deductible does not apply
Health Promotion:	No Charge Deductible does not apply	40% Deductible does not apply
Disease Prevention:	No Charge Deductible does not apply	40% Deductible does not apply
Family Planning including female sterilization, patient education and counseling:	No Charge Deductible does not apply	40% Deductible does not apply

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)

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Routine Nursery Care and Physician charges for a newborn while the mother is confined:	20%	40%
Adult Preventive screening:	No Charge Deductible does not apply	40% Deductible does not apply
Adult Routine Physical Examinations:	No Charge Deductible does not apply	Not Covered
Adult Preventive Visions Screenings and Exams:	No Charge Deductible does not apply	Not Covered
Adult Routine Preventive Retinal Photography Screenings:	No Charge Deductible does not apply	40% Deductible does not apply
Other Hearing screenings:	No Charge Deductible does not apply	Not Covered
Other Family Planning such as fertility testing and counseling:	$25 Copayment Deductible does not apply	40%
Vasectomy services or procedures:	No Charge Deductible does not apply	100% Deductible does not apply
AIDS Vaccine:	No Charge Deductible does not apply	40% 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	Not Covered
Iron deficiency anemia screening for Covered Person:	No Charge Deductible does not apply	40% Deductible does not apply

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE PARTICIPATING PROVIDER TIER	 NON-PARTICIPATING PROVIDER TIER
Foreign Travel Immunizations:	No Charge Deductible does not apply	Not Covered
Hemoglobin A1C testing for individuals diagnosed with diabetes: [2]	No Charge Deductible does not apply	40% Deductible does not apply
Retinopathy Screening for individuals diagnosed with diabetes: [2]	No Charge Deductible does not apply	40% Deductible does not apply
Low Density Lipo-Protein testing for individuals diagnosed with heart disease: [2]	No Charge Deductible does not apply	40% Deductible does not apply
International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders: [2]	No Charge Deductible does not apply	40% Deductible does not apply
Peak flow meters for individuals diagnosed with asthma: [2]	20% Deductible does not apply	40%

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.

Glucometers including lancets, test strips, control solution and batteries for individuals diagnosed with diabetes: [2]	20% Deductible does not apply	20%

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.

[2]This service or supply is treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition.

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 for up to a 30-day supply* Deductible does not apply	Not Covered
Tier 2: Brand Name Drugs:	$50 Copayment for up to a 30-day supply* Deductible does not apply	Not Covered
Tier 3: Specialty Drugs:	20% for up to a 30-day supply*, (not to exceed $250 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:	20% for up to a 30-day supply Deductible does not apply	Not Covered

**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.

SCHEDULE OF COVERAGE

COVERED SERVICES	YOUR COST SHARE	
	PARTICIPATING PROVIDER TIER	NON-PARTICIPATING PROVIDER TIER
	PARTICIPATING (MedImpact) PHARMACY TIER	NON-PARTICIPATING PHARMACY TIER

Your Cost Share for orally administered anti-cancer drugs shall not exceed $200 for a 30-day supply.

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.*

OPTIONAL BENEFITS:

Adult Vision Care (including frames prescription lenses and prescription contact lenses):	Not Covered	Not Covered

[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 ACA that are received at the Non-Participating Provider tier, however, may be subject to Deductibles, Coinsurance and Copayments.

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 more 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 For Southern California: KFHP Claims Department, P.O. Box 7004, Downey, CA 90242-7004; For Northern California: KFHP Claims Department, P.O. Box 12923, Oakland, CA 94604-2923 is the Administrator of your medical coverage while Delta Dental is the Administrator of the Pediatric Dental coverage. 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).

Air Ambulance Service means medical transport by a rotary wing air ambulance, or fixed wing air ambulance, as defined under applicable federal law, for patients.

Allowance means a specified credit amount that can be used toward the purchase price of a covered item. If the price of the item(s) selected exceeds the Allowance, amounts in excess of the Allowance are paid by the Covered Person and that

payment does not apply toward the satisfaction of the annual Out of Pocket Maximum.

Ancillary Services means for purposes of determining when no surprise billing federal notice and consent requirements apply:

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

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:

1. 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.
2. The treatment is provided under a Treatment Plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
    a) A Qualified Autism Service Provider.
    b) A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.

c) A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.

3. 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:

   a) Describes the patient's behavioral health impairments to be treated.

   b) 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.

   c) Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.

   d) Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

4. 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 the KPIC upon request.

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 has 24-hour-a-day Registered Nurse services.

Biomarker means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacological responses to a specific therapeutic intervention. A biomarker includes, but is not limited to, gene mutations or protein expression.

Biomarker testing means the analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.

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; 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 but does not include accident only, credit, disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
2. The federal Medicare program pursuant to Title XVIII of the Social Security Act.
3. The Medicaid program pursuant to Title XIX of the Social Security Act.
4. Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
5. A health plan offered under 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS).
6. A medical care program of the Indian Health Service or of a tribal organization.
7. A state health benefits risk pool.
8. A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
9. A public health plan as defined in federal regulations authorized by Section 2701(c)(1)(I) of the Public Health Service Act, as amended by Public Law 104-191.
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504)).

Deductible means the amount of Covered Charges a Covered Person must incur, while insured under the Group Policy, before any benefits will be payable during 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. In a family plan, once the total of Covered Charges applied toward each

family member's individual Deductible equals the family Deductible amount, the 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 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. Covered Charges for Emergency Care Services obtained from a Non-Participating Provider will apply toward satisfaction of the Deductible at the Participating Provider tier.

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

Dental Consultant means a Dentist who is responsible for the review and final adjudication of claims and re-evaluation requests that require professional review to ensure that the service was deemed necessary, appropriate and meets Generally Accepted Dental Practice Standards or has reasonable prognosis.

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 recognized natural child; and any other child for whom You have assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by You, as certified at the time of enrollment of the child, and annually thereafter; or, foster children if you or your Spouse have the legal authority to direct their care.

Domestic Partner is an adult in a domestic partnership. A Domestic Partner may be regarded as your 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:

- designed for repeated use;
- mainly and customarily used for medical purposes;
- not generally of use to a person in the absence of a sickness or Injury; and
- approved for coverage under Medicare, except for apnea monitors; or
- 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 Service means:

1. An appropriate medical screening examination as required under the Emergency Medical Treatment and Active Labor Act, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, that is within the capability of the emergency department of a hospital or the Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition;
2. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment, as are required under the Emergency Medical Treatment and Active Labor Actor as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished);

3. Other Covered Services that are furnished by a Non-Participating Provider after You are stabilized and as part of an outpatient observation or an inpatient or outpatient stay with respect to the same Visit in which the Emergency Services described in item 1. and 2. above are furnished.

4. The Covered Services described in item 3. above are not Emergency Services if all of the following conditions are met:

   a. The attending emergency physician or treating provider determines that the You are able to travel using nonmedical transportation or nonemergency medical transportation to an available Participating Provider or facility located within a reasonable travel distance, taking into account Your medical condition;

   b. The provider or facility furnishing such additional items and services satisfies the applicable notice and consent requirements with respect to such items and services as described under the **ACCESS TO HEALTH CARE** section of this Certificate of Insurance, provided that the written notice also satisfies the following requirements as applicable:

      i. In the case of a Participating Provider emergency facility and a Non-Participating Provider, the written notice must also include a list of any Participating Providers at the facility who are able to furnish such items and services involved and You may be referred, at Your option, to such Participating Provider.

      ii. In the case of a Non-Participating emergency facility, the written notice must include the good faith estimated amount that You may be charged for items or services furnished by the Non-Participating Provider emergency facility or by Non-Participating Providers with respect to the visit at such facility (including any item or service that is reasonably expected to be furnished by the Out-of-Network emergency facility or Out-of-Network Providers in conjunction with such items or services);

   c. You (or your authorized representative) are in a condition to receive the information described in item 4 b. above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and Your or Your authorized representative provide informed consent in accordance with applicable State law.

For purposes only of this definition, the following terms are defined as follows:

- "Authorized representative" means an individual authorized under State law to provide consent on behalf of a patient, provided that such individual is not a provider affiliated

with the facility or employee of the facility, unless such provider or employee is a member of Your family.

- "Visit" as used only in this Section regarding Emergency Services means with respect to items and services furnished to an individual at a health care facility, includes, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

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 Covered Person in active labor, the health of the Covered Person or their 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.

Generally Accepted Dental Practice Standards means treatment that is consistent with sound, professionally recognized dental standards of practice as determined by the treating licensed Dentist acting within the scope of their practice in California for the dental condition in question.

Generally Accepted Standards of Mental Health and Substance Use Disorder Care means standards of care and clinical practice that are generally recognized by Health Care Providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to California Insurance Code Section 10144.51. Valid, evidence-based sources establishing Generally Accepted Standards of Mental Health and Substance Use Disorder Care include peer-reviewed scientific studies

and medical literature, clinical practice guidelines and recommendations of nonprofit Health Care Provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

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.

Health Care Provider means any of the following:

1. A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.
2. An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.
3. A Qualified Autism Service Provider or Qualified Autism Service Professional certified by a national entity pursuant to Section 1374.73 of the Health and Safety Code and Section 10144.51.
4. An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.
5. An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.
6. A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.
7. A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.
8. A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

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).
3. 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.

Iatrogenic Infertility means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

Indemnity Plan means a KPIC indemnity plan type in which Covered Persons are reimbursed for Covered Charges.

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

Injury means 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, 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.

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 3 b) below;
2. For Covered Services listed in (a) through (c) below, furnished by a Non-Participating Provider, the Out-of-Network Rate less any Cost Share owed by You:
    a. Emergency Services; or
    b. Non-Emergency Services rendered by a Non-Participating Provider at Participating Provider facilities including Ancillary Services and Covered Services for unforeseen urgent medical needs; or
    c. Air Ambulance Services.

Your Cost Share will be calculated based on the Recognized Amount and will be treated as Participating Provider Cost Sharing for the purpose of accumulation to Your Deductible, if any, and Participating Provider Out-of-Pocket Maximum.

3. For all other Covered Services from a Non-Participating Provider, the lesser of:

   a. Usual, Customary and Reasonable Charge (UCR).

      The UCR is the charge generally made by a Physician or other provider of Covered Services. The charge cannot exceed the general level of charge made by other providers within an area in which the charge is incurred for Injury or sickness comparable in severity and nature to the Injury or sickness being treated. The general level of charges is determined in accord with schedules on file with the authorized Administrator. For charges not listed in the schedules, KPIC will establish the UCR. KPIC reserves the right to periodically adjust the charges listed in the schedules.

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

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

   b. The Negotiated Rate.

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

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

c. The Actual Billed Charges for the Covered Services:

The charges billed by the provider for Covered Services.

For dental services, outpatient prescription drugs dispensed and rendered by Out-of-Network Providers, the amount payable by KPIC is the lesser of the Actual Billed Charges or the same amount paid to a Participating Provider for the same service or item.

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

We will determine the Maximum Allowable Charge and whether such item or service is a Covered Service under the Group Policy.

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

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.

<u>For COVID-19 preventive Covered Services rendered by Non-Participating Providers, the following rules apply:</u>

a) Non-Participating Provider reimbursement for COVID-19 covered preventive services will be in an amount that is reasonable, as determined in comparison to prevailing market rates for such service.

Medical Review Program means the organization or program that: evaluates proposed services and/or items to determine that they are Covered Services and Medically Necessary. If the Medical Review Program determines that such services and/or items are not Covered Services and/or is not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven (7) days per week at 1-888-251-7052 or visit https://healthy.kaiserpermanente.org/northern-california/community-providers/permanente-advantage for more information regarding Covered Services that require precertification

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.

This definition of Medically Necessary does not apply to benefits for Mental Health and Substance Use Disorders. Please refer to the definition of Medically Necessary

Treatment of a Mental Health or Substance Use Disorder for the medically necessary definition that applies to Mental Health and Substance Use Disorders benefits.

Medically Necessary Treatment of a Mental Health or Substance Use Disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

a) In accordance with the Generally Accepted Standards of Mental Health and Substance Use Disorder Care.
b) Clinically appropriate in terms of type, frequency, extent, site, and duration.
c) Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other Health Care Provider.

Medical Necessity coverage determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge will be made exclusively by using the following nonprofit professional specialty association guidelines:

- For a primary Substance Use Disorder diagnosis, The ASAM Criteria developed by the American Society of Addiction Medicine;
- For a primary Mental Health diagnosis in adults age 19 and older, Level of Care Utilization System (LOCUS) developed by the American Association for Community Psychiatry (AACP);
- For a primary Mental Health diagnosis in children ages 6-18, Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) developed by AACP and the American Academy of Child & Adolescent Psychiatry (AACAP);
- For a primary Mental Health diagnosis in children ages 5 and younger, Early Childhood Service Intensity Instrument (ECSII) developed by AACAP.

Medically Necessary Treatment of Mental Health and Substance Use Disorders are covered under the same terms and conditions applied to other medical conditions under this Plan

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

Mental Health and Substance Use Disorders means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by Health Care Providers practicing in relevant clinical specialties.

Medically Necessary Treatment of Mental Health and Substance Use Disorders are covered under the same terms and conditions applied to other medical conditions under this Plan.

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 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.

Out-of-Network Rate means one of the following:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to this Plan and KPIC, Non-Participating Provider, and the item or service, the amount for the item or service determined in accordance with the All-Payer Model Agreement.
2. If there is no such All-Payer Model Agreement applicable to the item or service, but a specified State law is in effect and applicable to this plan, KPIC, Non-Participating Providers and the item and service, the amount for the item or service determined in accordance with such specified State law.
3. If there is no such All-Payer Model Agreement or specified State law applicable to this plan, KPIC, the Non-Participating Provider and the item or service, the initial payment made by us or the amount subsequently agreed upon by KPIC and the Non-Participating Provider.
4. If none of the three payment methodologies described in (1)-(3) above apply, an amount determined by a certified independent dispute resolution (IDR) entity pursuant to the federal IDR process described under the Public Health Service Act.

Out-of-Pocket means the Cost Share incurred by a Covered Person.

Out-of-Pocket Maximum means the maximum amount of Cost Share 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. Cost sharing for Emergency Care Services, including emergency hospital care and emergency medical transportation, obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider and the Non-Participating Provider tiers.

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. In most instances, a higher level of benefits applies to Covered Services received from preferred providers and facilities. 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.

GENERAL DEFINITIONS

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 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 Medical 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 the form of a penalty.

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

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 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.

Qualifying Payment Amount means the amount calculated using the methodology described in applicable federal regulation for the same or similar item or service provided by a facility or provider of the same or similar facility type or in the same or similar specialty, as applicable, in the geographic region in which the item or service is furnished with respect to the same insurance market.

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

1. 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.
2. Provides treatment and implements services pursuant to a Treatment Plan developed and approved by the Qualified Autism Service Provider.
3. Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
4. 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.
5. 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:

1. Provides Behavioral Health Treatment, which may include clinical case management and case supervision of a qualified autism service provider.
2. Is supervised by a Qualified Autism Service Provider.
3. Provides treatment pursuant to a Treatment Plan developed and approved by the Qualified Autism Service Provider.
4. Is either of the following:
    a. 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.
    b. A psychological associate, an associate marriage and family therapist, an associate clinical social worker or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology.

5. And:

    a. 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.

    b. If an individual meets the requirement described in clause (b) of subparagraph (4) above, the individual shall also meet the criteria set forth in the regulations adopted pursuant to Section 4686.4 of the Welfare and Institutions Code for a Behavioral Health Professional.

6. And, 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:

1. 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

2. 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.

Recognized Amount means:

1. In a State that has an All-Payer Model Agreement under section 1115A of the Social Security Act that applies to the plan, KPIC, Non-Participating Provider, and the item or service, the amount for the item or service in accordance with the All-Payer Model Agreement.

2. If there is no such All-Payer Model Agreement applicable to the item or service, then, in a State which has in effect a specified State law that applies to the plan, KPIC, Non-Participating Provider and the item or service, the amount for the item or service is determined in accordance with such specified State law.
3. If neither an All-Payer Model Agreement or a specified State law applies to the item or service, then the lesser of: the amount billed by the Non-Participating Provider or the Qualifying Payment Amount.

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, or other craniofacial conditions, such as Apert, Pfeiffer and Crouzon Syndromes, and hemifacial microsomia.

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 Treatment of a Mental Health or Substance Use Disorder 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.

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 Covered Person 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 Covered Person or unborn child), "Stabilize" means to deliver (including the placenta).

Substance Use Disorder – Please see definition of "Mental Health and Substance Use Disorders".

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 described in the **subsection Enrollment Rules for Eligible Employee or Dependent** provision set forth below under this section.

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 or is a disabled child of any age. The word **"child"** includes: a) Your step-child; b) adopted child; c) child of Your Domestic Partner; d) recognized natural child; e) any other child for whom You have assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by You, as certified at the time of enrollment of the child, and annually thereafter; f) foster children if you or your Spouse have the legal authority to direct their care.

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.

Initial enrollment of a Disabled Dependent child age 26 or over

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. 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.

