KAISER PERMANENTE
Kaiser Permanente Insurance Company

12/26/2023

MARY FULLER
18000 INTERNATIONAL BLVD
SUITE 800
SEATTLE, WA 98188

Re: GROUP Policy Number: 847, 003
GROUP Policyholder: LYNDEN INCORPORATED

Dear Policyholder:

Thank you for choosing Kaiser Permanente Insurance Company (KPIC). Enclosed is a copy of the 2023 Certificate of Insurance for your group's Added Choice plan. It describes the current 2023 Added Choice out-of-plan (non-HMO) benefits underwritten by Kaiser Permanente Insurance Company (KPIC). The enclosed Certificate of Insurance (Certificate) became effective on your group's renewal date occurring during 2023. A copy of the 2023 Certificate has been mailed to the home address of your employees insured under the Added Choice plan.

Your 2023 Certificate of Insurance ("Certificate") is being revised with the following attached Riders. The Certificate and the Riders describes the current 2023 Added Choice out-of-plan (non-HMO) benefits underwritten by Kaiser Permanente Insurance Company (KPIC).:

- Outpatient Prescription Drug Benefit Rider detailing your outpatient prescription drug benefits. This rider is effective upon your groups renewal in 2023.

- No Surprises Act (NSA) Amendment protects you from surprise billing and prohibits surprise bills for emergency services from an out-of-network contracted provider or facility. This rider was effective January 1, 2022.

- Cigna PPO Provider Integration Amendment Rider effective January 1, 2023, incorporates Cigna integration. Contracted Providers outside of the following Kaiser Permanente states: California, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and District of Colombia (hereafter referred to as "KP states") states will be Cigna.

For your convenience also attached is a copy of your 2023 Certificate.

Upon your group's renewal in the upcoming plan year - 2023, provisions of the No Surprises Act (NSA) Amendment and the Cigna PPO Provider Integration Amendment Riders will be incorporated to your Certificate.

Please read the Certificate and the attached riders carefully and retain it for future reference. If you have any questions regarding your account, please contact your Kaiser Permanente account manager or write to:

Kaiser Foundation Health Plan, Inc.
711 Kapiolani Boulevard, Suite 400
Honolulu, Hawaii 96813

Please provide the attached Rider to all affected Insured Employees along with a copy of the Certificate.

Thank you for your participation in the Added Choice plan.

Sincerely,

KAISER PERMANENTE INSURANCE COMPANY

Enclosures

KAISER PERMANENTE®

Kaiser Permanente Insurance Company

Hawaii

Point of Service Large Group *(Non-Grandfathered Coverage)*

Certificate of Insurance

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

This Certificate describes benefit coverages funded through a Group Insurance Policy 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. If the Group Policy and this Certificate differ, the Group Policy will govern. A copy of the Group Policy is available at the Policyholder's office. This Certificate supersedes and replaces any that may have been issued to You previously for the coverage described herein.

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

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

TABLE OF CONTENTS

The Sections of the Certificate appear in the order set forth below

CERTIFICATE OF INSURANCE 1
TABLE OF CONTENTS 2
INTRODUCTION 3
CONTRACTED PROVIDER CARE/NON-CONTRACTED PROVIDER CARE 4
SCHEDULE OF COVERAGE - INDEMNITY 5
DEDUCTIBLES AND MAXIMUMS 8
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE 10
CONTINUATION OF MEDICAL BENEFIT REQUIRED BY FEDERAL LAW (COBRA) 12
EXTENSION OF BENEFIT 13
DEFINITIONS 14
PRECERTIFICATION THROUGH THE MEDICAL REVIEW PROGRAM 24
BENEFITS 26
GENERAL LIMITATIONS AND EXCLUSIONS 35
GENERAL PROVISIONS 38
COORDINATION OF BENEFITS 40
CLAIMS AND APPEALS PROCEDURES 43

INTRODUCTION

A Member under this Plan is entitled to choose between two types of coverage at the point-of-service (POS) when treatment or service is requested and/or rendered.

Kaiser Foundation Health Plan, Inc., Hawaii Region (herein called Health Plan) provides specified medical and Hospital services ("In-Network Services") provided, prescribed or directed by a Health Plan Physician as described in the Added Choice Service Agreement/ Group Agreement.

Kaiser Permanente Insurance Company (herein called KPIC) provides the Out-of-Network coverage as set forth in the Group Policy. The benefits covered under the two types of coverage are not the same. Some services are covered by Health Plan and KPIC, while other services are covered only by Health Plan or KPIC.

Neither Health Plan nor KPIC is responsible for any Member's decision to receive treatment, services or supplies under either type of coverage. Nor is Health Plan or KPIC liable for the qualifications of providers or treatment, services, or supplies provided under the other party's coverage. The Group Policy sets forth KPIC's coverage, limitations, and exclusions. The Added Choice Service Agreement/ Group Agreement sets forth Health Plan's coverage, limitations and exclusions.

IMPORTANT: No payment will be made by KPIC under the Group Policy for treatment (including confinement(s)), services or supplies to the extent such treatment, services or supplies were provided, arranged, paid for or are payable by Health Plan as In-Network services under the Added Choice Service Agreement/Group Agreement.

CONTRACTED PROVIDER CARE/NON-CONTRACTED PROVIDER CARE

KPIC pays for Covered Services and supplies under the Group Policy from either a Contracted Provider or Non-Contract Provider. A Contracted Provider is a Hospital, Skilled Nursing Facility or any other medical or health related provider who has contracted with KPIC for the purpose of reducing health care costs by negotiating fees. A Non-Contracted Provider is a Hospital, Skilled Nursing Facility or any other medical or health related provider who has not contracted with KPIC to support the Added Choice product.

A list of Contracted Providers in the Added Choice Service Area will be given to you at the time your coverage becomes effective. Any changes to this list will be provided not less than annually. You may contact Member Services during regular business hours to receive current information on these providers.

When a Member receives Covered Services, KPIC will pay, after satisfaction of the applicable calendar year deductible and Coinsurance, the Percentage Payable of the Maximum Allowable Charge. The Maximum Allowable Charge is the lesser of: 1) The Usual and Customary Charge; 2) the Negotiated Rate; or 3) the actual billed charge. Please refer to the Definitions section for further explanation of the Maximum Allowable Charge.

When receiving Covered Services from a Contracted Provider, the Member is typically only responsible for the deductible and Coinsurance. If, however, a Non-Contract Provider is utilized, the Member is responsible for the difference between the Maximum Allowable Charge and the amount the Provider actually charged, in addition to any applicable deductible and Coinsurance amounts due under the Group Policy.

SCHEDULE OF COVERAGE - INDEMNITY

NOTE: The following 3 pages provide a summary of the Percentage Payable for Covered Services. Please read the entire Certificate for complete information regarding your benefits, exclusions and limitations.

Covered Persons:	Employee and Dependents (if elected)
MAXIMUM BENEFIT WHILE INSURED:	
Medical:	Unlimited
CALENDAR YEAR DEDUCTIBLES:	
Individual Deductible:	$100
Family Deductible:	$300
OUT-OF -POCKET MAXIMUM:	
Individual Out-of-Pocket Maximum:	$2,000
Family Out-of-Pocket Maximum:	$6,000

COVERED SERVICES:	**PERCENTAGE PAYABLE:**
Physician Office Visits:	80%
Hospital Room and Board (including detoxification):	80%
Lab and X-ray:	80%
Surgery:	80%
Well Child Care from birth through age 5:	80%, deductible waived
Extended Well Child Care (routine pediatric care) from age 6 through 18:	80%
Routine Adult Physicals:	80%
Pregnancy and childbirth:	80%
Elective Abortion – limited to two occurrences while insured under the Group Policy:	80%

SCHEDULE OF COVERAGE - INDEMNITY

COVERED SERVICES:	PERCENTAGE PAYABLE:
Extended Care/Skilled Nursing Facility – limited to a calendar year maximum of 120-days:	80%
Outpatient Rehabilitation Services (including short term physical therapy, occupational and/or speech therapy) – limited to a maximum of 60 visits per calendar year:	80%
Home Health Services – limited to 150 visits per calendar year:	80%
Serious Mental Illness:	80%
Mental and Nervous Disorders (does not include Serious Mental Illness):	
Hospital Confinement:	80%
Non-Hospital Residential Services; Partial Hospitalization Services; and Day Treatment Services:	80%
Outpatient Services:	80%
Substance Abuse	
Inpatient:	80%
Non-Hospital Residential Services; Partial Hospitalization Services; and Day Treatment Services:	80%
Outpatient Services:	80%
Hospice Care – limited to a maximum while insured of 210 days:	80%
Preventive Services (PPACA):	100%, Deductible waived
Other Preventive Services:	80%, unless otherwise noted
Outpatient diabetes self-management training, and education:	80%
Durable Medical Equipment:	80**%**
Treatment of Autism:	80**%**
Applied Behavior Analysis:	80**%**
Orthodontic Services:	80%, limited to a maximum of $5,500 per treatment phase.*

SCHEDULE OF COVERAGE - INDEMNITY

**This limit will not apply to dependent children until the end of the month in which the dependent child reaches age 19.*

IMPORTANT: Pre-certification is required prior to all Hospital confinements and select outpatient services. If precertification is not obtained, benefits otherwise payable will be reduced by $300 each time pre-certification is required and not obtained, up to a maximum penalty of $1,000 per calendar year. For complete details regarding pre-certification please see the section of this Certificate entitled "**PRECERTIFICATION THROUGH THE MEDICAL REVIEW PROGRAM."**

DEDUCTIBLES AND MAXIMUMS

Maximum Allowable Charge

Payments under the Group Policy are based upon the Maximum Allowable Charge for Covered Services. The Maximum Allowable Charge may be less than the amount actually billed by the provider. Covered Persons are responsible for payment of deductible and Coinsurance amounts, Copayments, and 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.)

Percentage Payable

The Percentage Payable by KPIC is applied to Covered Charges after any applicable deductible has been met. The Percentage Payable and the Covered Services to which it applies are set forth in the Schedule of Coverage.

Individual Deductible

The Individual Deductible is set forth in the Schedule of Coverage and applies separately to each Covered Person during each calendar year. When Covered Charges equal to the Deductible are incurred and submitted to Us, the Deductible will have been met for that Covered Person. The Deductible applies to all Covered Charges incurred by a Covered Person during a calendar year, unless otherwise indicated in the Schedule of Coverage.

In addition, some Covered Services may be subject to additional or separate deductible amounts, as shown in the Schedule of Coverage. These additional or separate deductibles are not subject to, nor do they contribute towards, satisfaction of the Individual Deductible or the Family Deductible.

Family Deductible

The Deductible for a family shall be satisfied when covered family members incur Covered Charge during a calendar year equal to the Family Deductible amount shown in the Schedule of Coverage.

If the Family Deductible is satisfied in a calendar year, then the Individual Deductible(s) will not be applied to any further Covered Charges incurred during the remainder of that calendar year.

Some Covered Services may be subject to additional or separate deductible amounts, as shown in the Schedule of Coverage. These additional or separate deductibles are not subject to, nor do they contribute towards, satisfaction of the Individual Deductible or the Family Deductible.

Percentage of Covered Charges Payable by KPIC

The Percentages Payable by KPIC, as shown in the Schedule of Coverage, are applied against the Maximum Allowable Charge for Covered Services, after any applicable deductibles have been met.

Out-of-Pocket Benefit Maximums

For a Member: When a Member's share of Covered Charges incurred equals the Out-of-Pocket Maximum (**shown in the Schedule of Coverage**) during a calendar year, the Percentage Payable will increase to 100 percent of further Covered Charges incurred by that same Member during the remainder of that calendar year.

For a Family: When the amount of Covered Charges incurred by all covered family members equals the Out-of-Pocket Maximum (**shown in the Schedule of Coverage**) during a calendar year, the Percentage Payable will increase to 100 percent of further Covered Charges incurred by covered family members during the remainder of that calendar year.

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.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Eligibility

The following persons will be eligible for insurance: All employees and their dependents who are eligible for and enrolled in Health Plan under the Added Choice Service Agreement/Group Agreement, except those who are eligible for Medicare as a primary payor. Please refer to the Coordination of Benefits section for further details.

Effective Date Of An Eligible Employee's Or Dependent's Insurance

The Effective Date of an eligible employee's or dependent's insurance will be the date the person becomes covered by Health Plan.

Rescission for Fraud or Intentional Misrepresentation

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

1. The effective date of Your coverage under the Group Policy if KPIC 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.

If You or Your Dependent's coverage under the Group 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 your right to an independent medical review.

Termination Of A Member's Insurance

Except as provided under the federal continuation of coverage law (COBRA), state continuation law, or the Group Policy's Extension of Benefits provisions, the Member's insurance will terminate on the earlier of the following dates:

1. the date the Member ceases to be covered by Health Plan;
2. the date the Group Policy is terminated;
3. the date a Member, or the Member's representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. the end of the grace period after the employer fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion;
5. the date the Member ceases to be eligible for coverage under the Eligibility section of the Group Policy or Health Plan; or
6. the date the Member relocates to a place outside of the geographic service area of a provider network, if applicable.

The Health Plan Added Choice Service Agreement/Group Agreement more fully explains eligibility, effective date and termination.

Exception: Coverage will continue and will not terminate due to the limiting age of 26 for dependent children who are incapable of self-sustaining employment due to handicap or mental retardation and are chiefly dependent on the Member for support and maintenance. Proof of incapacity and dependency

must be provided to KPIC within 31 days of attaining the limiting age and such proof must be submitted annually after the first 2 years.

CONTINUATION OF MEDICAL BENEFIT REQUIRED BY FEDERAL LAW (COBRA)

For an explanation of the Continuation of Medical Benefit required by Federal Law, refer to the Health Plan Added Choice Service Agreement/Group Agreement.

CONTINUATION OF COVERAGE REQUIRED BY STATE LAW

If an employee is hospitalized or otherwise prevented by Sickness from working, the employer shall enable the employee to continue the employee’s coverage by contributing to the amounts paid by the employer toward such premium prior to the employee's Sickness for the period that such employee is hospitalized or prevented by Sickness from working. This obligation shall not exceed a period of three months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of the employee's regular wages in such case, whichever is longer.