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 termination notice to the Insured Employee at least 90 days prior to the date of the Dependent child's attainment of limiting age. KPIC shall require the Insured Employee's submission of proof of such incapacity and dependency during the period commencing 60 days before and ending 60 days after the child's 26th birthday. Coverage will continue while KPIC is making a determination as to the child's eligibility for continued coverage.

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 for Eligible Employee or Dependent

If You are an Eligible Employee, Your effective date of insurance is determined by the Enrollment Rules that follow. Your Dependent's effective date is likewise determined by the following Enrollment Rules:

1. **Initial Open Enrollment**
   The Policyholder will offer an initial enrollment to newly Eligible Employees and Dependents when the Employee is first eligible for coverage.

Effective date. Initial enrollment for newly eligible Employees and Dependents is effective following completion of any waiting period or probationary period, if required by the Policyholder. In the absence of a waiting period or probationary period, the enrollment becomes effective according to the eligibility rules established by the Policyholder, either on the date of hire or on the first day of the calendar month following the month in which the employee was hired.

If You did not enroll Yourself and/or Your Dependents during the initial enrollment period, You and/or Your Dependents will need to wait until the next Open Enrollment period to enroll or during the Special Enrollment Period or as a Late Enrollee, as described below.

2. **Rolling Enrollment Period**

   Employers can purchase coverage for their small group at any time in the year (rolling enrollment). The Policyholder's plan year must consist of the 12- month period beginning with the employer's effective date of coverage.

3. **Annual Employer Election Period**. The Policyholder shall be afforded an annual employer election of no less than 30 days prior to the completion of the Policyholder's plan year and before the annual employee Open Enrollment period, in which the Policyholder may change its participation for the next plan year.

   KPIC will provide notification to the Policyholder of the annual election period in advance of such period.

4. **Annual Open Enrollment**

   Open Enrollment refers to a standardized annual period of time, of no less than 30 days prior to the completion of the employer's plan year for Eligible Employees to enroll. During the annual open enrollment period, Eligible Employees and Dependents can apply for or change coverage without incurring the status of being a Late Enrollee.

   Effective date. Enrollment is effective on the first day following the end of the prior plan year. Open Enrollment occurs only once per year. The Policyholder will notify You when Open Enrollment is available in advance of such period.

5. **Late Enrollment**

   If You do not enroll yourself and/or Your Dependent when first eligible, You and/or Your Dependent may apply for coverage at any time during the year as a Late Enrollee, but You and/or Your Dependent will only be eligible to enroll during the next Open Enrollment Period, or during a Special Enrollment Period if You and/or Your Dependent have experienced a triggering event.

6. **Special Enrollment – Exceptions to Late Enrollment**

   You and/or Your Dependent may be able to enroll for coverage prior to Open Enrollment if You and/or Your Dependent have experienced a special enrollment triggering event. You and/or Your Dependent must request coverage within 60 days of a triggering event. Special enrollment triggering events include:

1) Loss of health care (minimum essential) coverage, resulting from any of the following:
    a. loss of employer sponsored coverage because You or Your Dependent no longer meet the eligibility requirements;
    b. Your or Your Dependent's employer no longer offers coverage or stops contributing premium payments;
    c. loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium);
    d. Your and/or Your Dependent's individual or group, Medi-Cal, Medicare, or other governmental coverage ends;
    e. for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission under section 10384.17 of the California Insurance Code (fraud or intentional misrepresentation of material fact); or
    f. loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code.
2) Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption or assumption of a parent-child relationship;
3) A valid state or federal court orders that You or Your dependent be covered;
4) Permanent relocation , such as moving to a new location and having a different choice of health plans;
5) Being released from incarceration;
6) The prior health coverage issuer substantially violated a material provision of the health coverage contract;
7) A network provider's participation in Your and/or Your Dependent's health plan ended when You and/or Your Dependent(s) were under active care for one of the following conditions:
    a. an acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration;
    b. a serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration;
    c. pregnancy;
    d. terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less;
    e. care of a newborn child between birth and age 36 months; or
    f. performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered insured.

8) A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code;
9) An individual demonstrates to the Department of Insurance, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

Effective date. In the case of birth, adoption, or placement for adoption, enrollment is effective on the date of birth, adoption, or placement for adoption. In the case of any other triggering event listed above, including marriage, or becoming a registered domestic partner, or loss of minimum essential coverage, enrollment is effective on the first day of the month following the date We receive the request for special enrollment.

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 60 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 60 days of the Order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

Effective date. Enrollment is effective on the first day of the month following the date We receive the request for special enrollment.

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 or becoming a registered domestic partner, enrollment is effective on the first day of the month following the date We receive the request for special enrollment. The Dependent must be enrolled within 60 days of their eligibility date or they will be considered a Late Enrollee.

Exception for Newborns

A newborn Dependent child is insured from the moment of birth for the first 31 days (including the date of birth). You must enroll the newborn Dependent within 60 days of that Dependent's birth in order for insurance to extend beyond the 60-day period. If coverage terminates at the expiration of the 60-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 within 60 days of his eligibility date in order for insurance to extend beyond the 60-day period. If coverage terminates at the expiration of the 60-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.

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 grace 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 Insured Dependent Coverage

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

1. the date You cease to be covered by KPIC;
2. the last day of the of the calendar month in which the person ceases to qualify as a Dependent;
3. the date 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. (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 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.

To the extent required by California law, if Your coverage terminates, KPIC will provide Your name, address and other contact information, such as email address to the state Exchange (Covered California) so that Covered California may communicate with You about available coverage options after You cease to be enrolled. You have the right to opt out of this transfer of Your information to Covered California, by calling toll-free 1-800-464-4000the telephone number on Your I.D. card.

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 30 days advance written notice. The rescission of coverage will be effective, on:

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

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

If Your or Your Dependent's Policy is rescinded, you have the right to appeal the rescission. Please refer to the APPEALS AND COMPLAINTS section of this Certificate for a description of the Appeals process and Your right to an Independent External 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. 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 level, the Covered Person must receive care from a Participating Provider. KPIC's Participating Provider network consists of the PHCS network within CA, CO, GA, HI, MD, OR, VA, WA and the District of Columbia (hereafter referred to as KP states) and the CIGNA PPO Network in all other states.

You may visit KPIC's contracted provider network web sites at: www.Multiplan.com/Kaiser for providers in CA, CO, GA, HI, MD, OR, VA, WA and the District of Columbia (hereafter referred to as KP states) and kp.org/CignaPPONetworkDirectory for providers for all other states. Additionally, a current printed listing of KPIC's Participating Providers directory directories are 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 ((TTY 711). The English version of this document is the official version. The foreign language version is for informational purposes only.

Geographic Standards for Access to Participating Providers

ACCESS TO HEALTH CARE

In accordance with the provisions of state law, access to health care from a Participating Provider will meet the following distance or travel time from the Covered Person's residence or place of work :

1. 15 miles or 30 minutes for Primary Care Physicians;
2. 15 miles or 30 minutes for Mental health or Substance Use Disorder providers;
3. 30 miles or 60 minutes for Specialty Care Provider; and
4. 15 miles or 30 minutes for Hospitals.

If medically appropriate care cannot be provided by a Participating Provider within the required distance or travel time shown above, 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.

Please see the **TIMELY ACCESS TO CARE** section of this Certificate for information about appointment wait time standards for Participating Providers.

No Surprise Billing Protections

The following services are subject to protections under state and or federal no surprise billing laws.

1. Out-of-Network Emergency Services,
2. Covered Services Provided by a Non-Participating Provider at a Participating Provider Facility
3. Out-of-Network Air Ambulance Services

Notwithstanding any provisions of this Certificate of Insurance to the contrary, when you receive the services listed in items 1-3 above you are protected from balancing billing, sometimes called surprise billing. Surprise billing or balance billing means

billing by a Non-Participating Provider for the difference between what KPIC agreed to pay and the full amount billed by the Non-Participating Provider. You are only responsible for the Participating Provider Cost Share for these services and the Cost Shares will be treated as Participating Provider Cost Shares for the purpose of accumulation to Your Deductible, if any, and Participating Provider Out-of-Pocket Maximum.

Non-Participating Providers rendering the Covered Services listed in the services described above, may not bill or collect more than Your Participating Provider Cost Share and may not bill You the difference between the Actual Billed Charges and the Maximum Allowable Charge.

Consent Requirements

A Non-Participating Provider may balance bill You when the Non-Participating Provider rendering services in a Participating Provider facility or Non-Participating emergency facility has satisfied the applicable notice and consent requirements, if permitted to provide notice and obtain consent, including but not limited to providing notice to You (or Your authorized representative) of the estimated charges for the items and services, that the provider is a Non-Participating Provider and has obtained written consent from You (or Your authorized representative) to be treated and balanced billed by the Non-Participating Provider.

The applicable state or federal notice and consent requirements do not apply to Non-Participating Providers with respect to:

1. Emergency Services until you are stabilized; and
2. Ancillary Services; and
3. Items or services that are Covered Services and are furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Participating Provider satisfied the notice and consent criteria.

Such items and services furnished by Non-Participating Providers will always be subject to the reimbursement described in the Maximum Allowable Charge definition and are prohibited from balance billing You.

Notwithstanding the above, for Non-Emergency Services Obtained from a Non-contracting Individual Health Professional at a Participating Provider Facility located in California, as applicable, the following applies:

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.

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 1-800- 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

P.O. BOX 1809

Pleasanton, CA 94566

1-800-788-0710

You may also fax this information to: KPIC Attn: KPIC Operations Grievance and Appeals Coordinator at 1-855-414-2318.

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 or Substance Use Disorder care provider shall be available within ten business days of the request for appointment;
6) Non-urgent follow-up appointments with a nonphysician Mental Health or Substance Use Disorder care provider for those undergoing a course of

treatment for an ongoing Mental Health or Substance Use Disorder condition, shall be available within ten business days of the prior appointment;

7) 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,

8) 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. For Mental Health and Substance Use Disorders, medical necessity will be based on the standards set forth under the definition of "Medically Necessary Treatment of a Mental Health or Substance Use Disorder".

NOTE: CIGNA PPO Network providers will obtain any necessary Precertification on your behalf. Please refer to the Precertification processes in this section, including a list of Covered Benefits subject to Precertification.

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.

PRECERTIFICATION

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

Medical Review Program means the organization or program that: evaluates proposed services and/or items to determine that they are Covered Services and Medically Necessary. If the Medical Review Program determines that such services and/or items are not Covered Services and/or is not Medically Necessary, Pre-certification will be denied. The Medical Review Program may be contacted twenty-four (24) hours per day, seven (7) days per week at 1-888-251-7052 or visit https://healthy.kaiserpermanente.org/northern-california/community-providers/permanente-advantage for more information regarding Covered Services that require precertification.

Precertification Through the Medical Review Program

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

1. Inpatient Hospital admissions and services.*
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. Weight loss drugs
10. The following specific treatments and procedures:
    a) Anodyne Therapy

b) Bariatric Surgery

c) Blepharoplasty, Pitosis Repair

d) Breast Augmentation/Implants

e) Breast Reduction

f) Clinical Trials

g) Cosmetic Procedures

h) Craniofacial Reconstruction

i) Dental Anesthesia

j) 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

k) Enteral Solutions

l) Fertility Preservation Services

m) Genetic Testing

n) Injectable medications

o) Imaging Services: MRI, MRA, CT, CTA, PET, EBCT

p) Implantable prosthetics (includes breast, bone conduction, cochlear, and ocular)

q) Medical Food Products including treatment of Phenylketonuria (PKU)

r) Non-Emergency Air or Ground Ambulance Transport

s) Orthognathic Surgery (non-dental jaw bone surgery)

t) Orthotics/Prosthetics

u) 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

v) 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.

w) Pediatric low vision aids

x) Pediatric Medically Necessary contact lenses

y) Radiation Therapy Services

z) Reconstruction Surgery (including all procedures by plastic surgeon)

aa) Spinal surgery

bb) Temporomandibular Joint Surgery

cc) Transgender Surgery

dd) Transplants

* **Precertification for inpatient admissions and services**

Precertification is required for all inpatient admissions and services except for the following:

- Maternity admissions and services for delivery of a child for a minimum of 48 hours for a vaginal delivery and 96 hours for a caesarean delivery.
- Emergency admissions or services. 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 the emergency admission.

- Length of stay following a mastectomy or lymph node surgical procedure. 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 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 ii) the date on which coverage of the Hospital Confinement by KPIC under This Plan terminates.

   c) 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.

   d) 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

   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 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; and/or b) Hospital discharge planning

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 Precertification requirements.

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.

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.

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

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

NOTE - Your right to receive information about Your Deductible and Out-of-Pocket Maximum accrual balances:

In accordance with California law, We will mail You notice of Your Deductible and Out-of-Pocket Maximum accrual balances for every month in which benefits were used, unless You elect to receive notice electronically. If You have elected to receive notice electronically, You may opt to receive mailed notices again at any time. Additionally, You may request Your most up-to-date Deductible and Out-of-Pocket Maximum accrual balance at any time.

To request information about Your accrual balances, including how to opt out of mailed notices and elect to instead receive Your accrual updates electronically, please contact KPIC at -800-788-0710 (TTY users call 711).

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.

NOTE: Covered Charges will apply towards satisfaction of the Deductible at the Participating Provider tier for the following Covered Services obtained from a Non-Participating Provider: 1) Emergency Care Services; 2) Emergency Ambulance Services; 3) Air Ambulance Services; and 4) Non-emergency services rendered by a Non-Participating Provider in a Participating Provider facility.

Benefit-specific deductibles

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

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 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.

Percentage Payable

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

Out-of-Pocket Maximums

Any part of a charge that does not qualify as a Covered Charge, will not be applied toward satisfaction of the Out-of-Pocket Maximum. Cost Sharing incurred under the following apply to the Out-of-Pocket Maximum:

1. Cost Sharing incurred for all Covered Services under the Participating Provider tier will be applied towards the Out-of-Pocket Maximum under the Participating Provider tier;

Cost Sharing incurred for all Covered Services under the Non-Participating Provider tier will be applied towards the Out-of-Pocket Maximum under the Non-Participating Provider tier, except as specified in the Schedule of Coverage.

Charges in excess of the Maximum Allowable Charge or Benefit Maximum and additional expenses a Covered Person must pay because Precertification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

Individual Out-of-Pocket Maximums: When the Covered Person's Cost Share equals the Out-of-Pocket Maximum 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 equals the family Out-of-Pocket Maximum 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 limits or maximums are shown in the Schedule of Coverage.

GENERAL BENEFITS

This section describes the general benefits provisions. Outpatient Prescription Drug Benefits are listed in the Outpatient Prescription Drug Benefits section. General limitations and exclusions are listed in the General Limitations and Exclusions section. Optional benefits are set forth under the sections entitled Optional Benefits, Limitations, and Exclusions. 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 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 or is Medically Necessary Treatment of a Mental Health or Substance Use Disorder;
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, including private room accommodation or semi-private room accommodation, upon determination by the attending Physician that such is Medically Necessary.

2. Room and Board in a Hospital Intensive Care Unit.

3. 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; (Note: If You are previously diagnosed with pervasive developmental disorder or autism, it is not required to receive a re-diagnosis to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism.)

   j) and 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.

4. Necessary Services and Supplies, including medication dispensed while confined in a Hospital or administered during other covered treatment, such as a Physician office visit.

5. 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.

6. Physicians' services, including office visits, and house calls when care can best be provided in Your home as determined by the Physician.

7. 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.

When non-emergency air ambulance services are obtained from a Non-Participating Provider, the Covered Charges will apply toward satisfaction of the Deductible at the Participating Provider tier, and to the Out-of-Pocket Maximum at the Participating Provider tier. Please refer to the, "No Surprise Billing Protections" provision in the **ACCESS TO HEALTH CARE** section of this Certificate for further information.

8. 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.

When emergency medical transportation is obtained from a Non-Participating Provider, the Covered Charges will apply toward satisfaction of the Deductible at the Participating Provider tier, and to the Out-of-Pocket Maximum at both the

Participating Provider and Non-Participating Provider tiers. Please refer to the, **No Surprise Billing Protections** provision in the **ACCESS TO HEALTH CARE** section of this Certificate for further information.

9. 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.
10. 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.
11. 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.
12. X-ray, other imaging including diagnostic mammogram and lab tests.
13. Ultraviolet light treatment
14. Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.
15. Genetic testing including 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 and all other laboratory tests for specific genetic disorders for which genetic counseling is available.
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 from nurses, medical social workers, and home health aides; the visit limit does not apply to physical, occupational, and speech therapists 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. Abortion services. Covered Services include abortion-related services, such as pre-abortion services and follow-up care. Abortion means any medical treatment, both surgical and non-surgical (other than experimental or investigational treatment) intended to induce the termination of a pregnancy except for the purpose of producing a live birth. Precertification is not required for inpatient and outpatient abortion services.
20. 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 including 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.

Covered Persons who elect to receive Hospice Care are not entitled to any other benefits under the Plan for the terminal illness while receiving hospice care.

21. Pre-admission testing, limited to diagnostic, x-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital Confinement for which a Room and Board charge is made.

22. 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.

23. 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.

24. Prosthetics (internally implanted).

25. 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.

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.

26. 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.

This benefit includes coverage for diabetic day-care self-management program, training, education and medical nutrition therapy services. 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.