EXTENSION OF BENEFIT

An extension will be provided to a Covered Person who is Totally Disabled or Hospital Confined on the date of termination of the Group Policy. No premium contribution is required. Upon receipt of due proof of the following, KPIC will pay benefits under the Group Policy as though coverage had not terminated:

1. such person incurred Covered Charges during the Total Disability or Hospital Confinement;
2. the Covered Charges are related to the Injury or Sickness causing the Total Disability or Hospital Confinement;
3. the Covered Charges would have resulted in a valid claim if this benefit had been in effect at the time the expenses were incurred; and
4. the Total Disability or Hospital Confinement has been continuous and uninterrupted.

This Extension of Benefit will terminate on the earlier of:

1. the date the Total Disability or Hospital Confinement ends; or
2. the end of the ninety-second day of an extension of benefits originating under this provision.

DEFINITIONS

The following terms have special meaning throughout the Certificate. Other parts of the Certificate contain definitions specific to those provisions.

ADMINISTRATOR: means Kaiser Foundation Health Plan, Inc. Regional Appeals Office 711 Kapiolani Blvd. Honolulu, HI 96813. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior notice.

APPLIED BEHAVIOR ANALYSIS: means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

AUTISM: means autism spectrum disorder as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.The treatment of Autism includes the following care prescribed or ordered for a Covered Person diagnosed with Autism by a Physician: (1) behavioral health treatment; (2) pharmacy care; (3) psychiatric care; (4) psychological care; (5) therapeutic care; and (6) applied behavior analysis. As used in this definition, the term used in items 1 through 6 above shall have the meaning prescribed by Hawaii state law at the time the expense is incurred.

AUTISM SERVICE PROVIDER: means any person, entity or group that provides treatment for Autism and meets the minimum requirements as established by the state.

BIRTH CENTER: 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 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 nurse midwife; and
5. has 24-hour-a-day Registered Nurse services.

BIRTH SERVICES: antepartum (before labor); intrapartum (during labor); and postpartum (after birth) care. This care is given with respect to:
1. uncomplicated pregnancy and labor; and
2. spontaneous vaginal delivery.

BOARD AND ROOM: all charges commonly made by a Hospital on its own behalf for room and meals essential to the care of registered bed patients.

CERTIFIED NURSE-MIDWIFE: any person certified as a nurse-midwife in the state in which treatment is received, and associated with a Physician for purposes of consultation and supervision.

CERTIFIED NURSE PRACTITIONER: any Registered Nurse 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 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, and associated with a Physician for the purposes of consultation and supervision.

CERTIFIED PSYCHIATRIC-MENTAL HEALTH CLINIC NURSE SPECIALIST: 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, and is associated with a Physician for purposes of consultation and supervision.

DEFINITIONS

COINSURANCE: that percentage of Covered Charges to be paid by the Member. The percentage of Covered Charges to be paid by the Member is the difference between the Percentage Payable by KPIC and the Maximum Allowable Charge. Members are also responsible for payment of any amounts in excess of the Maximum Allowable Charge for a Covered Service.

COPAYMENT: all Copayments applicable to the Covered Services incurred by the Member are shown in the Schedule of Coverage. Applicable Copayments must be satisfied by the Member before benefits can be paid. Copayments are applied on a per visit or per service basis.

COVERED CHARGES: the Maximum Allowable Charge for a Covered Service.

COVERED SERVICES: the services as defined and listed under the section entitled Benefits.

DAY TREATMENT SERVICES: treatment services provided by a Hospital, Mental Health Outpatient Facility, or Non-Hospital Facility to Members who, because of their conditions, require more than periodic hourly service. Such services shall be prescribed by a Physician or psychologist and carried out under the supervision of a Physician or psychologist. Day Treatment Services require less than twenty-four (24) hours of care and a minimum of three (3) hours in any one day.

DRUG DEPENDENCE OUTPATIENT SERVICES: drug dependence nonresidential treatment provided on an ambulatory basis to patients with drug dependence problems that includes psychiatric or psychological interventions prescribed and performed by state licensed physicians or certified psychologists.

DURABLE MEDICAL EQUIPMENT: medical equipment that is:
1. Designed for repeated use;
2. Mainly and customarily used for medical purposes;
3. Not generally of use to a person in the absence of a Sickness or Injury;
4. Approved for coverage under Medicare;
5. Not primarily and customarily for the convenience of the Covered Person; and
6. Appropriate for use in the home, including oxygen use in conjunction with prescribed Durable Medical Equipment.

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 the *Patient Protection and Affordable Care Act of 2010 (PPACA)* as then constituted or later amended.

EMERGENCY MEDICAL CONDITION: A medical condition, including psychiatric conditions, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; and/or
3. Serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES (EMERGENCY CARE): All of the following with respect to an Emergency Medical Condition:
1. A medical screening examination (as required under the *Emergency Medical Treatment and Active Labor Act*) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition;

2. Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the *Emergency Medical Treatment and Active Labor Act* requires to Stabilize the patient

EXPENSES INCURRED: expenses a Covered Person incurs at the time a Covered Service is rendered.

EXTENDED CARE OR SKILLED NURSING FACILITY: an institution (or a distinct part of an institution) which: 1) provides 24-hours-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. Extended Care services includes nursing care, occupational and speech therapy, medical social services, prescribed drugs, medical supplies and durable medical equipment ordinarily furnished by the Skilled Nursing Facility.

FREE-STANDING SURGICAL FACILITY: a legally operated institution which is accredited by Joint Commission Accreditation of Health Organization (JCAHO) or other similar organization, and:
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 who require 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.

HEALTH PLAN: Kaiser Foundation Health Plan, Inc. (Hawaii region). All references to Health Plan refer to coverage under the Added Choice Service Agreement/Group Agreement.

HOSPICE CARE: home-based palliative and supportive care by a licensed hospice for terminally ill patients. 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 6 months.

HOSPITAL: an institution which is accredited by Joint Commission Accreditation of Health Organizations (JCAHO) or other similar organization, and:
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 an Extended Care or Skilled Nursing Facility or similar institution.

HOSPITAL CONFINEMENT: being registered as a bed patient in a Hospital upon the recommendation of a Physician.

INBORN ERROR OF METABOLISM: a disease caused by an inherited abnormality of the body chemistry of a person that is characterized by deficient metabolism, originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate, or fat.

IN-HOSPITAL SERVICES: the provision of medical, nursing, or therapeutic services 24 hours a day in a Hospital.

INJURY: accidental bodily injury of a Member.

INSURED DEPENDENT: an eligible dependent of the Insured Employee, is enrolled in Health Plan as an Added Choice Member and covered under the Group Policy.

INSURED EMPLOYEE: a Covered Person who is an employee of the Policyholder, enrolled in Health Plan as an Added Choice Member and covered under the Group Policy.

INTENSIVE CARE UNIT: 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 Board and Room; and
5. provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.

INTRAVENOUSLY ADMINISTERED CHEMOTHERAPY: a physician-prescribed cancer treatment that is administered through injection directly into the patient's circulatory system by a physician assistant, nurse, practitioner, nurse, or other medical personnel under the supervision of a physician and in a hospital, medical office, or other clinical setting.