Such programs will only apply to diabetic programs directed and supervised by a licensed Physician certified in internal medicine or pediatrics. The diabetic self-management program may be provided by a health care professional, including but not limited to, a Physician, a Registered Nurse, a registered pharmacist, or a registered dietitian. Benefits will be limited to those charges of the first program that a Covered Person has been certified to have completed.

27. 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.

28. Rehabilitative Services. The following Services are covered

    a) Physical therapy rendered by a certified physical therapist or other provider practicing within the scope of their license or registration.

b) Speech therapy rendered by a certified speech therapist or certified speech pathologist.

c) Occupational therapy rendered by a certified occupational therapist.

d) Pulmonary therapy.

e) Multidisciplinary rehabilitation 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.

29. Respiratory therapy rendered by a certified respiratory therapist

30. Mental Health Services that are Medically Necessary for prevention, diagnosis and treatment of a Mental Health condition are covered under the same terms and conditions applied to other medical conditions under this Plan. This includes all benefits listed elsewhere in this General Benefits section. Covered Services include:

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) Hospital-based intensive outpatient care;

(2) Multidisciplinary treatment in an intensive outpatient psychiatric treatment program;

(3) Electroconvulsive Therapy (ECT),

(4) Psychiatric observation for an acute psychiatric crisis.

(ii) Mental health partial hospitalization;

(iii) Services that are Medically Necessary Treatment of Mental Health and Substance Use Disorder for gender dysphoria, including outpatient reconstructive surgery, administered hormones, and fertility preservation*; and

(iv) Behavioral Health Treatment Program for Pervasive Development Disorder or Autism (including treatment provided in the home). (Note: If You are previously diagnosed with pervasive developmental disorder or autism, it is not required to receive a re-diagnosis to maintain coverage for behavioral health treatment for pervasive developmental disorder or autism.)

c) Inpatient mental health care including the following:

i) Inpatient psychiatric 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 psychiatric residential care facility, including 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.

*See also "Transgender Surgery and other Medically Necessary treatment of Mental Health and Substance Use Disorder for treatment of gender dysphoria" in this **GENERAL BENEFITS** section.

31. Substance Use Disorder services that are Medically Necessary for prevention, diagnosis, and treatment of a Substance Use Disorder are covered under the same terms and conditions applied to other medical conditions under this Plan. This includes all benefits listed elsewhere in this General Benefits section. Covered Services include:

a) Inpatient Substance Use Disorder care:

i. Inpatient detoxification: hospitalization only for medical management of withdrawal symptoms, including room and board, physician

services, drugs, dependency recovery services, education, and counseling;

ii. Treatment in a residential care facility, including transitional residential recovery services for Substance Use Disorder treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

b) Outpatient office visit Substance Use Disorder care:

i. Individual and group Substance Use Disorder counseling;

ii. Medication-assisted treatment

c) Outpatient (other items and services other than office visit services) for Substance Use Disorder 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. Day-treatment programs;

ii. Intensive outpatient programs;

iii. Treatment at a licensed and certified Opioid Treatment Program. Treatment includes delivery or administration of opioid agonist treatment medications, including methadone therapy;

iv. Medical treatment for withdrawal symptoms;

v. Methadone therapy at a licensed treatment center for treatment of withdrawal symptoms and maintenance treatment.

32. Transplant services in connection with an organ or tissue transplant procedure, harvesting the organ, tissue, or bone marrow and treatment of complications, 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).

33. Allergy testing and treatment, services, material and serums.

34. Treatment for breast cancer. Some services may be considered preventive benefits and are covered at no Cost Share. Please refer to Preventive Care Exams

and Services in this General Benefits section for coverage of preventive benefits to screen for or diagnose breast cancer.

35. Fertility Services, except in vitro fertilization. Fertility Services are 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. Please refer to your Schedule of Coverage to determine if these services have been selected by your employer as part of the plan benefit.

36. 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.

37. 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, or other craniofacial conditions, such as Apert, Pfeiffer and Crouzon Syndromes, and hemifacial microsomia. Reconstructive breast surgery following a mastectomy including reconstruction of the healthy breast to produce a symmetrical appearance; prostheses; and treatment of complications 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.

38. 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:

a) under seven years of age; or

b) developmentally disabled; or

c) 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.

39. Dental services for radiation treatment. Coverage is limited to dental evaluation, x-rays, fluoride treatment, and extractions necessary to prepare Your jaw for radiation therapy of cancer in Your head or neck.

40. 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 is limited to the extent that the cost of such formulas or special food products exceed the cost of a normal diet.

41. 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. For benefits to be payable, the second medical opinion must be rendered by a Physician who agrees not to treat the Covered Person's diagnosed condition. The Physician offering the second medical opinion may not be affiliated with the Physician offering the original medical opinion.

42. Behavioral Health Treatment for Pervasive Developmental Disorder or Autism. (Note: If You are previously diagnosed with pervasive developmental disorder or autism, it is not required to receive a re-diagnosis to maintain coverage for 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) A Qualified Autism Service Provider.

b) A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.

c) A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.

43. Bariatric surgery and associated services that are Medically Necessary for the treatment of obesity in adults by modification of the gastrointestinal tract to reduce nutrient intake and absorption. Covered hospital inpatient care related to the bariatric surgical procedures includes room and board, x-ray, imaging, laboratory, and Physician Services. For Medically Necessary associated services related to a covered bariatric surgical procedure that You receive under this Plan, refer to the coverage information in this Certificate for the specific service. Under the Precertification process through the Medical Review Program, the proposed treatment will be evaluated using clinical guidelines on the identification, evaluation, and treatment of obesity in adults. Please refer to the **PRECERTIFICATION** section for information about Precertification through the Medical Review Program.

44. 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.

45. Special contact lenses for aniridia for adults age 19 and over. Coverage is limited to up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).

46. 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.

47. Acupuncture services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain).

48. Habilitative Services. the following services are covered:

    a) Physical therapy rendered by a certified physical therapist or other provider practicing within the scope of their license or registration.

    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.

49. Routine Eye Exams for Refraction for adults age 19 and over, including coverage for eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses.

50. Foreign travel immunizations.

51. 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.

52. 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.

53. Transgender Surgery and other Medically Necessary Treatment of Mental Health and Substance Use Disorders for the treatment of gender dysphoria, including, but not limited to gender affirming surgeries that include genital surgery (e.g., hysterectomy, oophorectomy and orchiectomy), breast/ chest surgery (e.g., mastectomy and breast augmentation) and aesthetic procedures to change secondary sex characteristics (e.g., tracheal shave and facial feminization surgery) and other services found to be Medically Necessary Treatment of Mental Health and Substance Use Disorders to create an appearance within the range of normal for the gender with which the

person identifies. Medically Necessary Treatment of Mental Health and Substance Use Disorders for the treatment of gender dysphoria also includes coverage for services such as fertility preservation, speech therapy and administered hormones, including puberty suppressing hormones. Gender dysphoria treatment is covered at the Mental Health Cost Share as shown in the Schedule of Coverage. Medically Necessary treatment of Mental Health and Substance Use Disorders are covered under the same terms and conditions applied to other medical conditions under this Plan. Please refer to the **PRECERTIFICATION** section for information about Precertification through the Medical Review Program. See also, "Mental Health Services for diagnosis and Medically Necessary Treatment of a Mental Disorder" in this **GENERAL BENEFITS** section.

54. Medically Necessary 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. Please refer to your Schedule of Coverage to determine if these services, including for the treatment of infertility and fertility services, have been selected by your employer as part of the plan benefit.
55. COVID-19 screening, testing, and immunizations. In compliance with state and federal law, coverage includes:
    - Medically Necessary screening and testing for COVID-19, including a visit to a medical office, emergency room, urgent care setting, hospital, or telehealth visit when the purpose of the visit is screening and/or testing for COVID-19, and associated lab testing and radiology services
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), regardless of whether the immunization is recommended for routine use.
56. Coverage for medically necessary biomarker testing, subject to utilization review management. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment decisions. Biomarker testing for screening purposes is not covered.

Pediatric Vision (children up to age 19)

The pediatric vision services described below are available to children up to age 19. This means that covered pediatric vision services are provided to a Covered Person until the last day of the month in which the Covered Person turns nineteen years of age. Unless otherwise stated, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or sickness will not apply to the following Covered Services. Please refer to Your Schedule of Coverage regarding each benefit in this section:

Exams

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

Eyewear The following eyewear is covered:

1. Lenses
    a. Single vision
    b. Conventional (Lined) Multifocal
    c. Lenticular
    d. Other optional lenses and treatments
        i. Ultraviolet Protective Coating
        ii. Polycarbonate Lenses
        iii. Gradient tinting
        iv. Blended Segment Lenses
        v. Intermediate Vision Lenses
        vi. Standard Progressives

vii. Premium Progressives

viii. Photochromic Glass Lenses

ix. Plastic Photosensitive Lenses (Transitions®)

x. Glass-grey #3 prescription sunglass lenses

xi. Polarized Lenses

xii. Standard Anti-Reflective (AR) Coating

xiii. Premium AR Coating

xiv. Ultra AR Coating

xv. Hi-Index Lenses

xvi. Oversized

Note: Lenses include choice of glass or plastic lenses. All lenses include scratch resistant coating.

2. Eyeglass frames, limited to standard frames (not including designer or deluxe frames). Please request standard, non-deluxe frames from Your optical retailer.
3. Contact lenses including evaluation, fitting, or follow-up care relating to contact lenses
4. Medically necessary contact lenses in lieu of other eyewear for the following conditions:
   a. Keratoconus,
   b. Pathological Myopia,
   c. Aphakia,
   d. Anisometropia,
   e. Aniseikonia,
   f. Aniridia,

g. Corneal Disorders,

h. Post-traumatic Disorders,

i. Irregular Astigmatism.

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

Other Vision Services

Low Vision services are services provided to children with a significant loss of vision but not total blindness. The goal of services is to maximize the remaining usable vision for children with low vision who have visual impairments not fully treatable by medical, surgical interventions or conventional eyewear or contact lenses. Coverage is limited to the following:

1. Comprehensive low vision evaluation
2. Low vision aids such as high-power spectacles, magnifiers, and telescopes
3. Follow up care

The following visions services are not covered:

All pediatric vision services not listed above including but not limited to:

1. Laser Vision Correction
2. Orthoptics
3. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
4. Replacement of lenses, frames or contacts.

5. Contact lens modification, polishing and cleaning.

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

The following preventive services are not subject to Deductibles, Copayments or Coinsurance as required by section 2713 of the Public Health Service Act (42 U.S.C. 300gg-13) and the "A" or "B" recommendations of the United States Preventive Services Task Force (USPSTF), the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP), and the guidelines of the Health Resources and Services Administration (HRSA). These recommendations may change from time to time, 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 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. To the extent not specified in a recommendation or guideline, we may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage of a recommended preventive health service.

Please consult with Your physician to determine what preventive services are appropriate for You."

GENERAL BENEFITS

I. Exams

1) Well-Baby, Child, Adolescent Exam according to HRSA guidelines

2) Well woman exam visits, including routine prenatal care and post partum follow-up office visits, according to HRSA guidelines.

II. Screenings

1) Abdominal aortic aneurysm screening

2) Asymptomatic bacteriuria screening

3) Anxiety screening for adolescent and adult Covered Persons, including those who are pregnant or postpartum according to HRSA guidelines.

4) Breast cancer mammography screening according to HRSA guidelines.

5) Behavioral/Social/Emotional Screening for children newborn to 21 years

6) Cervical dysplasia screening including Human Papilloma Virus (HPV) screening and Pap test according to HRSA guidelines.

7) Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy. Colonoscopies after a positive non-invasive stool-based screening test or direct visualization screening test. 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.

8) Depression screening, including suicide risk as an element of universal depression screening for children ages 12-21.

9) Diabetes screening for non pregnant Covered Persons with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus according to HRSA guidelines.

10) Gestational and post partum diabetes screening according to HRSA guidelines.

11) Hepatitis B virus infection screening: for pregnant Covered Persons

12) Hematocrit or Hemoglobin screening in children

13) Hypertension (High blood pressure) screening

14) Lead Screening

15) Lipid disorders screening

16) Lung cancer screening with low-dose computed tomography including a counseling visit to discuss the screening

17) Newborn congenital hypothyroidism screening

18) Newborn hearing loss screening

19) Newborn metabolic/hemoglobin screening

20) Newborn sickle cell disease screening

21) Newborn Phenylketonuria screening

22) Obesity screening

23) Osteoporosis screening

24) Pre-eclampsia screening with blood pressure measurements throughout pregnancy.

25) Rh (D) incompatibility screening for pregnant Covered Persons

26) Sexually transmitted infection screening such as chlamydia, gonorrhea , syphilis and HIV screening

27) Type 2 diabetes mellitus screening

28) Sudden cardiac arrest and sudden cardiac death risk assessment in children ages 12-21

29) Tuberculin (TB)Testing

30) Urinary incontinence screening according to HRSA guidelines.

31) Visual impairment in children screening

III. Health Promotion:

1) Screening by asking questions about unhealthy drug use in adults age 18 years or older. Screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred.

2) Alcohol and drug misuse assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse

3) Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease.

4) Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children

5) Counseling for midlife Covered Persons with normal or overweight body mass index to maintain weight or limit weight gain to prevent obesity, according to HRSA guidelines.

6) Offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.

7) Tobacco use screening and tobacco-caused disease counseling and interventions. All FDA-approved tobacco cessation prescription or over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs for non-pregnant Covered Persons. Coverage of FDA-approved tobacco cessation prescription or over-the-counter medications for pregnant Covered Persons is described below under the "Other Preventive Care" subsection of this General Benefits section.

8) Referral for testing for breast and ovarian cancer susceptibility, genetic counseling and BRCA mutation testing

9) Sexually transmitted infections counseling

10) Discuss use of risk-reducing medications, such as tamoxifen, raloxifene, or aromatase inhibitors, with Covered Persons who are at increased risk for breast cancer and at low risk for adverse medication effects.

11) When prescribed by a licensed health care professional authorized to prescribe drugs:

a) aspirin in the prevention of preeclampsia in pregnant Covered Persons, according to the USPSTF.

b) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.

c) topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children

d) folic acid supplementation for Covered Persons according to HRSA guidelines..

e) vitamin D to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.

12) Interventions to promote breastfeeding according to HRSA guidelines. The following additional services are covered: breastfeeding support and counseling by a provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the post partum period; breast milk storage supplies; any equipment and supplies as clinically indicated to support Covered Persons and babies with breast feeding difficulties; and the purchase of a breast pump. In lieu of purchase of a breast pump, rental of a hospital-grade electric breast pump (including a hospital-grade double breast pump kit), 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.

13) All prescribed FDA-approved contraceptive methods, including but not limited to drugs, cervical caps, vaginal rings, continuous extended oral

contraceptives, patches, condoms and the lactation amenorrhea method according to HRSA guidelines and applicable California law. This includes all FDA-approved cleared or granted contraceptive products that are determined by an individual's medical Provider to be medically appropriate. Also included are: contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, sterilization procedures, follow-up and management of side effects, counseling for continued adherence, and device removal, and patient education and counseling. Items and services that are integral to the furnishing of a recommended preventive service such as a pregnancy test needed before provision of certain contraceptives is included in contraceptive coverage.

14) Screening, counseling and other interventions such as education, harm reduction strategies and referral to appropriate supportive services for interpersonal and domestic violence, according to HRSA guidelines.

15) Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls.

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

17) Counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer

IV. Disease prevention:

1) Immunizations as recommended by ACIP. 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 Covered Persons who are at high risk of HIV acquisition. In addition, the following related services for HIV PrEP initiation and follow-up care are covered:

   a. Services for initiation of HIV Prep, including:

      i. HIV testing

      ii. Kidney function testing

      iii. Serologic testing for hepatitis B and C virus

      iv. Hepatitis B vaccination

      v. Testing for Sexually Transmitted Infections (STIs)

      vi. Pregnancy testing (when appropriate)

   b. Follow-up and monitoring services, including:

      i. HIV testing every 3 months,

      ii. Office visits to a primary care provider or specialist for prescribing and medication management,

      iii. Lab testing to monitor effects of medication

Please refer to Your Schedule of Coverage regarding each benefit in this section. The recommendations and guidelines may change from time to time. For a complete list of current preventive services required under the 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

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 tests are not Covered Services under the Preventive Exams and Services (described in this section) but may be Covered Services as Outpatient Care and may be subject to Cost Shares, as applicable.

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:

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

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 and hearing exams limited to services to determine the need for a hearing correction

5. Routine Preventive Vision Screenings for adults age 19 and over and routine eye exams for refractions

6. Routine Preventive Retinal Photography Screenings. for adults age 19 and over.

7. 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) The charge of a Physician for consultation for removal of implanted contraceptive devices;

   c) Charges for the following procedures:

      i) vasectomy; and

      ii) fertility testing and counseling.

See also "Abortion services" in this **GENERAL BENEFITS** section.

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.

d) Consultations for insertion of internally implanted time-release contraceptives or intrauterine devices (IUDs);

e) Consultations for monitoring and management of contraceptive devices;

f) Reversal of voluntary sterilization

Please refer to Health Promotion under Preventive Care Exams and Services in this General Benefits section for coverage of contraceptive methods.