LICENSED PRACTICAL NURSE: an individual who has received: 1) specialized nursing training; and 2) practical nursing experience. He or she is licensed to perform nursing service by the state in which he or she performs such service, and associated with a Physician for purposes of consultation and supervision. This definition will include licensed vocational nurses with the above qualifications.

LOW-DOSE MAMMOGRAPHY: the x-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

LOW-PROTEIN MODIFIED FOOD PRODUCT: a food product that: 1) is specifically formulated to have less than one gram of protein per serving; 2) is prescribed or ordered by a Physician as Medically Necessary for the dietary treatment of an Inborn Error of Metabolism; and 3) does not include a food that is naturally low in protein.

MAXIMUM ALLOWABLE CHARGE: the lesser of:

1. <u>The Usual and Customary Charge.</u>
   The Usual and Customary (U&C) Charge is the lesser of: (a) the charge generally made by a Physician or other supplier of services, medicines, or supplies; or (b) the general level of charge made by Physicians or other suppliers within an area in which the charge is incurred for Injury or Sickness comparable in severity and nature to the Injury of Sickness being treated. 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 Maximum Allowable Charge. KPIC reserves the right to periodically adjust the charges listed in the schedules.

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

   If the Maximum Allowable Charge is the U&C Charge, the Member 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. <u>The Negotiated Rate.</u>
   The authorized Administrator or KPIC may have a contractual arrangement with the provider or supplier of Covered Services under which discounts have been negotiated for certain services or supplies. Any such discount is referred to as the Negotiated Rate. If there is a Negotiated Rate, the provider will accept the Negotiated Rate as payment in full for Covered Services, subject to the payment of Deductibles and Coinsurance by the Member.

3. The Actual Billed Charges for the Covered Services.
   The charges billed by the provider for Covered Services.

Exception For Emergency Services rendered by Non-Contracted Providers:

If the amount payable for Emergency Services is less than the Actual Billed Charges submitted by the Non-Contracted Provider, KPIC must pay at least the greater of the following:

1. The Negotiated Rate for the Emergency Service. If there is more than one Negotiated Rate with a for a particular Emergency Service, then such amount shall be the median of these Negotiated Rates, treating the Negotiated Rate with each provider as a separate Negotiated Rate, and using an average of the middle two Negotiated Rates (if there is an even number of Negotiated Rates).
2. The amount it would pay for the Emergency Service if it used the same method (for example, Usual and Customary charges) that it generally uses to determine payments for services rendered by Non-Contracted Providers and if there were no cost sharing (for example, if it generally pays 80% of UCR and the cost sharing is 20%, this amount would be 100% of UCR).
3. The amount that Medicare (Part A or B) would pay for the service.

Under any of the above, KPIC may deduct from its payment: (1) any Contracted Provider Copayments and/or Coinsurance amounts that would have been paid had the Emergency Service been rendered by a Contracted Provider; and/or (2) any Non-Contracted Provider deductible amounts.

MEDICAL FOOD: a food that is formulated to be consumed or administered enterally under the supervision of a Physician and is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation.

MEDICALLY NECESSARY: services that, in the judgment of KPIC, are:

1. essential for the diagnosis or treatment of a Member's Injury or Sickness;
2. in accord with generally accepted medical practice in the community;
3. appropriate with regard to standards of medical care; and
4. provided at the most appropriate supply, level and facility.

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

MEDICARE: the Federal Health Insurance for the Aged and Disabled Act, Title XVII of the Social Security Amendment of 1965 as then constituted or later amended.

MEMBER: an eligible employee or dependent enrolled in Health Plan and covered under the Group Policy.

MENTAL HEALTH OUTPATIENT FACILITY: a mental health establishment, clinic, institution, center or community mental health center that provides for the diagnosis, treatment, care or rehabilitation of mentally ill persons, that has been accredited by the Joint Commission on Accreditation of Health Care Organizations or the Commission on Accreditation of Rehabilitation Facilities.

MENTAL HEALTH OUTPATIENT SERVICES: mental health nonresidential treatment provided on an ambulatory basis to patients with mental illness that includes psychiatric or psychological interventions prescribed and performed by a Physician or a licensed psychologist.

MONTH: 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: any charges made by a Hospital on its own behalf for necessary medical services and supplies actually administered during any covered Hospital Confinement or other covered treatment. The term does not include charges for:
1) Board and Room; 2) an Intensive Care Unit; or 3) the services of a private duty nurse, Physician, or other practitioner.

NON-HOSPITAL FACILITY: a facility for the care or treatment of alcohol dependent, drug dependent, or mentally ill persons, which has been accredited by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. If residential, such a facility must also be licensed as a special treatment facility by the Department of Health.

NON-HOSPITAL RESIDENTIAL SERVICES: the provision of medical, psychological, nursing, counseling, or therapeutic services to Members suffering from alcohol dependence, drug dependence, or mental illness by a non-hospital residential facility, according to individualized treatment plans.

OUT-OF-NETWORK: means those benefits underwritten by KPIC and set forth in the Group Policy. Unless otherwise stated in the Group Policy, KPIC will not pay for services provided, arranged, paid for or payable by Health Plan.

ORAL CHEMOTHERAPY: a United States Food and Drug Administration-approved, physician-prescribed cancer treatment that is taken orally in the form of a tablet or capsule and may be administered in a hospital, medical office, or other clinical setting or may be delivered to the patient for self-administration under the direction or supervision of a physician outside of a hospital, medical office, or other clinical setting.

OROFACIAL ANOMALIES: means cleft lip or cleft palate and other birth defects of the mouth and face affecting functions such as eating, chewing, speech, and respiration.

ORTHODONTIC SERVICES: means direct for consultative services provided by a licensed dentist with a certification in orthodontics by the American Board of Orthodontics.

PARTIAL HOSPITALIZATION SERVICES: treatment services provided by a Hospital or Mental Health Outpatient Facility to Members who, because of their conditions, require more than periodic hourly service. Such services shall be prescribed by a Physician or Psychologist. Partial Hospitalization Services require less than twenty-four (24) hours of care and a minimum of three (3) hours in any one day.

PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA): means Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended.

PERCENTAGE PAYABLE: the percentage of Covered Charges payable by KPIC as set forth in the Schedule of Coverage. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services.

PHYSICIAN: a practitioner who is duly licensed as a physician in the state in which treatment is received. He or she must be practicing within the scope of that license. For purposes of this definition, Physician shall include a advance practice registered nurse operating within the scope of his/her license. In addition, whenever Covered Service are within the lawful scope of practice of a psychologist, the person entitled to benefits or performing the Covered Service shall be entitled to reimbursement or payment when the Covered Service is performed by a licensed Physician or a licensed psychologist.

POLICYHOLDER: the employer(s) shown on the Face Page of the Group Policy.

POLICY YEAR: a period of time: 1) beginning with the Group Policy Effective Date of any year; and 2) terminating on the same date of the succeeding year. If the Group Policy Effective Date is February 29, such date will be considered to be February 28 in any year having no such date.

PREVENTIVE SERVICES: measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive services:

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.

REGISTERED NURSE: a professional nurse who has the right to use the title Registered Nurse (R.N.) in the state in which services are provided, and associated with a Physician for purposes of consultation and supervision.