8. 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

9. Prenatal alpha-fetoprotein screening, including services though participation in the California Prenatal Screening Program.

10. Health education counseling programs and programs for stress management and chronic conditions such as asthma.

11. FDA approved tobacco cessation prescription or over-the-counter medications by a licensed health care professional authorized to prescribe drugs for pregnant Covered Persons.

12. Iron deficiency anemia screening for pregnant Covered Persons

13. Iron supplementation for children from 6 months to 12 months of age .

14. Venipuncture for ACA preventive lab screenings. If a venipuncture is for the purpose of drawing blood for both ACA preventive and Non-ACA preventive labs, a cost share may apply.

15. Behavioral counseling interventions to promote a healthy diet and physical activity for cardiovascular disease (CVD) prevention in adults with CVD risk factors and type 2 diabetes mellitus.

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

17. The following services and items are treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:

    a. Hemoglobin A1C testing for individuals diagnosed with diabetes.

    b. Retinopathy Screening for individuals diagnosed with diabetes.

    c. Low Density Lipo-Protein testing for individuals diagnosed with heart disease.

    d. International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders.

    e. DME items:

        i. Peak flow meters for individuals diagnosed with asthma.

        ii. Glucometers including lancets, test strips, control solution and batteries for individuals diagnosed with diabetes.

18. Prostate Cancer Screening

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 in accordance with applicable state and federal laws.

When Emergency Care Services are obtained from a Non-Participating Provider, the Covered Charges will apply toward satisfaction of the Deductible at the Participating Provider tier, and to the Out-of-Pocket Maximum at both the Participating Provider and Non-Participating Provider tiers. Please refer to the, "No Surprise Billing Protections" provision in the **ACCESS TO HEALTH CARE** section of this Certificate for further information.

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.

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.

Pediatric Dental (children up to age 19)

Coverage for Pediatric Dental services is limited only to children up to age 19. This means that covered Pediatric Dental services are provided to a Covered Person until the last day of the month in which the Covered Person turns nineteen years of age. Several categories of benefits are covered, when the services are provided by a licensed Provider and when they are necessary and customary under the Generally Accepted Standards of Dental Practice. Precertification is not required in order to obtain covered pediatric dental benefits.

Covered Dental Services

Unless otherwise indicated in Your Schedule of Coverage, KPIC will pay the percentage payable of the Maximum Allowable Charge for the following Covered Dental Services:

When a Covered Person is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under the Contract include one (1) additional oral exam and either one (1) additional routine cleaning; one (1) additional periodontal scaling and root planing per quadrant; or one (1) additional periodontal maintenance procedure. Written confirmation of the pregnancy must be provided by the Covered Person or her Provider when the claim is submitted.

Teledentistry.

A Benefit appropriately provided through teledentistry is covered on the same basis and to the same extent that the Benefit is covered when delivered through in-person diagnosis, consultation or treatment. Cost sharing for Benefits delivered through teledentistry will not exceed the cost sharing that applies to the same Benefit when delivered in-person.

Schedule of Covered Services

The codes and nomenclature in this schedule are copyright of the American Dental Association. This table represents codes and nomenclature excerpted from the version of Current Dental Terminology (CDT)© in effect at the date of this printing. Our administration of benefits, limitations and exclusions under this plan at all times will be based on the current version of CDT whether or not a revised table is provided.

Code Procedure

DIAGNOSTIC AND PREVENTIVE

DIAGNOSTIC: Diagnostic services are the necessary procedures to assist the Provider in evaluating Your dental health and to determine necessary treatments, including x-rays and oral exams. Diagnostic services include:

Clinical oral examinations	
D0120	Periodic oral examination - established patient: once every 6 months per provider
D0140	Limited oral examination - problem focused: once per patient per provider
D0145	Oral examination for a patient under three years of age and counseling with primary caregiver
D0150	Comprehensive oral examination - new or established patient: once per patient per provider
D0160	Detailed and extensive oral examination - problem focused, by report: once per patient per provider
D0170	Re-examination - limited, problem focused (established patient; not post-operative visit) : 6 in 3 months, not to exceed 12 in 12 months
D0171	Re-evaluation - post-operative office visit
D0180	Comprehensive periodontal examination - new or established patient
Radiographs/diagnostic imaging (including interpretation)	
D0210	Intraoral - comprehensive series of radiographic images: once (D0210 OR D0230 per provider every 36 months

D0220	Intraoral - periapical first radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
D0230	Intraoral - periapical each additional radiographic image: maximum of 20 images (D0220, D0230) in 12 months per provider
D0240	Intraoral - occlusal radiographic image: maximum of 2 in 6 months per provider
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector: once per date of service
D0251	Extra-oral posterior dental radiographic image: 4 per date of service
D0270	Bitewing - single radiographic image: once per date of service
D0272	Bitewings - two radiographic images: once every 6 months per provider
D0273	Bitewings - three radiographic images
D0274	Bitewings - four radiographic images: once every 6 months per provider, age under 10
D0277	Vertical bitewings - 7 to 8 radiographic images: maximum of 4
D0310	Sialography
D0320	Temporomandibular joint arthrogram, including injection: maximum of 3 per date of service
D0322	Tomographic survey: twice in 12 months per provider
D0330	Panoramic radiographic image: once (D0210 OR D0230) in 36 months per provider

D0340	2D cephalometric radiographic image – acquisition, measurement and analysis: twice in 12 months per provider
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally: maximum of 4 per date of service
D0396	3D printing of a 3D dental surface scan
D0460	Pulp vitality tests
D0470	Diagnostic casts: once per provider
Oral pathology laboratory	
D0502	Other oral pathology procedures, by report
D0601	Caries risk assessment and documentation, with a finding of low risk: one procedure (D0601, D0602, D0603) every 12 months per provider
D0602	Caries risk assessment and documentation, with a finding of moderate risk: one procedure (D0601, D0602, D0603) every 12 months per provider
D0603	Caries risk assessment and documentation, with a finding of high risk: one procedure (D0601, D0602, D0603) every 12 months
D0701	Panoramic radiographic image – image capture only
D0702	2-D cephalometric radiographic image – image capture only
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally –image capture only
D0705	Extra-oral posterior dental radiographic image – image capture only

D0706	Intraoral – occlusal radiographic image – image capture only
D0707	Intraoral – periapical radiographic image – image capture only
D0708	Intraoral – bitewing radiographic image – image capture only
D0709	Intraoral – comprehensive series of radiographic images – image capture only
D0801	3D intraoral surface scan- direct: once per date of service
D0802	3D dental surface scan- indirect: once per date of service
D0803	3D facial surface scan- direct: once per date of service
D0804	3D facial surface scan- indirect: once per date of service
D0999	Unspecified diagnostic procedure, by report

PREVENTIVE

Preventive services are the necessary procedures and techniques to prevent the occurrence of dental abnormalities or diseases. Preventive cleaning, including scaling in presence of generalized moderate or severe gingival inflammation – full mouth (periodontal maintenance is considered to be a Basic Benefit for payment purposes), topical application of fluoride solutions, space maintainers. Preventive services include:

Dental prophylaxis	
D1110	Prophylaxis- adult: once every 6 months
D1120	Prophylaxis- child: once every 6 months
Topical fluoride treatment	

Pediatric Dental Benefits

D1206	Topical application of fluoride varnish: once every 6 months and frequency limitation applies towards D1208
D1208	Topical application of fluoride – excluding varnish: once every 6 months and frequency limitation applies towards D1206
Other preventive services	
D1310	Nutritional counseling for control of dental disease
D1320	Tobacco counseling for the control and prevention of oral disease
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use
D1330	Oral hygiene instructions
D1351	Sealant- per tooth once per permanent molar every 36 months per provider if they are without caries (decay) or restorations on the occlusal surface.
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth: once per tooth every 36 months per provider
D1353	Sealant repair- per tooth
D1354	Application of caries arresting medicament- per tooth: once every 6 months
D1355	Caries preventive medicament application – per tooth
D9310	Consultation- diagnostic service provided by dentist or physician other than requesting dentist or physician
D9311	Consultation with a medical health care professional

D9995	Teledentistry - synchronous; real-time encounter
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review
D9997	Dental case management - patients with special health care needs
Space maintenance (passive appliances)	
D1510	Space maintainer - fixed – unilateral-per quadrant: once per quadrant per patient through age 17
D1516	Space maintainer - fixed – bilateral, maxillary: once per arch per patient through age 17
D1517	Space maintainer - fixed – bilateral, mandibular: once per arch per patient through age 17
D1520	Space maintainer - removable – unilateral-per quadrant: once per quadrant per patient through age 17
D1526	Space maintainer - removable – bilateral, maxillary: once per arch per patient through age 17
D1527	Space maintainer - removable – bilateral, mandibular: once per arch per patient through age 17
D1551	Re-cement or re-bond bilateral space maintainer – maxillary: once per provider per quadrant or arch through age 17
D1552	Re-cement or re-bond bilateral space maintainer - mandibular: once per provider per quadrant or arch through age 17
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant: once per provider per quadrant or arch through age 17

D1556	Removal of fixed unilateral space maintainer- per quadrant
D1557	Removal of fixed bilateral space maintainer- maxillary
D1558	Removal of fixed bilateral space maintainer- mandibular
D1575	Distal shoe space maintainer – fixed, unilateral- per quadrant: once per quadrant per lifetime; under age 9

BASIC SERVICES

RESTORATIVE

Restorative services provide the necessary procedures to restore the teeth; other than cast restorations. Restorative services include:

Amalgam restorations (including Polishing)	
D2140	Amalgam- one surface, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2150	Amalgam- two surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2160	Amalgam- three surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2161	Amalgam- four or more surfaces, primary or permanent: once in 12 months for primary teeth, once in 36 months for permanent teeth
Resin – based composite restorations- direct	

D2330	Resin-based composite - one surface, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2331	Resin-based composite - two surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2332	Resin-based composite - three surfaces, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2335	Resin-based composite - four or more surfaces (anterior): once in 12 months for primary teeth, once in 36 months for permanent teeth
D2390	Resin-based composite crown, anterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2391	Resin-based composite - one surface, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2392	Resin-based composite - two surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2393	Resin-based composite - three surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2394	Resin-based composite - four or more surfaces, posterior: once in 12 months for primary teeth, once in 36 months for permanent teeth

CROWNS, INLAYS, ONLAYS

Crowns, Inlays, Onlays and are provided to treat cavities that cannot be restored with amalgam, silicate or direct composite (resin) restorations. Crowns, Inlays, Onlays Services include:

Other restorative services	
D2710	Crown - resin-based composite (indirect): once in 5 years, age 13+
D2712	Crown - 3/4 resin-based composite (indirect): once in 5 years, age 13+
D2721	Crown - resin with predominantly base metal: once in 5 years, age 13+
D2740	Crown - porcelain/ceramic : once in 5 years, age 13+
D2751	Crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
D2781	Crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
D2783	Crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
D2791	Crown - full cast predominantly base metal: once in 5 years, age 13+
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration: once in 12 months per provider
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core: performed in conjunction with recementation of existing or new crown and is not separately payable
D2920	Re-cement or re-bond crown: once in 12 months per provider

D2921	Reattachment of tooth fragment, incisal edge or cusp: once in 12 months.
D2928	Prefabricated porcelain/ceramic crown – permanent tooth: once in 36 months
D2929	Prefabricated porcelain/ceramic crown – primary tooth: once in 12 months
D2930	Prefabricated stainless steel crown - primary tooth: once in 12 months
D2931	Prefabricated stainless steel crown - permanent tooth: once in 36 months
D2932	Prefabricated resin crown: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2933	Prefabricated stainless steel crown with resin window: once in 12 months for primary teeth, once in 36 months for permanent teeth
D2949	Restorative foundation for an indirect restoration
D2950	Core buildup, including any pins when required
D2951	Pin retention - per tooth, in addition to restoration: once per tooth for permanent teeth
D2952	Post and core in addition to crown, indirectly fabricated: once per tooth
D2953	Each additional indirectly fabricated post - same tooth
D2954	Prefabricated post and core in addition to crown: once per tooth
D2955	Post removal
D2957	Each additional prefabricated post - same tooth

D2971	Additional procedures to customize crown to fit under an existing partial denture framework
D2976	Band stabilization – per tooth
D2980	Crown repair necessitated by restorative material failure
D2989	Excavation of a tooth resulting in the determination of non-restorability
D2991	Application of hydroxyapatite regeneration medicament – per tooth
D2999	Unspecified restorative procedure, by report

OTHER BASIC SERVICES

Unclassified treatment	
D9110	Palliative treatment of dental pain – per visit : once per date of service per provider regardless of the number of teeth and/or areas treated
D9120	Fixed partial denture sectioning
Anesthesia	
D9210	Local anesthesia not in conjunction with operative or surgical procedures: once per date of service per provider
D9211	Regional block anesthesia
D9212	Trigeminal division block anesthesia
D9215	Local anesthesia in conjunction with operative or surgical procedures
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia
D9222	Deep sedation/general anesthesia – first 15 minutes

D9223	Deep sedation/general anesthesia – each subsequent 15 minute increment
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia
D9239	Intravenous moderate (conscious) sedation/analgesia – first 15 minutes
D9243	Intravenous moderate conscious sedation/analgesia – each subsequent 15 minute increment
D9248	Non-intravenous conscious sedation: once per date of service
Professional consultation	
D9410	House/extended care facility call
D9420	Hospital or ambulatory surgical center call
Professional visits	
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed: once per date of service per provider
D9440	Office visit – after regularly scheduled hours: once per date of service per provider
Drugs	
D9610	Therapeutic parenteral drug, single administration: maximum of 4 injections per date of service
D9612	Therapeutic parenteral drugs, two or more administrations, different medications
D9910	Application of desensitizing medicament: once in 12 months per provider for permanent teeth
Miscellaneous	

D9930	Treatment of complications (post-surgical) – unusual circumstances, by report: once per date of service per provider
D9951	Occlusal adjustment – limited: once in 12 months, age 13+
D9999	Unspecified adjunctive procedure, by report

MAJOR SERVICES

ENDODONTICS

Endodontic services provide the procedures for the treatment of tooth pulp. Endodontic services include:

Pulpotomy	
D3110	Pulp cap – direct (excluding final restoration)
D3120	Pulp cap – indirect (excluding final restoration)
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament
D3221	Pulpal debridement, primary and permanent teeth
D3222	Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration): once per primary tooth
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration): once per primary tooth
Endodontic therapy	

D3310	Endodontic therapy, anterior tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3346)
D3320	Endodontic therapy, premolar tooth (excluding final restoration): once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3347)
D3330	Endodontic therapy, molar tooth (excluding final restoration) : once per tooth for initial root canal treatment (root canal therapy retreatment processed as D3348)
D3331	Treatment of root canal obstruction; non-surgical access
D3333	Internal root repair of perforation defects
Endodontic retreatment	
D3346	Retreatment of previous root canal therapy – anterior
D3347	Retreatment of previous root canal therapy – premolar
D3348	Retreatment of previous root canal therapy – molar
Apexification/recalcification procedures	
D3351	Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.): once per permanent tooth
D3352	Apexification/recalcification – interim medication replacement: once per permanent tooth
Aplcoectomy/periradicular services	
D3410	Apicoectomy – anterior

D3421	Apicoectomy – premolar (first root)
D3425	Apicoectomy – molar (first root)
D3426	Apicoectomy (each additional root)
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site
D3430	Retrograde filling – per root
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery
Other endodontic services	
D3471	Surgical repair of root resorption - anterior
D3472	Surgical repair of root resorption – premolar
D3473	Surgical repair of root resorption – molar
D3910	Surgical procedure for isolation of tooth with rubber dam
D3999	Unspecified endodontic procedure, by report

PERIODONTICS

Periodontic services provide the procedures for the treatment of gums and bones that support the teeth. Periodontic services include:

Surgical Services	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+

D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4249	Clinical crown lengthening – hard tissue
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant: once per quadrant in 36 months, age 13+
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site
Non-surgical periodontal services	
D4341	Periodontal scaling and root planning – four or more teeth per quadrant: once per quadrant in 24 months, age 13+
D4342	Periodontal scaling and root planning – one to three teeth per quadrant
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation: once every 6 months
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth
Other periodontal services	

D4910	Periodontal maintenance: once in a calendar quarter and only in the 24 months following the last scaling and root planing, age 13+
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff): included in fee for completed service (D4210, D4211, D4260, D4261) if same provider. Once per patient to different provider.
D4999	Unspecified periodontal procedure, by report: age 13+

Note: on Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

Administration of this plan design must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

PROSTHODONTICS, REMOVABLE

Removable Prosthetic Benefits are provided to replace missing, natural teeth. Removable Prosthetic Benefits include:

Complete dentures	
D5110	Complete denture – maxillary: once in 5 years
D5120	Complete denture – mandibular: once in 5 years
D5130	Immediate denture – maxillary: once per patient
D5140	Immediate denture – mandibular: once per patient
Partial dentures	
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth): once in 5 years
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth): once in 5 years