SERIOUS MENTAL ILLNESS: schizophrenia, schizo-affective disorder, and bipolar types I and II, obsessive compulsive disorder, dissociative disorder, delusional disorder, and major depression, as defined in the most recent version of the Diagnostic and Statistical Manual of the American Psychiatric Association, which is of sufficient severity to result in substantial interference with the activities of daily living.

SERVICE AREA: The islands of Kauai, Lanai, Maui, Molokai, Oahu, and the Island of Hawaii.

SICKNESS: illness or a disease of a Member. Sickness will include congenital defects or birth abnormalities.

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

SUBSTANCE ABUSE SERVICES: the provision of medical, psychological, nursing, counselling or therapeutic services in a response to a treatment plan for alcohol or drug dependence or both. They must include, where appropriate, a combination of after care and individual, group and family counselling services provided by certified substance abuse staff.

SURROGACY ARRANGEMENT: An arrangement in which a woman (the surrogate) agrees to become pregnant and surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether the woman receives payment for being a surrogate. Please refer to “**Surrogacy Arrangements**” provision under the **GENERAL PROVISIONS** section for information about Your obligations to Us in connection with a Surrogacy Arrangement, including Your obligation to reimburse Us for any Covered Services that baby (or babies) receive.

TOTAL DISABILITY: (1) inability of the Member, due solely to disease or Injury, to perform with reasonable continuity the substantial and material duties of regular and customary work; and (2) an Insured Dependent's complete inability, due solely to disease or Injury, to engage in the normal activities of a person of the same sex and age. The Member must not in fact be working for pay or profit.

TREATMENT EPISODE: one admission to an accredited Hospital or Non-Hospital Facility, or office of a qualified Physician or certified psychologist for treatment of alcohol or drug dependence or both as stipulated in a prescribed treatment plan, and which would generally produce remission in persons who complete the treatment. The treatment plan may include In-hospital, non-hospital residential day treatment or alcohol or Drug Dependence Outpatient Services or any combination thereof. An admission for detoxification services only is not a Treatment Episode.

URGENT CARE CENTER: a facility legally operated to provide health care services in emergencies or after hours. It is not part of a Hospital.

URGENT CARE SERVICES: means initial care for a sudden Sickness or Injury, when the Member is temporarily away from the Service Area, which is required to prevent serious deterioration of the Member’s health and which cannot be delayed until the Member’s return to the Service Area or to a designated Hospital or medical office in another Health Plan Region.

TELEHEALTH: means the use of telecommunications services, including, but not limited to, real-time video conferencing-based communications; secure interactive and non-interactive web-based communications, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services for information to parties separated by distance. To be eligible as a Covered Service, a Physician-patient relationship must exist between the Covered Person and one of the Physicians. Standard telephone contacts, facsimile transmission, or email text, in combination or by itself, does not constitute a telehealth service.

PRECERTIFICATION THROUGH THE MEDICAL REVIEW PROGRAM

Medical Review Program

"Medical Review Program" means the vendor, organization or program that: 1) evaluates proposed treatment or services to determine if the proposed treatment or service is Medically Necessary; and 2) assures that the care received is appropriate and Medically Necessary to the Member's health care needs. Precertification will not result in payment of benefits that would not otherwise be payable under the Group Policy.

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

1. All inpatient admissions, including residential treatment and skilled nursing facility admissions;
2. Outpatient surgery (performed at a Hospital , Ambulatory Surgery Center or other licensed facility;
3. Outpatient procedures (limited to: Hyperbaric oxygen, EECP, Plasma pharesis (MS), Anodyne therapy, Pill endoscopy, Radiofrequency ablation, sclerotherapy, stab phlebectomy, Uvulo-palato-pharyngoplasty (UPPP) & laser-assisted UPPP, sleep studies, Vagal nerve stimulation, Resection, Hemispherectomy, Corpus colostomy surgery, Implants);
4. Reconstruction Surgery;
5. Applied Behavior Analysis:
6. Pain Management Services (radiofrequency ablation, implantable pumps, spinal cord stimulator, injections);
7. Upper Airway Procedures;
8. Non-Emergent (scheduled) Air or Ground Ambulance Transport;
9. Genetic Testing;
10. Orthotics/Prosthetics;
11. Implantable Prosthetics;
12. Home Health & Home Infusion Services;
13. Infertility Procedures;
14. Outpatient Injectable Drugs;
15. Durable Medical Equipment;
16. Temporomandibular joint disorders (TMJ) /Orthagnathic Surgery;
17. Radiation Therapy Services;
18. Clinical Trials;
19. Imaging Service: Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Computerized Axial Tomography (CTA), Positron Emission Tomography (PET), Electronic Beam Computed Tomography (EBCT), Single-Photon Emission Computerized Tomography (SPECT)

The Medical Review Program Vendor may be reached at 1-800-238-5742, 24-hours per day, 7 days per week.

IMPORTANT: If precertification is not obtained, benefits otherwise payable will be reduced by $300 each time precertification is required and not obtained, up to a maximum penalty of $1,000 per calendar year. This reduction will apply 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) will be similarly reduced; or 2) will not be covered at all if deemed not to be Medically Necessary.

Precertification Procedures

1. The Member 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 Health Plan's coverage of the Hospital Confinement 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 48 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; or
   b. Deny precertification entirely; or
   c. Deny the requested treatment or service, but precertify an alternative treatment or service; and
   d. Send the precertification or denial in writing to the Member or the individual legally responsible for the Member, the attending Physician, and if applicable, to the Hospital.

3. Under the Medical Review Program a Member may be required to:
   a. Obtain a second opinion from a Physician selected from a panel of three or more Physicians designated by the Medical Review Program. If the Member is required to obtain a second opinion, it will be provided at no charge to the Member;
   b. Participate in the Medical Review Program's case management, Hospital discharge planning and long-term case management programs; and
   c. Obtain from the attending Physician information required by the Medical Review Program relating to the medical condition and the requested treatment or service.

Failure To Comply With The Precertification Procedures

Failure to comply with any of the precertification procedures set forth above, will result in a reduction of benefits as described herein. The dollar amount of any reduction in benefits will not count toward satisfaction of any deductible, Coinsurance or Out-of-Pocket Maximum.

Appeal Process

If a request for precertification is denied, in whole or in part, the Member, or the individual legally responsible for the Member, will be: 1) notified in writing; and 2) given an opportunity for review. Any request for review must be filed in writing to the Medical Review Program Vendor within 60 days of the date of denial at:

Permanente Advantage Appeals Department
8954 Rio San Diego Dr, 4th Floor, Ste 406
San Diego, CA 92108
Phone: 1-888-525-1553

Please refer to the **CLAIMS AND APPEALS PROCEDURES** section for a detailed discussion of the grievance and appeals process and Your right to an independent medical review.

BENEFITS

Insuring Clause

Upon receipt of satisfactory notice of claim and proof of loss, KPIC will pay per calendar year, after satisfaction of the applicable Deductibles and Coinsurance, the Percentage Payable of the Maximum Allowable Charge of the Expenses Incurred during a calendar year by the Member due to an Injury or Sickness, provided:

1. the expense is incurred while insured for this benefit;
2. the Expense Incurred is for a Covered Service that is Medically Necessary;
3. the Member has satisfied any applicable deductibles, Copayments, or other amounts payable;
4. the expense is not a duplication of benefits paid or payable by Health Plan; and
5. the expense is for a Covered Service prescribed or ordered by the attending Physician or by a provider duly licensed to provide medical services without the referral of a Physician.

Such payment:

1. will not exceed the Maximum Benefit While Insured or any other applicable maximum shown in the Schedule of Coverage or listed elsewhere in the Group Policy;
2. will be subject to the limitations shown in the Schedule of Coverage;
3. will be subject to the General Limitations and Exclusions;
4. may be subject to precertification; and
5. will not duplicate any other benefits paid or payable by KPIC.

To the extent an item or service is a Covered Service under the Group Policy, and consistent with the reasonable medical management techniques specified under this insurance plan with respect to frequency, method, treatment, or setting for an item or service, KPIC will not discriminate based on a provider's license or certificate under applicable state law. Nothing in this Certificate shall be construed to prohibit benefits for Covered Services rendered by any health care provider who is acting within the scope of the provider's license or certificate under applicable state law.

Covered Services:

1. Board and Room in a Hospital (private room only when Medically Necessary).
2. Board and Room in a Hospital Intensive Care Unit.
3. Board and Room and other services of an Extended Care or Skilled Nursing Facility.
4. Necessary Services and Supplies, including prescription drugs, administered during a Hospital Confinement or other covered treatment.
5. Emergency Care when not covered by Health Plan.
6. treatment in an Urgent Care Center when not covered by Health Plan.
7. Physician services.
8. blood, blood derivatives, and blood products, limited to whole blood, red cell products, cryoprecipitates, Rh immune globulin, platelets, plasma and fresh frozen plasma. Covered Services will include expenses incurred for the collection, processing and storage of autologous blood donations when prescribed by a Physician for a covered surgery.
9. nursing care by a Registered Nurse or, if none is available as certified by the attending Physician, nursing care by a Licensed Practical Nurse.
10. nursing care by a Certified Nurse Practitioner; Certified Psychiatric-Mental Health Clinical Nurse Specialist or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
11. physical therapy rendered by a certified physical therapist. The attending Physician must determine that the condition is subject to significant improvement within two months.
12. speech therapy rendered by a certified speech therapist or certified speech pathologist. The speech disorder must result from Injury or Sickness of specific organic origin. The therapy must be considered progressive therapy, not maintenance therapy. It must be rendered for a condition that a Physician determines is subject to significant improvement within two months.
13. respiratory therapy rendered by a certified respiratory therapist.

14. occupational therapy rendered by a certified occupational therapist. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within two months.
15. x-rays or laboratory exams.
16. hearing exams.
17. treatment of infertility, limited to: a) diagnostic imaging and laboratory procedures; b) outpatient prescription drugs (only if provided under separate Rider); c) injectables (if administered in a Physician's office); and d) outpatient expenses arising from artificial insemination or in vitro fertilization. Benefits for in vitro fertilization are limited to one procedure while a Health Plan/KPIC member. If you receive benefits for in vitro fertilization services under any Health Plan/KPIC plan, you will not be eligible for in vitro fertilization benefits under any other Health Plan/KPIC plan.. For opposite sex couples, In vitro fertilization is covered provided when the following apply:
    1. the patient is the Insured Employee or the covered dependent spouse of the Insured Employee'
    2. the Member's oocytes are fertilized with the Member's spouse's sperm;
    3. the Member and the Member's spouse have a history of infertility of at least five years duration; or infertility is associated with one or more of the following medical conditions:
        a. endometriosis;
        b. exposure in utero to diethylstilbestrol, commonly known as DES;
        c. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy);
        d. abnormal male factors contributing to the infertility;
    4. the Member has been unable to attain a successful pregnancy through other applicable infertility treatments for which coverage is available.

    If You as the patient do not have a history where you participated in natural conception using your own eggs and partner sperm, you must meet the following criteria to determine proper infertility:
    a. You are not known to be otherwise infertile, and
    b. You have failed to achieve pregnancy following three cycles of physician directed, appropriately timed intrauterine insemination.

    For in vitro fertilization procedures to be eligible for coverage, the procedure must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization

18. diagnosis, evaluation and treatment in connection with substance abuse for charges which would be a Covered Service under the Policy in connection with any other Sickness. Covered Services will include:
    a. detoxification services provided either in a Hospital or in a Non-Hospital Facility which has a written affiliation agreement with a Hospital for emergency, medical, and mental health support services. The following services shall be covered under detoxification services: a) Board and Room; b) diagnostic x-rays; c) laboratory testing; and d) drugs, equipment use, special therapies, and supplies;
    b. Non-Hospital Residential Services;
    c. Partial Hospitalization Services
    d. Day Treatment Services

    Treatment of Substance abuse must be provided under an individualized treatment plan approved by a Physician or Psychologist and must be reasonably expected to produce remission of the Member's condition.

19. diagnosis, evaluation and treatment in connection with mental illness for charges that would be a Covered Service under the Policy in connection with any other Sickness. Treatment will also include:
    a. Non-Hospital Residential Services;
    b. Partial Hospitalization Services provided by a Hospital or Mental Health Outpatient Facility; and
    c. Day Treatment Services.

Mental illness treatment must be provided under an individualized treatment plan approved by a Physician or Psychologist which is reasonably expected to produce remission of the Member's condition.

20. Hospice Care, limited to: a) nursing care; b) physical, respiratory, speech or occupational therapy; c) medical social services; d) services of home health aides and homemakers; e) medical supplies, and drugs; f) Physician services; g) short-term inpatient care, including respite care and care for pain control and acute and chronic symptom management; h) counseling and bereavement services; i) services of volunteers; j) referral visits during which the Member is advised of hospice care options, regardless of whether or not the Member is eventually admitted to hospice care; and k) residential hospice room and board expenses directly related to the hospice care being provided. Members who elect to receive Hospice Care are not entitled to any other benefits under the Group Policy for the terminal illness.
21. outpatient surgery in a Free-Standing Surgical Facility including after-care and anesthesiology services.
22. Hospital charges for use of its surgical room on an outpatient basis.
23. preadmission testing. This is 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 Board and Room charge is made.
24. Birth Services in a Birth Center.
25. home health services. These are health services that can be safely and effectively provided in an Insured Person's or Insured Dependent's home by health care personnel. The services must be: a) prescribed or directed by a Physician; and b) provided by duly licensed and accredited home health providers acting within the scope of their license and accreditation. This does not include:
    i. homemaker care; or
    ii. care that the Physician determines may be appropriately provided in an outpatient facility or Hospital, to the extent such care is provided or offered to be provided in such setting.
26. dressings and splints when administered by a Physician.
27. anesthesia and its administration provided by a licensed anesthesiologist.
28. surgically implanted prosthetic devices and aids, such as surgical mesh, stents, bone cement, implanted nuts, bolts, screws, and rods.
29. Covered Services will include Expenses Incurred for reconstructive surgery and an internally implanted breast prosthetic following a mastectomy. If requested, an external prosthetic will be provided instead of an internally implanted breast prosthetic.
30. Expenses Incurred for Medical Foods and Low-protein Modified Food Product for the treatment of an Inborn Error of Metabolism. To be eligible for coverage, the Medical Food or Low-protein Modified Food Product must be: i) be prescribed as Medically Necessary for the treatment of an Inborn Error of Metabolism; and ii) consumed or administered enterally under the supervision of a Physician.
31. Covered Services rendered for the treatment of Serious Mental Illness.
32. allergy testing and treatment materials. Allergy tests are limited to no more than one series per calendar year.
33. outpatient injectable or intravenous medications and their administration when prescribed by a Physician and administered during a Physician office visit.
34. outpatient diabetes self-management training, education, equipment and supplies when prescribed by a Physician or other health care professional authorized to prescribe. Benefits for self-management training and education will be limited to the first program the Member is certified to have completed. Diabetes equipment is limited to the purchase or rental of equipment which:
    a. can stand repeated use;
    b. is primarily and customarily used to serve a medical purpose;
    c. is generally not useful in the absence of Injury or Sickness;
    d. is appropriate for use in the home;
    e. is not primarily and customarily for the convenience of the Member; and
    f. provides direct aid or relief of the Member's medical condition.