D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5221	Immediate maxillary partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5222	Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests and teeth): once in 5 years
D5223	Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
D5224	Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth): once in 5 years
Adjustment to dentures	
D5410	Adjust complete denture – maxillary: per provider, once per date of service and twice in 12 months
D5411	Adjust complete denture – mandibular: per provider, once per date of service and twice in 12 months
D5421	Adjust partial denture – maxillary: per provider, once per date of service and twice in 12 months
D5422	Adjust partial denture – mandibular: per provider, once per date of service and twice in 12 months

Repairs to complete dentures	
D5511	Repair broken complete denture base, mandibular: per provider, once per arch per date of service and twice in 12 months
D5512	Repair broken complete denture base, maxillary: per provider, once per arch per date of service and twice in 12 months
D5520	Replace missing or broken teeth – complete denture (per tooth): per provider, 4 per arch per date of service and twice in 12 months
D5611	Repair resin denture base, mandibular: per provider, once per arch per date of service and twice in 12 months
D5612	Repair resin denture base, maxillary: per provider, once per arch per date of service and twice per arch in 12 months
D5621	Repair cast partial framework, mandibular: per provider, once per arch per date of service and twice per arch in 12 months
D5622	Repair cast partial framework, maxillary: per provider, once per arch per date of service and twice per arch in 12 months
D5630	Repair or replace broken clasp – per tooth: per provider, 3 per date of service and twice per arch in 12 months
D5640	Replace missing or broken teeth – partial denture per tooth: per provider, 4 per arch per date of service and twice per arch in 12 months
D5650	Add tooth to existing partial denture per tooth: per provider, 3 per date of service and once per tooth

D5660	Add clasp to existing partial denture – per tooth: per provider, 3 per date of service and twice per arch in 12 months
Denture reline procedures	
D5730	Reline complete maxillary denture (direct): once in 12 months
D5731	Reline complete mandibular denture (direct): once in 12 months
D5740	Reline maxillary partial denture (direct): once in 12 months
D5741	Reline mandibular partial denture (direct): once in 12 months
D5750	Reline complete maxillary denture (indirect): once in 12 months
D5751	Reline complete mandibular denture (indirect): once in 12 months
D5760	Reline maxillary partial denture (indirect): once in 12 months
D5761	Reline mandibular partial denture (indirect): once in 12 months
Other removable prosthetic services	
D5850	Tissue conditioning, maxillary: twice per prosthesis in 36 months
D5851	Tissue conditioning, mandibular: twice per prosthesis in 36 months
D5862	Precision attachment, by report: included in fee for prosthetic and restorative procedure and not separately payable

D5863	Overdenture – complete maxillary
D5864	Overdenture – partial maxillary: once in 5 years
D5865	Overdenture – complete mandibular
D5866	Overdenture- partial mandibular: once in 5 years
D5899	Unspecified removable prosthodontic procedure, by report
Maxillofacial Prosthetics	
D5911	Facial moulage (sectional)
D5912	Facial moulage (complete)
D5913	Nasal prosthesis
D5914	Auricular prosthesis
D5915	Orbital prosthesis
D5916	Ocular prosthesis
D5919	Facial prosthesis
D5922	Nasal septal prosthesis
D5923	Ocular prosthesis, interim
D5924	Cranial prosthesis
D5925	Facial augmentation implant prosthesis
D5926	Nasal prosthesis, replacement
D5927	Auricular prosthesis, replacement
D5928	Orbital prosthesis, replacement
D5929	Facial prosthesis, replacement
D5931	Obturator prosthesis, surgical
D5932	Obturator prosthesis, definitive

D5933	Obturator prosthesis, modification: twice in 12 months
D5934	Mandibular resection prosthesis with guide flange
D5935	Mandibular resection prosthesis without guide flange
D5936	Obturator prosthesis, interim
D5937	Trismus appliance (not for TMD treatment)
D5951	Feeding aid
D5952	Speech aid prosthesis, pediatric
D5953	Speech aid prosthesis, adult
D5954	Palatal augmentation prosthesis
D5955	Palatal lift prosthesis, definitive
D5958	Palatal lift prosthesis, interim
D5959	Palatal lift prosthesis, modification: twice in 12 months
D5960	Speech aid prosthesis, modification: twice in 12 months
D5982	Surgical stent
D5983	Radiation carrier
D5984	Radiation shield
D5985	Radiation cone locator
D5986	Fluoride gel carrier
D5987	Commissure splint
D5988	Surgical splint
D5991	Vesiculobullous disease medicament carrier
D5999	Unspecified maxillofacial prosthesis, by report

PROSTHODONTICS, FIXED

Fixed Prosthetic Benefits are provided to replace missing, natural teeth. Fixed Prosthetic Benefits include:

Implant services	
D6010	Surgical placement of implant body: endosteal implant
D6011	Surgical access to an implant body (second stage implant surgery)
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant
D6013	Surgical placement of mini implant
D6040	Surgical placement: eposteal implant
D6050	Surgical placement: transosteal implant
D6055	Connecting bar – implant supported or abutment supported
D6056	Prefabricated abutment – includes modification and placement
D6057	Custom fabricated abutment – includes placement
D6058	Abutment supported porcelain/ceramic crown
D6059	Abutment supported porcelain fused to metal crown (high noble metal)
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)
D6061	Abutment supported porcelain fused to metal crown (noble metal)
D6062	Abutment supported cast metal crown (high noble metal)

D6063	Abutment supported cast metal crown (predominantly base metal)
D6064	Abutment supported cast metal crown (noble metal)
D6065	Implant supported porcelain/ceramic crown
D6066	Implant supported crown- porcelain fused to high noble alloys
D6067	Implant supported crown- high noble alloys
D6068	Abutment supported retainer for porcelain/ceramic FPD
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)
D6072	Abutment supported retainer for cast metal FPD (high noble metal)
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)
D6074	Abutment supported retainer for cast metal FPD (noble metal)
D6075	Implant supported retainer for ceramic FPD
D6076	Implant supported retainer FPD- porcelain fused to high noble alloys
D6077	Implant supported retainer for metal FPD- high noble alloys

D6080	Implant maintenance procedures when a full arch fixed hybrid prosthesis removed and reinserted, including cleansing of prosthesis and abutments
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure
D6082	Implant supported crown- porcelain fused to predominantly base alloys
D6083	Implant supported crown- porcelain fused to noble alloys
D6084	Implant supported crown- porcelain fused to titanium and titanium alloys
D6085	Interim implant crown: included in fee for implant services and not separately payable
D6086	Implant supported crown- predominantly base alloys
D6087	Implant supported crown- noble alloys
D6088	Implant supported crown- titanium and titanium alloys
D6089	Accessing and retorquing loose implant screw- per screw
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site
D6090	Repair of implant/abutment supported prosthesis
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported

	prosthesis, per attachment
D6092	Re-cement or re-bond implant/abutment supported crown: once in 12 months per provider
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture: once in 12 months per provider
D6094	Abutment supported crown – (titanium)
D6096	Remove broken implant retaining screw
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys
D6098	Implant supported retainer - porcelain fused to predominantly base alloys
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys
D6100	Surgical removal of implant body
D6105	Removal of implant body not requiring bone removal or flap elevation
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular
D6114	Implant /abutment supported fixed denture for edentulous arch – maxillary

D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular
D6118	Implant/abutment supported interim fixed denture for edentulous arch- mandibular
D6119	Implant/abutment supported interim fixed denture for edentulous arch- maxillary
D6120	Implant supported retainer – porcelain fused to titanium and titanium alloys
D6121	Implant supported retainer for metal FPD – predominantly base alloys
D6122	Implant supported retainer for metal FPD – noble alloys
D6123	Implant supported retainer for metal FPD – titanium and titanium alloys
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments
D6190	Radiographic/surgical implant index, by report
D6191	Semi-precision abutment – placement
D6192	Semi-precision attachment – placement
D6194	Abutment supported retainer crown for FPD- titanium and titanium alloys
D6195	Abutment supported retainer- porcelain fused to titanium and titanium alloys

D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant: 1 in 24 months
D6198	Remove interim implant component
D6199	Unspecified implant procedure, by report
Fixed partial pontics	
D6211	Pontic - cast predominantly base metal: once in 5 years, age 13+
D6241	Pontic - porcelain fused to predominantly base metal: once in 5 years, age 13+
D6245	Pontic - porcelain/ceramic: once in 5 years, age 13+
D6251	Pontic - resin with predominantly base metal: once in 5 years, age 13+
Fixed partial denture retainers - crowns	
D6721	Retainer crown - resin with predominantly base metal: once in 5 years, age 13+
D6740	Retainer crown - porcelain/ceramic: once in 5 years, age 13+
D6751	Retainer crown - porcelain fused to predominantly base metal: once in 5 years, age 13+
D6781	Retainer crown - 3/4 cast predominantly base metal: once in 5 years, age 13+
D6783	Retainer crown - 3/4 porcelain/ceramic: once in 5 years, age 13+
D6784	Retainer crown ¾ - titanium and titanium alloys: once in 5 years, age 13+
D6791	Retainer crown - full cast predominantly base metal: once in 5 years, age 13+

Other fixed partial denture services	
D6930	Re-cement or re-bond fixed partial denture: once in 12 months per same provider
D6980	Fixed partial denture repair necessitated by restorative material failure: once in 12 months of initial placement or previous repair by same provider
D6999	Unspecified fixed prosthodontic procedure, by report: once in 12 months of initial placement by same provider

ORAL AND MAXILLOFACIAL SURGERY

Extractions (including local anesthesia, suturing, if needed, and routine postoperative care)	
D7111	Extraction, coronal remnants- primary tooth
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Surgical extractions (including local anesthesia, suturing, if needed, and routine postoperative care)	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth – completely bony
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)

D7252	Partial extraction for immediate implant placement
D7259	Nerve dissection
Other surgical procedures	
D7260	Oroantral fistula closure
D7261	Primary closure of a sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth: once per arch regardless of the number of teeth involved for permanent anterior teeth
D7280	Exposure of an unerupted tooth
D7283	Placement of device to facilitate eruption of impacted tooth
D7284	Excisional biopsy of minor salivary glands
D7285	Incisional biopsy of oral tissue-hard (bone, tooth): once per arch per date of service
D7284	Excisional biopsy of minor salivary glands
D7286	Incisional biopsy of oral tissue-soft: maximum of 3 per date of service
D7290	Surgical repositioning of teeth: once per arch for permanent teeth for patients in active orthodontic treatment
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report: once per arch
Alveoloplasty – surgical preparation of ridge for dentures	
D7310	Alveoloplasty in conjunction with extractions- four or more teeth or tooth spaces, per quadrant

D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
Vestibuloplasty	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization): once per arch in 5 years
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue): once per arch
Surgical excision of lesions	
D7410	Excision of benign lesion up to 1.25 cm
D7411	Excision of benign lesion greater than 1.25 cm
D7412	Excision of benign lesion, complicated
D7413	Excision of malignant lesion up to 1.25 cm
D7414	Excision of malignant lesion greater than 1.25 cm
D7415	Excision of malignant lesion, complicated
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm

D7460	Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461	Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7465	Destruction of lesion(s) by physical or chemical method, by report
Excision of bone tissue	
D7471	Removal of lateral exostosis (maxilla or mandible)
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7485	Surgical reduction of osseous tuberosity
D7490	Radical resection of maxilla or mandible
D7509	Marsupialization of odontogenic cyst
Surgical incision	
D7510	Incision and drainage of abscess- intraoral soft tissue: once per quadrant per same date of service
D7511	Incision and drainage of abscess- intraoral soft tissue - complicated (includes drainage of multiple fascial spaces): once per quadrant per same date of service
D7520	Incision and drainage of abscess- extraoral soft tissue
D7521	Incision and drainage of abscess- extraoral soft tissue- complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue: once per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system: once per date of service

D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone: once per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
Treatment of fracture- simple	
D7610	Maxilla- open reduction (teeth immobilized, if present)
D7620	Maxilla- closed reduction (teeth immobilized, if present)
D7630	Mandible- open reduction (teeth immobilized, if present)
D7640	Mandible- closed reduction (teeth immobilized, if present)
D7650	Malar and/or zygomatic arch- open reduction
D7660	Malar and/or zygomatic arch- closed reduction
D7670	Alveolus closed reduction may include stabilization of teeth
D7671	Alveolus, open reduction may include stabilization of teeth
D7680	Facial bones- complicated reduction with fixation and multiple surgical approaches
Treatment of fracture – compound	
D7710	Maxilla open reduction
D7720	Maxilla – closed reduction
D7730	Mandible – open reduction
D7740	Mandible – closed reduction
D7750	Malar and/or zygomatic arch – open reduction

D7760	Malar and/or zygomatic arch – closed reduction
D7770	Alveolus – open reduction stabilization of teeth
D7771	Alveolus, closed reduction stabilization of teeth
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches
Reduction of dislocation and management of other temporomandibular joint dysfunctions	
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7865	Arthroplasty
D7870	Arthrocentesis
D7871	Non-arthroscopic lysis and lavage
D7872	Arthroscopy - diagnosis, with or without biopsy
D7873	Arthroscopy : lavage and lysis of adhesions
D7874	Arthroscopy : disc repositioning and stabilization
D7875	Arthroscopy : synovectomy

D7876	Arthroscopy : discectomy
D7877	Arthroscopy : debridement
D7880	Occlusal orthotic device, by report
D7881	Occlusal orthotic device adjustment: once per date of service per provider, two in 12 months per provider
D7899	Unspecified TMD therapy, by report
Repair of traumatic wounds	
D7910	Suture of recent small wounds up to 5 cm
Complicated suturing	
D7911	Complicated suture - up to 5 cm
D7912	Complicated suture - greater than 5 cm
Other repair procedures	
D7920	Skin graft (identify defect covered, location and type of graft)
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation
D7940	Osteoplasty - for orthognathic deformities
D7941	Osteotomy - mandibular rami
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944	Osteotomy - segmented or subapical
D7945	Osteotomy - body of mandible
D7946	Lefort I (maxilla - total)
D7947	Lefort I (maxilla - segmented)
D7948	Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft

D7949	Lefort II or lefort III - with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952	Sinus augmentation via a vertical approach
D7955	Repair of maxillofacial soft and/or hard tissue defect
D7961	Buccal / labial frenectomy (frenulectomy)
D7962	Lingual frenectomy (frenulectomy)
D7963	Frenuloplasty
D7970	Excision of hyperplastic tissue - per arch
D7971	Excision of pericoronal gingiva
D7972	Surgical reduction of fibrous tuberosity
D7979	Non-surgical sialolithotomy
D7980	Surgical sialolithotomy
D7981	Excision of salivary gland, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7991	Coronoidectomy
D7995	Synthetic graft - mandible or facial bones, by report
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999	Unspecified oral surgery procedure, by report

D9950	Occlusion analysis- mounted case: once in 12 months, age 13+
D9952	Occlusal adjustment- complete: once in 12 months, age 13+

ORTHODONTICS

Orthodontic treatment is a benefit of this dental plan only when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

D8080	Comprehensive orthodontic treatment of the adolescent dentition: once per patient per phase of treatment
D8091	Comprehensive orthodontic treatment with orthognathic surgery
D8210	Removable appliance therapy
D8220	Fixed appliance therapy
D8660	Pre-orthodontic treatment examination to monitor growth and development
D8670	Periodic orthodontic treatment visit: once per calendar quarter
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)): once per arch for each authorized phase of orthodontic treatment
D8681	Removable orthodontic retainer adjustment. Included in fee for complete orthodontic service and not separately payable..
D8696	Repair of orthodontic appliance – maxillary: once per appliance

D8697	Repair of orthodontic appliance – mandibular: once per appliance
D8698	Re-cement or re-bond fixed retainer – maxillary: once per provider
D8699	Re-cement or re-bond fixed retainer – mandibular: once per provider
D8701	Repair of fixed retainer, includes reattachment – maxillary: Included in fee for complete orthodontic service and not separately payable.
D8702	Repair of fixed retainer, includes reattachment – mandibular: Included in fee for complete orthodontic service and not separately payable.
D8703	Replacement of lost or broken retainer – maxillary: once per arch
D8704	Replacement of lost or broken retainer – mandibular: once per arch
D8999	Unspecified orthodontic procedure, by report

Note: The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.

LIMITATIONS

- All Services

Services that are more expensive than the form of treatment customarily provided under Generally Accepted Dental Practice standards are called "Optional Services." Optional Services also include the use of specialized techniques instead of standard procedures.

If an Enrollee receives Optional Services, an alternate Benefit will be allowed, which means KPIC will base Benefits on the lower cost of the customary service or standard procedure instead of on the higher cost of the Optional Service. The Enrollee will be responsible for the difference between the higher cost of the Optional Service and the lower cost of the customary service or standard procedure.

If the Provider discounts, waives, or rebates any portion of Your co-insurance amount, KPIC only provides as benefits the applicable allowances reduced by the amount that such fees, or allowances are discounted, waived or rebated.

Claims shall be processed in accordance with Our standard processing policies. The processing policies may be revised from time to time; therefore, We shall use the processing policies that are in effect at the time the claim is processed. We may use dentists (Dental Consultants) to review treatment plans, diagnostic materials and/or prescribed treatments to determine Generally Accepted Dental Practice Standards and to determine if treatment has a favorable prognosis.