35. Diabetic drugs or insulin when prescribed by an authorized health care professional, but only when your coverage under this plan does not include coverage for outpatient prescription drugs provided through an available Rider. Covered Charges for diabetic drugs and insulin are limited to a 30-day supply per prescription or refill. Covered Charges for diabetic drugs and insulin are not subject to the Calendar Year Deductible but are subject to the Out-of-Pocket Maximum.
36. transportation by ambulance to or from an acute care Hospital or Skilled Nursing Facility where treatment is being rendered. Air ambulance will only be covered when Medically Necessary for the purpose of transporting the Member for receipt of acute care, and the Member's condition requires the services of an air ambulance for safe transport.
37. 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.
38. growth hormone therapy if human growth hormone is for replacement therapy to treat:
    a. Hypothalamic-pituitary axis damage caused by primary brain tumors, trauma, infection or radiation therapy;
    b. Turner's syndrome;
    c. Growth failure secondary to chronic renal insufficiency awaiting renal transplant;
    d. AIDS-wasting or cachexia without evidence of suspected or overt malignancy and where other modes of nutritional support s have been tried;
    e. Short stature due to growth hormone deficiency;
    f. Prader-Willi Syndrome;
    g. Neonatal hypoglycemia secondary to growth hormone deficiency; or
    h. Severe growth hormone deficiency in adults.

39. Durable Medical Equipment limited to the standard item that will adequately meet the medical needs of the Covered Person.
40. Eye examinations for eyeglasses.
41. Intravenously Administered Chemotherapy and Oral Chemotherapy for the treatment of cancer.
42. Telehealth services.
43. Orthodontic Services for treatment of Orofacial Anomalies resulting from birth defects or birth defect syndromes. Treatment of Orofacial Anomalies includes the care prescribed, provided, or ordered for a Covered Person diagnosed with an Orofacial Anomaly by a craniofacial team that included a licensed dentist, orthodontist, oral surgeon, and Physician, and is coordinated between specialists and providers subject to a written treatment plan approved by the Covered Person's Physician.
44. Diagnosis and treatment of Autism for Covered Persons. Covered treatment will include Applied Behavior Analysis. For benefits to be payable, care must be provided: (a) by a licensed Autism Service Provider; (b) within the United States; and (c) according to a written treatment plan approved by the Covered Person's Physician.
45. Nutritional counseling provided by a licensed dietitian when the Covered Person has been diagnosed with an eating disorder by a qualified Physician.

Preventive Services:

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

The following preventive services are covered under the Group Policy as required by the Patient Protection Affordable Care Act (PPACA) and are not subject to the Deductibles, Coinsurance. Consult with Your physician to determine what preventive services are appropriate for You.

(A). *Exams:*

1. Well-Baby, Child, Adolescent Exam according to the Health Resources and Services Administration (HRSA) guidelines.

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

(B) Screenings:

1. Abdominal aortic aneurysm screening
2. Anxiety screening in adolescent and adult women, including those who are pregnant or postpartum
3. Asymptomatic bacteriuria screening
4. Breast cancer mammography screening
5. Behavioral/Social/Emotional Screening for newborn children to 21 years.
6. Cervical cancer and dysplasia screening including HPV screening
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, 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 women with a history of gestational diabetes who have not previously been diagnosed with type 2 diabetes mellitus.
10. Gestational diabetes and post-partum screening
11. Hepatitis B and Hepatitis C virus infection screening
12. Hematocrit or Hemoglobin screening in children
13. Hypertension (High blood pressure screening)
14. Lead Screening
15. Lipid disorders screening
16. Lung cancer screening with low-dose computed tomography including a counseling visit to discuss the screen in adults who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. One pack-year is equal to smoking one pack per day for one year, or two packs per day for half a year.
17. Newborn congenital hypothyroidism screening
18. Newborn hearing loss screening
19. Newborn metabolic/hemoglobin screening
20. Newborn sickle cell disease screening
21. Newborn Phenylketonuria screening
22. Pre-eclampsia screening with blood pressure measurements throughout pregnancy
23. Obesity screening
24. Osteoporosis screening
25. Pre-eclampsia screening with blood pressure measurements throughout pregnancy
26. Rh (D) incompatibility screening for pregnant women
27. Sexually transmitted infection screening such as chlamydia, gonorrhea, syphilis, HIV, screening
28. Sudden cardiac arrest and sudden cardiac death risk assessment in children 12-21
29. Type 2 diabetes mellitus screening
30. Tuberculin (TB) Testing
31. Urinary incontinence screening in women
32. Visual impairment in children screening

(C) 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. Unhealthy alcohol use and drug misuse assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse
3. Behavioral counseling interventions to promote healthy diet and physical activity for persons with cardiovascular disease.
4. Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children.
5. Counseling for midlife women with normal or overweight body mass index to maintain weight or limit weight gain to prevent obesity.
6. Offer pregnant persons effective behavioral counseling interventions aimed at promoting healthy weight gain and preventing excess gestational weight gain in pregnancy.
7. Tobacco use screening and tobacco-caused disease counseling and interventions, including FDA approved tobacco cessation prescription or over-the-counter medications by a licensed health care professional authorized to prescribe drugs for individuals who are not pregnant.
8. When prescribed by a licensed health care professional authorized to prescribe drugs:
   a) aspirin in the prevention of cardiovascular disease and preeclampsia in pregnant women and colorectal cancer.
   b) iron supplementation for children from 6 months to 12 months of age.
   c) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
   d) topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children
   e) folic acid supplementation for women planning or capable of pregnancy for the prevention of neural tube defects.
9. Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and referral for BRCA mutation testing
10. Sexually transmitted infections counseling
11. Discuss use of risk-reducing medications such as tamoxifen, raloxifene, or aromatase inhibitors, with women who are at increased risk of breast cancer and at low risk of adverse medication effects.
12. Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and counseling by a provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the post-partum period; breast milk storage supplies; and equipment and supplies as clinically indicated to support women and babies with breast feeding difficulties;, and the purchase of a breast pump. A hospital-grade electric breast pump, including any equipment that is required for pump functionality, is covered when Medically Necessary and prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.
13. All prescribed FDA-approved contraceptive methods for women with reproductive capacity, including but not limited to drugs, cervical caps, vaginal rings, continuous extended oral contraceptives and patches. This includes all FDA-approved cleared or granted contraceptive products that are determined by an individual's medical Provider to be medically appropriate. This includes contraceptives which require medical administration in a Physician's office, implanted devices and professional services to implant them, female sterilization procedures, follow-up and management of side effects, counseling for continued adherence, device removal and patient education and counseling. Over the counter FDA approved contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs. In addition, fertility awareness-based methods, including the lactation amenorrhea method, although less effective, is covered for women desiring an alternative method. A non-preferred contraceptive or drug will be covered at the preferred cost share level when Your physician determines a generic or preferred contraceptive drug or device is not medically appropriate.