If a primary dental procedure includes component procedures that are performed at the same time as the primary procedure, the component procedures are considered to be part of the primary procedure for purposes of determining the benefit payable under this Contract. If the Provider bills separately for the primary procedure and each of its component parts, the total benefit payable for all related charges will be limited to the maximum benefit payable for the primary procedure.

- Diagnostic and Preventive Services:
    1. Roentgenology (x-rays) is limited as follows:
        a. We will limit the total reimbursable amount to the Providers Contracted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Providers Contracted Fee for a complete intraoral series.
        b. When a panoramic film is submitted with supplemental film(s), We will limit the total reimbursable amount to the Providers Contracted Fee for a complete intraoral series.
        c. If a panoramic film is taken in conjunction with an intraoral complete series, We consider the panoramic film to be included in the complete series.
        d. Complete intraoral and panoramic film x-rays are limited to once every thirty six (36) consecutive months per provider. Additional panoramic films may be

allowed when documented as essential for a follow up/post-operative exam (such as oral surgery).

e. Bitewing x-rays of two or more radiographic images, are limited to once every six (6) months per provider. Bitewing x-rays of four radiographic images are limited to Covered Persons under the age of 10. Bitewings x-rays of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.

f. Image capture procedures are not separately allowable services. Cephalometric image and tomographic surveys are covered twice (2) in any 12 month period. Diagnostic casts are covered once per provider and only for the evaluation of Orthodontic Services when coveredand are provided once per provider unless special circumstances arre documented (such as trauma or pathology which as affected the course of orthodontic treatment). see Orthodontic Limitations as age limits may apply. However, 3D images are not a covered benefit.

g. The fee for pulp vitality tests is included in the fees for diagnostic, restorative, endodontic and emergency procedures and is not payable separately.

2. Prophylaxis services (cleanings) are limited to limited to not more than twice in a Calendar Year.

3. Sealants are limited as follows:
   a. Once per tooth per provider every 36 months and only to permanent molars if they are without caries (decay) or restorations on the occlusal surface.
   b. Repair or replacement of a sealant on any tooth within 24 months of its application is included in the fee for the original placement by the original provider.

Intraoral - periapical radiographic images are limited to a maximum of 20 in any 12 month period.

4. Intraoral - occlusal radiographic images are limited to two (2) in any six (6) month period.

5. Topical application of fluoride solutions is limited to twice in a 6 month period.

6. KPIC will cover oral examinations (except after hours exams and exams for observation) no more than once every six (6) months per provider and routine cleanings, including scaling in presence of generalized moderate or severe gingival inflammation (including periodontal maintenance or any combination thereof) no more than once every six (6) months.

7. Limited comprehensive oral examinations are covered once per patient per provider. Re-evaluation – limited, problem focused exams (established patient; not post-operative visits) are covered up to six (6) times in a three (3) month period and up to a maximum of 12 in a 12 month period. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation.

8. Space maintainer limitations:
    a. Except for distal shoe space maintainers, space maintainers are limited to the initial appliance for a Covered Person under age 18 and covered once per quadrant in a lifetime, except bilateral fixed space maintainers which are covered once per arch.
    b. Distal shoe space maintainer - fixed - unilateral is limited to children 8 and younger and is limited to once per quadrant per lifetime. A separate/additional space maintainer can be allowed after the removal of a unilateral distal shoe.
    c. Recementation of space maintainer is limited to once per lifetime per applicable arch or quadrant.
    d. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider's office.

- **Basic Services:**

Restorative Services are limited as follows:

a. Treatment of caries for a tooth that can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations. Any other restoration such as a crown or jacket is considered an Optional Service.

b. Composite resin or acrylic restorations in posterior teeth are Optional Services.

c. Replacement of a restoration is covered only when it is defective (as evidenced by conditions such as recurrent caries or fracture) and replacement is dentally necessary.

- **Major Services:**

Oral Surgery benefit is limited as follows:

a. The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
b. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth are covered once per arch regardless of number of teeth involved for permanent, anterior teeth only.

c. Surgical repositioning of teeth and transseptal fiberotomy/supra crestal fiberotomy, by report procedures are covered once per arch for permanent teeth for patients in active orthodontic treatment.
d. Vestibuloplasty Limitations
    i. Ridge extension (secondary epithelialization) is covered once per arch in a (5) five year period.
    ii. Ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) is covered once per arch in a lifetime.
e. Removal of lateral exostosis (maxilla or mandible) and of torus mandibularis, as well as the surgical reduction of osseous tuberosity, are limited to once per quadrant per lifetime.
f. Removal of torus palatinus is limited to once per lifetime.
g. Incision and drainage of abscess – intraoral soft tissue is limited to one (1) per quadrant on the same date of service.
h. Partial ostectomy/sequestrectomy for removal of non-vital bone is limited to one (1) per quadrant on the same date of service.

Endodontics – Root canal therapy, including culture canal, is limited as follows:

a. Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
b. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
c. We will not cover replacement of an amalgam, prefabricated crown or resin-based composite restorations (fillings) within 12 months of treatment for primary teeth or 36 months of treatment for permanent teeth. Replacement restorations performed within 12 months for primary teeth and within 24 months for permanent teeth are included in the fee for the original restoration.
d. Protective restorations (sedative fillings) are allowed once per tooth per provider in a six (6) month period when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.
e. Therapeutic pulpotomy is limited to once per tooth per lifetime for baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.
f. Pulpal therapy (resorbable filling) for anterior primary teeth and pulpal debridement for primary and permanent teeth are limited to once per tooth per lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 12 months is considered part of the original procedure.
g. Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime

limit per tooth with the fee for the final visit included in the fee for the final root canal.

h. Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.
i. Pin retention is covered once per tooth per lifetime for permanent teeth. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.
j. Palliative treatment is allowed once per date of service per provider regardless of the number of teeth and/or areas treated, and the fee for palliative treatment provided in conjunction with any procedures other than images or select Diagnostic procedures is considered included in the fee for the definitive treatment.

.Periodontics benefit is limited as follows:

a. Benefits for periodontal scaling and root planning in the same quadrant are limited to once in every 24-month period for a Covered Person age 13 and older.
b. Periodontal surgery in the same quadrant is limited to once in every 36-month period for a Covered Person age 13 and older and includes any surgical re-entry or scaling and root planing.
c. Periodontal services, including covered graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periradicular surgery, ridge augmentation or implants.
d. Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.
e. Periodontal maintenance is limited to Enrollees age 13 and older once in a calendar quarter and only in the 24 months following the last scaling and root planing. A full mouth debridement is included in in the fee for other periodontal procedures and is not payable separately
f. Full mouth debridement is not allowed when performed by the same dentist/dental office on the same day as evaluation procedures.
g. Caries risk assessments are allowed once in 36 months.
h. Interim caries arresting medicament applications are covered once per tooth every six (6) months when Enrollee has a caries risk assessment and documentation with a finding of high risk.

When implant procedures are a covered benefit, scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure is covered as a basic benefit and are limited to once in a 24-month period.

Note: Procedure codes that include periodontal maintenance, and full mouth debridement are covered as a Basic Benefit, and routine cleanings including scaling in

the presence of generalized of moderate or severe gingival inflammation are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

Crowns benefit is limited as follows:

a. Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional. Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown.
b. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
c. Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.
d. Crowns, excluding prefabricated crowns, are limited to a Covered Personage 13 and older and are covered not more often than once in a five (5) year period except when We determine the existing Crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.
e. Post and core services are covered once per tooth in a lifetime on permanent teeth.
f. Crown repairs are not a benefit within12 months of initial crown placement of previous repair for the same provider.
g. When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.
h. Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within 12 months of the initial placement. After 12 months, payment will be limited to one (1) recementation in a 12 month period by the same Provider/Provider office.

Fixed Bridge benefit is limited as follows:

a. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an Optional Service.
b. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person thirteen (13) years of age or older and the patient's

oral health and general dental condition permits. For children under the age of thirteen (13), it is considered an Optional Service. If performed on an Enrollee under the age of thirteen (13), the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

c. Fixed bridges used to replace missing posterior teeth are considered an Optional Service when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
d. Fixed bridges are an Optional Service when provided in connection with a partial denture on the same arch. However, when a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.
e. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
f. The Plan allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction. Full mouth reconstruction is considered an Optional Service.

Removable Prosthetic benefit is limited as follows:

a. Partial dentures will not be replaced within thirty-six (36) consecutive months, unless:
    i. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
    ii. The denture is unsatisfactory and cannot be made satisfactory
b. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. Removable Denture Repairs are covered once per arch per date of service per provider and not more than twice per arch in any twelve (12) month period per provider. Adding teeth to an existing partial denture is covered once per tooth and is limited to a maximum of three (3) per date of service per provider. However, more elaborate or precision appliances, if chosen by the patient and the Provider, and are not necessary to satisfactorily restore an arch are considered Optional Services. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered Optional Services.
c. Fixed partial dentures (bridgework) are not generally covered but shall be considered for Precertification only when medical conditions or employment preclude the use of a removable partial denture. The Enrollee shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered. Approved fixed partial dentures are a benefit once in a 60 month period and only for a Covered Person age 13 and older.

Medical conditions, which preclude the use of a removable partial denture, include:

i. the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,
ii. the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,
iii. patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

d. Tissue conditioning is limited to two (2) per denture.
e. Implants are considered an Optional Service. However, Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Us for medical necessity for Precertification. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. The fee for accessing and retorquing a loose implant screws is included in the fee for the delivery of the implant supported prosthesis, when performed within 6 months of the placement of the prosthesis. Exceptional medical conditions include, but are not limited to:
    i. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.
    ii. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.
    iii. Skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
    iv. Traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.
f. Palatal lift prosthesis modification and speech aid prosthesis modification are limited to twice in a 12 month period.
g. Prosthodontics that were provided under any program will be replaced only after five (5) years have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Immediate dentures are a benefit once per patient per lifetime. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a program will be made if We determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature.
h. TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.

i. Occlusion analysis – mounted case, and occlusal adjustments, limited and complete, are limited to one (1) in 12 months for diagnosed TMJ dysfunction for permanent dentition and only for a Covered Person age 13 and older.
j. Application of desensitizing medicament is limited to once in a 12 month period for permanent teeth only.
k. We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments for the first six (6) months after placement and relines for the first 12 months after placement.
    i. Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment, adjustments are limited to twice in a 12 month period per provider and relining is limited to once in a 12 month period.
    ii. Tissue conditioning is limited to two (2) per prosthesis in a 36 month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline service.
l. Recementation of fixed partial dentures is not a benefit within 12 months of a previous re-cementation by the same provider.

Orthodontic Services is limited as follows:

a. We will pay or otherwise discharge the Cost Share shown in Our Schedule of Coverage for Essential Health Benefits when provided by a Provider and when necessary and customary under Generally Accepted Dental Practice Standards and for medically necessary Orthodontic Services. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Precertification is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. Benefits for medically necessary orthodontics will be provided in periodic payments based on continued enrollment.
b. Cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
c. Services are limited to medically necessary orthodontics when provided by a Provider.. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a Precertification is obtained.

d. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist.
e. The automatic qualifying conditions are:
    i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the Precertification request,
    ii. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the Precertification request,
    iii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
    iv. A crossbite of individual anterior teeth causing destruction of soft tissue,
    v. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
    vi. Severe traumatic deviation.

The following documentation must be submitted with the request for Precertification of services by the Provider:

a. The following documentation must be submitted with the request for Precertification of services by the Provider:
    i. ADA 2006 or newer Claim Form with service code(s) requested;
    ii. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
    iii. Cephalometric radiographic image or panoramic radiographic image;
    iv. HLD score sheet completed and signed by the Orthodontist; and
    v. Treatment plan.
b. The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.
c. Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
d. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for a Covered Person under the age of 19 and shall be prior authorized.

i. Orthodontics, including oral evaluations and all treatment, must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law. The dentist of record must perform an in-person clinical evaluation of the patient (or the telehealth equivalent where required under applicable law to be reimbursed as an alternative to an in-person clinical evaluation) to establish the need for orthodontics and have adequate diagnostic information, including appropriate radiographic imaging, to develop a proper treatment plan. All orthodontic services, including direct to consumer orthodontics, must be provided by a licensed dentist authorized to deliver care in Your state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.

e. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
f. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
g. Pre-orthodontic treatment visits are allowed once every three (3) months up to a maximum of six (6) per Enrollee.
h. Removable and fixed appliance therapy are allowed once per Enrollee age six (6) to 12.
i. When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, We will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist's charge for the specialized orthodontic appliance or procedure.
j. Repair of an orthodontic appliance inserted under this dental plan is covered once per appliance per lifetime. The replacement of an orthodontic appliance inserted under this dental plan is covered once per arch per lifetime.
k. Replacement of a lost or broken retainer is a benefit once per arch in a lifetime and only within 24 months following date of service of orthodontic retention.
l. The removal of fixed orthodontics appliances for reasons other than completion of treatment is not a covered benefit.
m. The fees for synchronous/asynchronous Teledentistry services are considered inclusive in overall patient management and are not separately payable services.

EXCLUSIONS

Pediatric Dental Benefits

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

1. Any service not specifically listed as a Covered Service under this Pediatric Dental Benefits section
2. Services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
3. Cosmetic surgery or procedures for purely cosmetic reasons.
4. Provisional and/or temporary restorations. Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
5. Treatment that increases the vertical dimension of an Occlusion, replaces tooth structure lost by Attrition or erosion or otherwise unless it is part of a treatment dentally necessary due to accident or injury.
    a. Occlusion means the way the teeth meet when the lower jaw (mandible) and upper jaw (maxilla) come together.
    b. Attrition means the wearing down of the surface of a tooth from chewing or grinding teeth.
6. Any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
7. Prescription drugs including topically applied medication for treatment of periodontal disease, pre-medication, analgesics, separate charges for local anesthetics, general anesthesia except as a Benefit in conjunction with a covered Oral Surgery procedure. Prescription drugs are medications provided after treatment (e.g. pain relief medication). Please refer to the **OUTPATIENT PRESCRIPTION DRUG BENEFITS** section of this Certificate for coverage of prescription drugs.
8. Experimental/investigational procedures.
9. Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia

and regional/or trigeminal bloc anesthesia are not separately payable procedures.

10. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
11. Laboratory processed crowns for a Covered Person under age 13.
12. Interim implants and endodontic endosseous implants.
13. Indirectly fabricated resin-based Inlays/Onlays.
14. Charges for hospitalization or any other surgical treatment facility, including hospital visits.
15. Treatment by a person who is not licensed as a Dentist or authorized to perform or deliver services in the state in which such services were delivered or performed.
16. Preventive plaque control programs, including oral hygiene instruction programs.
17. Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
18. Procedures that are determined not to be Medically Necessary based on the professional review of the submitted documentation by a Dental Consultant We designate.
19. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
20. Treatment or materials for which no charge is made, for which the Covered Person is not legally obligated to pay or for which no charge would be made in the absence of coverage under this Plan.
21. Services covered under the dental plan but exceed Benefit limitations.
22. Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a Precertification is obtained.

23. Missed and/or cancelled appointments.
24. Action taken to schedule and assure compliance with patient appointments are inclusive with office operations and are not a separately payable service.
25. The fees for care coordination are considered inclusive in overall patient management and are not a separately payable service.
26. Dental case management motivational interviewing and patient education to improve oral health literacy.
27. Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin, and cementum.
28. Corticotomy (specialized oral surgery procedures associated with orthodontics)
29. the fee for teledentistry services are considered inclusive in overall patient management and are not a separately payable service.
30. Antigen or antibody testing.
31. Services or supplies for sleep apnea

Your Choice of Dental Providers

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

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support Your right to freedom of choice regarding Your Provider. This assures that You have full access to the dental treatment You need from the dental office of Your choice. You may see any Provider for Your covered treatment, whether the Provider is a PPO, Premier or a Non-Delta Dental Provider. In addition, You and your family members can see different Providers.

Participating or Premier Provider

When You choose a PPO or Premier Provider, Your out-of-pocket costs may be less. To take full advantage of Your benefits, we highly recommend You verify a dentist's participation status within with Your dental office before each appointment. Review the section titled "Claims Provision" for an explanation of payment procedures to understand the method of payments applicable to Your dentist selection and how that may impact Your out-of-pocket costs.

Locating a Delta Dental PPO or Premier Provider

There are two ways in which you can locate a PPO or Premier Provider near You:

- You may access information through our web site at: www.deltadentalins.com. This web site includes a Provider search function allowing You to locate PPO Providers or Premier Providers by location, specialty and network type; or
- You may also call our Customer Service Center toll-free at 1-800-835-2244 and one of our representatives will assist You. We can provide you with information regarding a Provider's network, specialty and office location.

IMPORTANT: If You receive dental services that are **not** covered services under this policy, a participating provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call KPIC or its Administrator Delta Dental at 1-800-835-2244. To fully understand Your coverage, You may wish to carefully review this Certificate of Insurance.

Predetermination of Your Dental Benefits

After an examination, Your Provider will talk to You about treatment You may need. The cost of treatment is something You may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, we encourage You to ask Your Provider to request for a Pre-determination of Benefits.

A Predetermination of Benefits does not guarantee payment. It is an estimate of the amount KPIC will pay if You are eligible and meet all the requirements of the Group Policy at the time the treatment You have planned is completed.

In order to receive Pre-determination of Benefits, Your Provider must send a statement of proposed treatment to our Administrator, Delta Dental listing the proposed treatment. Delta Dental will send Your Provider a Notice of Predetermination of Benefits which estimates how much of the treatment costs KPIC will pay and how much You will have to pay. After You review the estimate with Your Provider and You decide to go ahead with the treatment plan, Your Provider returns the statement to the following address for payment after treatment has been completed.

Delta Dental of California

P.O. Box 997330

Sacramento, CA 95899-7330

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination of Benefit is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual maximum when completed services are submitted to KPIC or to Delta Dental.

Pre-determination of Benefits help prevent any misunderstanding about Your financial responsibilities.

Definitions:

The following definitions apply to the Pediatric Dental coverage:

Benefit means those Covered Dental Services which are made available to Covered Persons under the terms of this Group Policy and which are listed as part of the Group Policy.

Covered Dental Services means those dental services set forth in the Benefits and Limitations section of this Certificate.

Delta Dental Premier® Provider (Premier Provider) means a Participating Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to:

1. accept the Premier Provider's Contracted Fee as payment in full for services provided under this dental insurance plan; and
2. complies with Delta Dental's administrative guidelines.

Delta Dental PPO℠ Provider (PPO Provider) means a Participating Dentist who contracts with Delta Dental or any other member company of the Delta Dental Plans Association and agrees to:

1. accept the PPO Provider's Contracted Fee as payment in full for services provided under this dental insurance plan; and
2. complies with Delta Dental's administrative guidelines.

Maximum Allowable Charge means the lesser of:

1. **The Usual and Customary Charge (U&C)**:

   The usual and customary charge is the lesser of: (a) the charge generally made by a Dentist; or (b) the general level of charge made by Dentists within an area in which the charge is incurred comparable in severity and nature to the service

or treatment being performed. The general level of charges is determined by KPIC in accord with schedules on file with the authorized Administrator. For charges not listed in the schedules, KPIC will establish the U&C. KPIC reserves the right to periodically adjust the charges listed in the schedules.

The term "area" as it would apply to any particular service 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 U&C Charge, the Covered Person will be responsible for payment to the provider of any amounts in excess of the U&C Charge for a Covered Service when the U&C Charge is less than the actual billed charges for the Covered Service.

2. **Premier or PPO Provider's Contracted Fee**

Delta Dental Premier Provider's Contracted Fee (Premier Provider's Contracted Fee) means the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for treating a Covered Person.

Delta Dental PPO Provider's Contracted Fee (PPO Provider's Contracted Fee) means the fee for each Single Procedure that a PPO Provider has contractually agreed to accept as payment in full for treating a Covered Person.

3. **Actual Billed Charges:**

The actual charges billed by the Dentist for Covered Dental Services.

Non-Delta Dental Provider means a licensed Provider who:

1. does not have Filed Fees/Negotiated Fees on file with Delta Dental; or
2. does not accept the Premier Provider's Contracted Fee or the PPO Provider's Contracted Fee as payment in full for services provided under this dental insurance plan; or
3. does not comply with Delta Dental's administrative guidelines.

Participating Dentist means a licensed Delta Dental Premier® Provider (Premier Provider) or Delta Dental PPO℠ Provider (PPO Provider) who:

1. accepts the Premier Provider's Contracted Fee or the PPO Provider's Contracted Fee as payment in full for services provided under this dental insurance plan; or
2. complies with Delta Dental's administrative guidelines.

Provider means a person licensed to practice dentistry when and where services are performed. A Provider shall also include a dental partnership, dental professional corporation or dental clinic.

Single Procedure means a dental procedure to which a separate procedure number has been assigned by the American Dental Association in the current version of Common Dental Terminology (CDT).

Submitted Fee means the amount that the Provider bills and enters on a claim for a specific procedure.

IMPORTANT: If You receive dental services that are **not** covered services under this policy, a participating provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options You may call KPIC or its Administrator Delta

Pediatric Dental Benefits

OUTPATIENT PRESCRIPTION DRUG BENEFITS

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.

Precertification

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

The purpose of Precertification 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 Precertification, the medication needs to be reviewed by Us to determine Medical Necessity before the prescription is filled. Precertification edits address clinical appropriateness, including genomic testing, safety issues, dosing restrictions and ongoing treatment criteria.

If a drug requires Precertification, your licensed prescribing provider will need to work with Us to pre-approve the drug. Precertified 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 Precertification. The most current formulary can be obtained by visiting kp.org/kpic/ppo. If you have questions about Precertification 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. Send the request form that is available on-line at MedImpact kp.org/kpic. The Covered Person or the licensed prescribing provider can also obtain a copy of the request form by calling 1-800-788-2949. Precertification 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 Precertification request is disapproved:

   a. The notice of disapproval must contain an accurate and clear written explanation of the specific reasons for disapproving the request.

   b. 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.

6. The prescription drug Precertification request shall be deemed approved in the event that:

   a. 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

   b. We accept any prescription drug Precertification form other than the prescribed request form and We did not send timely disapproval.

7. 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.

8. Prescription drug Precertification 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 Precertification 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 Precertification 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.*

Exception Requests

You or Your designated assignee or the licensed prescribing provider may request an exception to the Outpatient Precertification 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 Precertification or step therapy, provided the drug is appropriately prescribed and is considered safe and effective for your condition.

However, further Precertification may be required for the continued coverage of a prescription drug prescribed pursuant to a Precertification 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 Precertification 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, MedImpactthe PBM 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, if such Experimental drugs that are 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;
5. 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.
6. Prescriptive medications for the treatment of diabetes;
7. Glucagon;
8. Episodic drugs prescribed for the treatment of sexual dysfunction disorders;
9. 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;
10. 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;
11. 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.
12. Weight loss drugs that are Medically Necessary and/or Precertified pursuant to the Medical Review Program.

13. 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.

14. All Medically Necessary outpatient prescription drugs pursuant to California Insurance Code section 10112.27 and California Code of Regulations Title 28 section 1300.67.24(a).

15. Orally administered anti-cancer medications used to kill or slow the growth of cancerous cells.

16. 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

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 good 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.

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. Charges for the administration of any drug when the drug does not require administration by medical personnel.
4. Contraceptive drugs and devices, except that contraceptive supplies prescribed for reasons other than contraceptive purposes are covered, such as a) decreasing the risk of ovarian cancer; b) eliminating symptoms of menopause; or c) when it is necessary to preserve the life or health of an insured.

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. Services or supplies other than Emergency Services received outside the United States.
3. Treatment, services, or supplies provided by any of the following:
   a) The Covered Person;
   b) The Covered Person's Spouse;
   c) The Covered Person's child, sibling or parent;
   d) The child, sibling or parent of the Covered Person's Spouse; or
   e) Any person who resides in the Covered Person's home.
4. 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; c) the removal of impacted wisdom teeth when imbedded in bone; d) Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; e) dental services necessary to prepare Your jaw for radiation therapy for cancer in Your head or neck; or dental care for children under the age of 19.
5. 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 transgender surgery services that are described under the General Benefits section.

6. Nonprescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician, except for: 1) formulas and special food products for treatment of Phenylketonuria (PKU); and, 2) Preventive Care; as described in the **GENERAL BENEFITS** section.

7. 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.

   Please refer to the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section of this Certificate for information about Independent Medical Review related to denied requests for experimental or investigational services.

8. Clinical Trial services that are provided solely to satisfy data collection and analysis needs and are not used in Your clinical management, and services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial.

9. Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems, except as otherwise provided for the treatment of Mental Health and Substance Use Disorders. This exclusion does not apply to covered Habilitative Services as described in the **GENERAL BENEFITS** section.

10. Weight loss programs (such as Weight Watchers and OPTIFAST), fitness programs and gym memberships rendered for the treatment of obesity or weight management.

11. Recreational therapy. This exclusion does not apply to Covered Services that are part of a Behavioral Health Therapy treatment plan and covered under "Mental Health Services" or to covered Habilitative Services as described in the **GENERAL BENEFITS** section.

12. Items and services that are not health care items and services, includingthose listed below. This exclusion does not apply to Covered Services that are part of a Behavioral Health Therapy treatment plan and covered under "Mental Health Services" or to covered Habilitative Services as described in the **GENERAL BENEFITS** section:

    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) Testing for aptitude, intelligence or interest, except this exclusion does not apply to psychological testing to evaluate a Mental Disorder

    i) 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

j) Teaching skills for employment or vocational purposes

k) Vocational training or teaching vocational skills

l) Professional growth courses

m) Training for a specific job or employment counseling

n) 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.

13. Non-surgical treatment of craniomandibular and temporomandibular joint disorders.

14. Personal comfort items such as telephone, radio, television, or grooming services.

15. 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 assistance with activities of daily living that is provided as part of covered home health care, hospice care, skilled nursing facility care, or inpatient hospital care.

16. 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. This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

17. Routine foot care such as trimming of corns and calluses

18. Services of a private duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility.

19. 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.

20. Living expenses or transportation, except as provided under Covered Services.

21. Reversal of sterilization.

22. Services provided in the home other than 1) Covered Services provided through a Home Health Agency; or 2). house calls when care can best be provided in Your home, as determined by the Physician

23. The following Home Health Care Services:

    a) meals,

    b) personal comfort items,

    c) housekeeping services.

24. 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 Covered Person (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 Covered Person 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.

25. Computed tomographic colonography screening (virtual colonoscopy) except when endoscopic colonoscopy screening cannot be safely performed, such as in anatomical blockage of the colon.

26. Biofeedback or hypnotherapy.

27. Hearing aids.

28. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye

29. Eyeglasses and contact lenses for adults age 19 or older, except for the following:

    a) Special contacts for aniridia as described under the **GENERAL BENEFITS** section;

    b) Eyewear following cataract surgery or eyewear to correct aphakia as described under the **GENERAL BENEFITS** section; and

30. Benefits provided under the Adult Vision Care Optional Benefit, if so elected by your Group. Please refer to the **SCHEDULE OF BENEFITS** to determine if Your Group elected the Adult Vision Care Optional Benefit Services for which no charge is normally made in the absence of insurance.

31. Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases unless clinically indicated.

32. 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. This exclusion does not apply to Medically Necessary services and Medically Necessary Treatments for Mental Health and Substance Use Disorder. This exclusion also does not apply to court-ordered treatment plans in accordance with applicable CA state law(s).

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.

Adult Vision Care. This benefit covers the cost of a refraction vision exam, prescription lenses, and prescription contact lenses. This benefit does not cover plain sunglasses, plastic lenses that are not medically indicated, contact lenses for cosmetic purposes, replacement of lost or broken frames or lenses, or athletic or industrial frames or lenses.

CALIFORNIA CONTINUATION OF MEDICAL BENEFIT (CAL-COBRA)

This section only applies to small employer groups with 2-19 eligible employees who are subject to California COBRA (Cal COBRA) and who are not offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as then constituted or later amended (COBRA).

Eligibility

A Covered Person may have a right to continue coverage 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 a Covered Person during a period of Cal-COBRA coverage is eligible for coverage as a Dependent provided proper written notice and election takes place.

Individuals Not Eligible for Cal-COBRA Continuation

Continuation of coverage under this provision is not available to and will not be provided for the following individuals:

1. Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as then constituted or later amended.
2. Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan. that provides coverage to individuals and that does not impose any exclusion or limitation with respect to any preexisting condition, other than a preexisting condition

limitation or exclusion that does not apply to or has been satisfied due to prior creditable coverage;

3. Individuals who are covered, become covered, or are eligible for federal COBRA coverage, except those individuals, who under applicable California law, are eligible for an extension of COBRA coverage.
4. Individuals who are covered, become covered, or are eligible for coverage pursuant to chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1;
5. Individuals who do not meet the notice requirements of this State Continuation of Coverage provision or fail to make the election in a timely manner;
6. Individuals who do not submit the correct premium amount for the continuation coverage as required by the Group Policy or who fail to satisfy other terms and conditions of the Group Policy.

Qualifying Events

Individuals will qualify for Cal-COBRA as follows:

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

B) If Your Dependent's insurance coverage ends due to: (1) Your death; (2) Your divorce or legal separation from Your spouse or Domestic Partner; or (3) Your Dependent reaching the limiting age for a Dependent.

(C) If You become entitled to Medicare benefits under Title XVIII of the Social Security Act, as then constituted or later amended, Your Medicare ineligible

spouse and Dependent eligible children may continue health coverage under the policy for the continuation of coverage period.

Termination of Cal-COBRA Continuation Coverage

Cal-COBRA coverage continues only upon timely payment of applicable monthly premiums to KPIC. Coverage will terminate on the earliest of:

1. the date the Covered Person requests coverage be terminated;
2. 36 months after the date the Covered Person's benefits under the Policy would have terminated because of the qualifying events set forth under (A) above ;
3. the end of the grace period. for which premium payments were made if the Covered Person ceases or fails to make timely premium. (The grace period is 30-days after the date that notice of nonreceipt of payment is sent to the Insured's address of record.);
4. 36 months after the date the Covered Person's benefits under the Policy would have terminated because of the qualifying events set forth under (B) and (C) above;
5. the date the individual is no longer eligible for continuation coverage as set forth under the **Individuals Not Eligible for Cal-COBRA Continuation** provision above;
6. the date the employer or any successor employer or purchaser of the employer, ceases to provide any group benefit plan to his or her employees;
7. the date the Covered Person moves out of KPIC's service area;
8. the date the Covered Person, or their representative, commits fraud or deception in using or obtaining the benefits provided under the Group Policy.

If a Covered Person's continuation coverage under the Group Policy is going to terminate earlier than specified by the Group Policy, the employer must notify the person of their right to obtain continuation coverage under the employer's new group coverage for the remainder of the continuation period. The employer must

provide this notice to persons insured under the continuation of coverage provision on the later of:

1. 30 days prior to the termination of the Group Policy; or
2. at the same time all Insured Employees are notified of the termination of the Group Policy.

The employer must also notify the succeeding carrier, in writing, of all individuals who are receiving continuation coverage so that necessary continuation election information can be forwarded to those individuals.

Extension For Disabled Covered Persons

A Covered Person may be eligible for an extension of Cal-COBRA continuation if all the following apply:

1. the Covered Person is:
   a. a former employee who has Cal-COBRA continuation because of the occurrence of event (A) listed under the Qualifying Events section of this provision; or
   b. a Dependent of the former employee and elected continuation coverage because of event (A) listed under the Qualifying Events section of this provision; and
2. Social Security determines under Title II or Title XVI of the Social Security Act that the Covered Person is disabled within the first 60 days of coverage under the Cal-COBRA continuation.

For those Covered Persons, the 18-month maximum period of continued health coverage for qualifying event (A) may be extended 11 months for a total

continuation period of 29 months. To obtain the extension, the Covered Person must notify the employer or KPIC of Social Security's determination within 60 days of the date of the determination letter and prior to the end of the original 18-month continuation of coverage period.

If Social Security subsequently determines that the Covered Person is no longer disabled, coverage will terminate on the later of:

1. the end of the original 18-month continuation of coverage period; or
2. the first day of the month that begins more than 31 days after Social Security determines the Covered Person is no longer disabled.

The Covered Person must notify the employer or KPIC that he or she is no longer disabled within 30 days of the date of Social Security determination.

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.

Notice Requirements and Requests for Continuation Coverage

Notice of Event

You or Your Dependent must notify KPIC of the following qualifying events:

1. the death of the Covered Person;
2. Your legal divorce or legal separation from Your spouse or Domestic Partner;
3. Your child reaching the limiting age for a Dependent or otherwise becoming ineligible for coverage under the Policy;
4. Your becoming entitled to Medicare benefits under Title XVIII of the United States Social Security Act (Medicare).

The notice must be given to KPIC within 60 days after the date the event occurs. If You or Your Dependent fails to give KPIC notice within the 60-day period, You and Your Dependent ill not qualify for continuation of coverage under this Cal-COBRA provision. You or Your Dependent must also still send KPIC a written request for continuation of coverage within the time limits set forth below in the Request for Continuation of Coverage section.

Notice Required of Employer

The employer must notify KPIC of the following events within 30 days of the date of the event:

1. The termination of the employee;
2. A reduction in hours of employment of the Insured Employee's employment;
3. The employer becoming subject to the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, as then constituted or later amended.

If the employer fails to provide KPIC with the required notice, KPIC will not be obligated to provide Cal-COBRA coverage to the affected employees or their dependents.

Notice to You and Your Dependent of Right of Continuation

Within 14 days of receiving a notice of a qualifying event, KPIC will provide You or Your Dependent the necessary premium information, enrollment forms and disclosures needed to allow You or Your Dependent to formally make the election of continuation coverage.

Request for Continuation of Coverage and Payment of Premium

Continuation of coverage under the Group Policy must be requested in writing and be delivered to KPIC by first-class mail or other reliable means of delivery, including personal delivery, express mail or private courier, within the 60-day period following the later of:

A. The date the Covered Person's coverage under the Group Policy terminated or will terminate by reason of a qualifying event; or

B. The date the Covered Person was sent notice of the right to continuation of coverage.

Payment of the first premium must be received by KPIC within 45 days of the date the Covered Person provided the written request to continue coverage under the Group Policy. The premium must be sent by first class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier. The first premium payment must equal an amount sufficient to pay all required premiums and all premiums due. If You or Your Dependent fails to submit the required premium amount within the 45-day period, the You and Your Dependent will not be eligible for continuation coverage under Cal-COBRA.

Premiums will be due monthly and will not exceed 110 percent of the applicable rate charged for a Covered Person, or if the continuation is for a covered Dependent, not more than the 110 percent of the rate charged for a similarly situated Insured Dependent under the Policy. However, If the Covered Person is determined to be disabled under Title II or Title XVI of the United States Social Security Act, premiums may be increased to up to 150 percent of the group rate after the first 18 months of continuation 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.

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 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).

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 benefits under Medi-Cal or California Crippled Children Services program or any other coverage provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.
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.

CLAIMS AND APPEALS PROCEDURES

This section explains provisions for filing Claims and Appeals arising from decisions made regarding benefit Claims under Your Group Policy.

This section contains the following:

- Definitions of Terms unique to this section
- General Claims and Appeals Provisions
- Internal Claims and Appeals Procedures
    - The Claims Process
    - The Internal Appeals Process
    - Providing Additional Information Regarding Your Claim
    - Pre-service Claims and Appeals
        - Pre-service Claim
        - Non-urgent pre-service Appeal
        - Urgent pre-service Appeal
    - Concurrent Care Claims and Appeals
        - Concurrent-care Claim
        - Non-urgent concurrent care Appeal
        - Urgent concurrent care Appeal
    - Post-Service Claims and Appeals
        - Post-service Claim
        - Post-service Appeal
    - Appeals of retroactive coverage termination (rescission)
        - Help With Your Appeal
- External Review

A. Definitions Related to Claims and Appeals Procedures

NOTE: For purposes of this **CLAIMS AND APPEALS PROCEDURES** section, the term "Medically Necessary" refers to both "Medically Necessary" and "Medically Necessary Treatment of Mental Health and Substance Use Disorders" as these terms are defined under the **GENERAL DEFINITIONS** section.

The following terms have the following meanings when used in this **CLAIMS AND APPEALS PROCEDURES** section:

Claim means a request for us to:

1. provide or pay for a Covered Service that You have not received (pre-service claim);
2. continue to provide or 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).

Appeal means a request for us to review our initial Adverse Benefit Determination.

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),
3. deny Your (or, if applicable, Your dependent's) application for individual plan coverage, or

4. uphold our previous Adverse Benefit Determination when You Appeal.

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

Except when simultaneous external review can occur, You must exhaust the internal claims and appeals procedure (as described below in this **CLAIMS AND APPEALS PROCEDURES** section) for Your Claim before You can request external review or seek judicial relief.

B. General Claims and Appeals Provisions

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

Claims related to your medical coverage under this Policy will be administered by:

For Southern California:
KFHP Claims Department
P.O. Box 7004
Downey, CA 90242-7004
Member Services
1-800-788-0710

For Northern California
KFHP Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
Member Services
1-800-788-0710

CLAIMS AND APPEALS PROCEDURES

Claims related to Your dental benefits under this Policy will be administered by:

Delta Dental of California

P.O. Box 997330

Sacramento, CA 95899-7330

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.

Notice of Claim You must give us written notice of claim within 20 days after the occurrence or commencement of any loss covered by this 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 Medical Record Number shown in Your Schedule of Coverage. The notice should be mailed to our Administrator at:

For Southern California:
KFHP Claims Department
P.O. Box 7004

Downey, CA 90242-7004
Member Services
1-800-788-0710

For Northern California
KFHP Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
Member Services
1-800-788-0710

For claims related to Your dental benefits under this Policy:

Delta Dental of California

P.O. Box 997330

Sacramento, CA 95899-7330

Claim Forms

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

Proof of Loss

You must give us written Proof of Loss, in the case of a claim for loss for which this Policy provides any periodic payment contingent upon continuing loss, within 90 days after the termination of the period for which we are liable. For any other loss, You must furnish written proof within 90 days after the date of such loss. If it is not reasonably possible to give us this timely proof, we will not reduce or deny Your claim if proof is filed with us as soon as reasonably possible. In any event, proof must be furnished

within 12 months from the time proof is otherwise required, unless legal capacity is absent.

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

Time for Payment of 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.

Pease refer to the **Internal Claims and Appeals Procedures** subsection under this section for specific provisions for filing an appeal for each type of Claim (Pre-service; Concurrent, and Post Service) in cases of any Adverse Benefit Determination.

Right of Recovery for Overpayment

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

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

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

benefits. In the 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.

For Southern California:
KFHP Claims Department
P.O. Box 7004
Downey, CA 90242-7004
Member Services
1-800-788-0710

For Northern California
KFHP Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
Member Services
1-800-788-0710

For claims related to Your dental benefits under this Policy:

Delta Dental of California

P.O. Box 997330

Sacramento, CA 95899-7330

Time Limitations

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

Legal Action

No legal action may be brought to recover on this Policy before 60 days from the date written Proof of Loss has been given to us as required under the Proof of Loss section.

No such action may be brought more than 3 years after the date written proof of loss is given to us. KPIC will review Claims and Appeals, and we may use medical experts to help us review them.

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 the number on Your ID card or 1-800-788-0710 (TTY 711).

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 the number on Your ID card or 1-800-788-0710 (TTY 711)

Appointing 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 include Your representative's name, address and telephone contact information with Your Appeal or You can call 1-800-788-0710 (TTY 711) to request an Authorized Representative Form. 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

P.O. BOX 1809

Pleasanton, CA 94566

1-800-788-0710

Help with Your Claim and/or Appeal

You may also contact the:

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

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. If You have questions about the codes contained in the Explanation of Benefits and how the claims were paid with respect to those codes, You may call 1-800-788-0710 (TTY 711).

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.

c. Internal Claims and Appeals Procedures

The Claims Process

There are several types of Claims, and each has a different procedure for sending Your Claim to us as described below in this Internal Claims and Appeals Procedures subsection:

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

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

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. The internal Appeals process is described below. Additionally, 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 review request within 180 days of Your receiving Our 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.

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 (KPIC)
KPIC Appeals
P.O. BOX 1809
Pleasanton, CA 94566
Phone: 1-800-788-0710
Fax: 1-855-414-2318

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

Kaiser Permanente Insurance Company (KPIC)
KPIC Appeals
P.O. BOX 1809
Pleasanton, CA 94566
Phone: 1-800-788-0710
Fax: 1-855-414-2318

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.

Pre-service Claims and Appeals. Pre-service Claims are requests that we provide or pay for a Service that You have not yet received. Failure to receive authorization before receiving a service that must be authorized or precertified in order to be a covered benefit may be the basis of reduction of Your benefits or for 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 1-888-251-7052.

Following are the procedures for filing a pre-service Claim, a non-urgent pre-service Appeal, and an urgent pre-service Appeal.

- **Pre-service Claim**
  - Send Your request in writing to us that You want to make a Claim for us to provide or pay for a Covered Service You have not yet received. Your request and any related documents You give us constitute Your Claim. You must either mail Your Claim to us or, fax Your Claim to Us at:

    Permanente Advantage Appeals Department
    8954 Rio San Diego Drive, Office 10R10
    San Diego, CA 92108
    Phone: 1-888-251-7052
    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 5 days

after we receive Your Claim. We may extend the time for making a decision for an additional 5 days if circumstances beyond our control delay our decision, if we notify You prior to the expiration of the initial 5 day period. If we tell You we need more information, we will ask You for the information within the initial 5 day decision period, and we will give You 45 days to send the information. We will make a decision within 5 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 5 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 provide or pay for all the Covered Services You requested), our Adverse Benefit Determination notice will tell You why we denied Your Claim and how You can Appeal.

- **Non-urgent pre-service Appeal**
  - Within 180 days after You receive our Adverse Benefit Determination notice, You must tell us in writing that You want to Appeal our denial of Your pre-service Claim. Please include the following: (1) Your name and Medical Record Number, (2) Your medical condition or relevant symptoms, (3) the specific

Service that You are requesting, (4) all of the reasons why You disagree with our adverse benefit denial, and (5) all supporting documents. Your request and the supporting documents constitute Your Appeal. You must either mail Your Appeal to:

Permanente Advantage Appeals Department
8954 Rio San Diego Drive, Office 10R10
San Diego, CA 92108
Phone: 1-888-251-7052
Fax: 1-866-338-0266

- Or, Fax Your Claim to : KPIC Attn: KPIC Operations Grievance and Appeals Coordinator at **(1-866-338-0266)**.
- We will review Your Appeal and send You a written decision within 5 days after we receive Your Appeal.
- 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.

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

Permanente Advantage Appeals Department
8954 Rio San Diego Drive, Office 10R10
San Diego, CA 92108
Phone: 1-888-251-7052
Fax: 1-866-338-0266

To file an oral appeal, call: 1-888-251-7052

- When You send Your Appeal, You may also request simultaneous external review of our initial 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 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 **"External Review**" provision under in this **CLAIMS AND APPEALS PROCEDURES** 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 give You oral or written notice of our decision 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, 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.

Concurrent Care Claims and Appeals. Concurrent care Claims are requests that KPIC continue to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If You have any general questions about concurrent care Claims or Appeals, please call 1-888-251-7052.

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.

Here are the procedures for filing a concurrent care Claim, a non-urgent concurrent care Appeal, and an urgent concurrent care Appeal:

- **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 mail Your Claim to us at:

Permanente Advantage Appeals Department
8954 Rio San Diego Drive, Office 10R10
San Diego, CA 92108
Phone: 1-888-251-7052
Fax: 1-866-338-0266

  - If You want us to consider Your Claim on an urgent basis and Your 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 5 days after we receive Your Claim. We may extend the time for making a decision for an additional 5 days if circumstances beyond our control delay our decision, if we send You notice before the initial 5 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 5 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 5 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), our Adverse Benefit Determination notice will tell You why we denied Your Claim and how You can Appeal.

- **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 mail Your Appeal to:

Permanente Advantage Appeals Department
8954 Rio San Diego Drive, Office 10R10
San Diego, CA 92108
Phone: 1-888-251-7052
Fax: 1-866-338-0266

  - We will review Your Appeal and send You a written decision as soon as possible if You care has not ended but not later than 30 days after we receive Your Appeal.

  - If we deny Your Appeal, our Adverse Benefit Determination decision will tell You why we denied Your Appeal and will include information about any further process, including external review, that may be available to You.

- **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 can submit your request for expedited review of your appeal by calling 1-888-251-7052 or faxing the request to 1-866-338-0266. You can also submit your written request for an expedited internal appeal to:

Permanente Advantage Appeals Department
8954 Rio San Diego Drive, Office 10R10
San Diego, CA 92108
Phone: 1-888-251-7052
Fax: 1-866-338-0266

To file an oral appeal, call: 1-888-525-1553

- When You send Your Appeal, You may also request simultaneous external review of our Adverse Benefit Determination. If You want simultaneous external review, Your Appeal must tell us this. You will be eligible for the simultaneous external review only if Your concurrent care 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 **External Review** provision under this **CLAIMS AND APPEALS PROCEDURES** section).

- 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 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, our Adverse Benefit Determination notice will tell You why we denied Your Appeal and will include information about any further process, including external review, that may be available to You.

Post-Service Claims and Appeals. Post-service Claims are requests that we for pay for services You already received. If You have any general questions about post-service Claims or Appeals, please call 1800-788-0710 (TTY 711).

Here are the procedures for filing a post-service Claim and a post-service Appeal:

- **Post-service Claim**
  - In accordance with the provisions of the **Notice of Claim** subsection of this **CLAIMS AND APPEALS PROCEDURES** section of this Certificate, Within 20 days after the date You received or paid for the 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:

For Southern California:
KFHP Claims Department
P.O. Box 7004
Downey, CA 90242-7004
Member Services
1-800-788-0710

For Northern California
KFHP Claims Department
P.O. Box 12923

Oakland, CA 94604-2923
Member Services
1-800-788-0710

For claims related to Your dental benefits under this Policy:

Delta Dental of California

P.O. Box 997330

Sacramento, CA 95899-7330

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

- If we deny Your Claim (if we do not pay for all the Services You requested), our Adverse Benefit Determination notice will tell You why we denied Your Claim and how You can Appeal.

- **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. You must either mail Your Appeal to:

Kaiser Permanente Member Relations Appeals
PO Box 1809
Pleasanton, CA 94566
Phone: 1-800-788-0710
Fax: 1-888-987-2252

- We will review Your Appeal and send You a written decision within 30 days after we receive Your Appeal.
- If we deny Your Appeal, our Adverse Benefit Determination 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.

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

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, CA 94612

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 either mail Your Appeal to:

Kaiser Permanente Insurance Company
One Kaiser Plaza
Oakland, CA 94612

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

- 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.

- **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

D. 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 the **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 below should be able to help You understand any further review rights available to You:

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

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 Department of Insurance should be contacted only after discussions with KPIC, or its agent or other representative:

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

1-800-788-0710 (TTY 711)

The Covered Person may also write to KPIC at:

For Southern California:
KFHP Claims Department
P.O. Box 7004
Downey, CA 90242-7004
Member Services
1-800-788-0710

For Northern California
KFHP Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
Member Services
1-800-788-0710

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

CLAIMS DISPUTE IMPORTANT NOTICE

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 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 **1-800-788-0710 (TTY 711)** 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:

YOUR RIGHT TO AN INDEPENDENT REVIEW

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 Medically Necessary Treatment of Mental Health and Substance Use Disorders; 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.

YOUR RIGHT TO AN INDEPENDENT REVIEW

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.

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.

Kaiser Permanente Insurance Company

One Kaiser Plaza

Oakland, California 94612

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 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 Covered Person 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 Covered Person 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.

YOUR RIGHT TO AN INDEPENDENT REVIEW

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:

For Southern California:
KFHP Claims Department
P.O. Box 7004
Downey, CA 90242-7004
Member Services
1-800-788-0710

For Northern California
KFHP Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
Member Services
1-800-788-0710

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.

Continuity of Care Under Federal Law

A Continuing Care Patient (as defined below) receiving care from a Participating Provider may elect to continue to receive transitional care from such provider if the provider's participating provider contract is Terminated or non-renewed for reasons other than for failure to meet applicable quality standards or for fraud; or if this Group Policy Terminates resulting in a loss of benefits with respect to such provider or facility. KPIC will notify each Covered Person who is a Continuing Care Patient at the time of termination or non-renewal on a timely basis of such termination and the Covered Person's right to elect transitional care.

When elected, benefits will be provided under the same terms and conditions as would have applied with respect to items and services that would have been covered had such termination not occurred, with respect to the course of treatment provided by such provider or facility relating to the Covered Person's status as a Continuing Care Patient.

Benefits will be provided during the period beginning on the date KPIC provides the Notice to the Continuing Care Patient of the termination and ending on the earlier of: (i) 90 days after the provision of the Notice; or (ii) the date on which such enrollee is no longer a continuing care patient with respect to such provider or facility.

The Covered Person will not be liable for an amount that exceeds the Cost Share that would have applied to the Covered Person had the termination not occurred.

Likewise, Cost Share for such services obtained from a Terminated provider or facility will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider tier. The Deductible, if any, for such services will likewise apply towards satisfaction of the Deductible at the Participating Provider tier.

For purposes of this subsection the following definitions apply:

Continuing Care Patient means an individual who, with respect to a provider or facility—

a. is undergoing a course of treatment for a Serious and Complex Condition from a Terminated provider or facility; or

b. is undergoing a course of institutional or inpatient care from the Terminated provider or facility; or

c. is scheduled to undergo nonelective surgery from the Terminated provider or facility, including receipt of postoperative care from such provider or facility with respect to such surgery; or

d. is pregnant and undergoing a course of treatment for the pregnancy from the Terminated provider or facility; or

e. is or was determined to be terminally ill (medical prognosis that the individual's life expectancy is 6 months or less)

Serious and Complex Condition means, with respect to a participant or beneficiary under a group health plan:

a. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

b. in the case of a chronic illness or condition, a condition that:

    1. is life-threatening, degenerative, potentially disabling, or congenital; and

    2. requires specialized medical care over a prolonged period of time.

Notice means the required communication sent to a Covered Person of the termination of a Terminated provider or facility and likewise informing the Covered Person's right to elect continuity of care.

Terminated/Terminates means with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

Completion of Covered Services by Terminated Provider Under State Law

YOUR RIGHT TO AN INDEPENDENT REVIEW

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. Maternal Mental Health Condition;
5. Terminal illness;
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 Covered Services that are Medically Necessary or Medically Necessary Treatment of Mental Health and Substance Use Disorders;
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.

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 Covered Person 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.

Value-Added Services

Voluntary health promotion programs may be available to You. These value-added services are offered in conjunction with this Plan and are not Covered Services under the Group Policy. Please call KPIC at the number on Your ID card to learn more about the services which may be available to You.

For purposes of this section, "*health promotion programs*" means value-added services offered to Covered Persons that do not constitute Covered Services under the Group Policy. These services may be discontinued at any time without prior notice.