14. Screening and counseling and other interventions, such as education, harm reduction strategies and referral to appropriate supportive services for interpersonal and domestic violence.
15. Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions.
16. Counseling of young adults, adolescents, children and parents of young children, about minimizing exposure to ultraviolet (UV) radiation for persons age 6 months to 24 years with fair skin types to reduce their risk of skin cancer. Counseling intervention for pregnant and postpartum persons who are at increased risk of perinatal depression.

(D) Disease Prevention

1. Immunizations as recommended by the Centers for Disease Control and HRSA.
2. Prophylactic gonorrhea medication for newborns to protect against gonococcal ophthalmia neonatorum.
3. Low to moderate dose statin drugs for the prevention of cardiovascular disease events and mortality when all the following criteria are met: 1) individuals are aged 40-75 years; 2) they have 1 or more cardiovascular risk factors; and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater.
4. Pre exposure prophylaxis (PrEP) with at least one drug providing effective antiretroviral therapy to persons who are at high risk of HIV acquisition as well as the following baseline and monitoring services:
    a. HIV testing – to confirm the absence of HIV infection before PrEP is started and testing for HIV every 3 months while PrEP is being taken
    b. Hepatitis B testing before PrEP is started.
    c. Hepatitis C testing before PrEP is started and periodically during treatment according to CDC guidelines.
    d. Creatinine testing and calculated estimated creatine clearance (eCrCl) or glomerular filtration rate (eGFR) is covered as follows:
        i. eCrCl or eGFR testing before starting PrEP to assess kidney function.
        ii. Creatinine and eCrCL or eGFR testing periodically consistent with CDC guidelines during treatment.
    e. Pregnancy testing for persons of childbearing potential before PrEP is started and periodically during treatment consistent with CDC guidelines.
    f. Sexually transmitted infection screening and counseling before PrEP is started and periodically during treatment consistent with CDC guidelines.
    g. Adherence counseling for assessment of behavior consistent with CDC guidelines.

Exclusions for Preventive Care

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

Note: The following services are not Covered Services under this Preventive Exams and Services benefit but may be Covered Services elsewhere in this General Benefits section:

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

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

For a complete list of current preventive services required under the Patient Protection Affordable Care Act, please call Customer Relations at 800-392-8649. You may also visit: www.healthcare.gov/center/regulations/prevention.html. Please note that for recommendations that have been in effect for less than one year, KPIC will have one year from the effective date to comply with the recommendations.

(E) Other Preventive Care

This Benefit section contains other Preventive Care not required by the Patient Protection Affordable Care Act. Those Preventive Care services are subject to the Deductible and coinsurance requirements unless otherwise stated. In the event of a duplication of preventative care benefits, duplicate benefits will not be paid, but the higher of the applicable benefits will apply.

The requirement that an Expense Incurred be for Medically Necessary Covered Services rendered to treat an Injury or Sickness will not apply to the following Covered Services:

1. routine nursery care and Physician services for a newborn while the mother is confined. Expenses Incurred for such services shall be considered separate from the mother's, and will be subject to the Deductible, Coinsurance, and Percentage Payable shown in the Schedule of Coverage.
2. well child care from birth through age 5. The care must be recommended by the attending Physician and be rendered at the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years and 5 years. Covered Services at each visit will include:
    a. physical examination;
    b. history;
    c. developmental assessment;
    d. anticipatory guidance;
    e. immunizations;
    f. laboratory tests;

    in keeping with prevailing medical standards. The above services shall not subject to the Deductible.
3. routine pediatric care ages 6 through 18 for health maintenance, including physical checkups and immunizations.
4. routine adult physical exams for health maintenance, including physical checkups, immunizations and other preventive medical services.
    a. Expenses Incurred for the following procedures:
    b. vasectomy; or tubal ligation.
5. Expenses Incurred for Covered Services received incident to elective abortions, including outpatient abortion drugs prescription by a Physician. Coverage is limited to two elective abortions while a while insured under the Group Policy.
6. treatment for pregnancy and childbirth.
7. The following services and items are covered as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition as described below, and only when prescribed for the purpose of preventing the chronic condition from becoming worse or preventing the development of a secondary condition:
    a. Hemoglobin A1C testing for individuals diagnosed with diabetes.
    b. Retinopathy Screening for individuals diagnosed with diabetes.
    c. Low Density Lipo-Protein testing for individuals diagnosed with heart disease.
    d. International Normalized Ratio (INR) testing for individuals diagnosed with liver disease or bleeding disorders.
    e. DME items:

i. Peak flow meters for individuals diagnosed with Asthma.
ii. Glucometers including lancets, strips, control solution and batteries for individuals diagnosed with Diabetes.

Benefits for Emergency Services or Urgent Care:

Benefits payable in connection with Emergency Services or Urgent Care may be payable by Health Plan under the Added Choice Service Agreement/Group Agreement. If so, they will not be covered under the Group Policy. "Emergency Services" are defined by Health Plan as medically necessary health services, including, but not limited to ambulance services and hospital services, that meet the prudent lay-person standard and were immediately required because of unforeseen illness or injury.

The prudent layperson standard is met when a medical condition manifests itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

“Urgent Care” is defined as initial care for a sudden Sickness or Injury that is required to prevent serious deterioration of the Member’s health.

Health Plan will make the determination if it will pay benefits under the Added Choice Service Agreement/Group Agreement.

Pregnancy Benefits:

Benefits will be payable for Covered Charges incurred in connection with pregnancy on the same basis as the treatment of an Injury or a Sickness. 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 96 hours following a Caesarian section. Maternity care, including Hospital admissions, require precertification. Please see the section of this Certificate entitled **Precertification Through the Medical Review Program** for complete details. In no case will KPIC require that a provider reduce the mother’s or child’s Hospital Confinement below the allowable minimums cited above.

GENERAL LIMITATIONS AND EXCLUSIONS

When a service is excluded, all services that are necessary or related to the excluded service are excluded. "Service" includes any treatment, therapeutic or diagnostic procedure, drug, facility, equipment or device. No payment will be made under any benefit of the Group Policy for Expenses Incurred for or in connection with the following, unless specifically stated otherwise in the Group Policy.

1. medical social services. This does not include those related to discharge planning in connection with: a) a covered Hospital Confinement; b) a covered Home Health Agency; or c) covered Hospice Care.
2. charges paid or payable by Health Plan.
3. charges in excess of the Maximum Allowable Charge.
4. weekend admission charges for non-Emergency Care services. This applies only to Friday through Sunday inclusive.
6. charges incurred for ambulance, emergency or urgent care that is covered by Health Plan.
7. confinement, treatment, services or supplies not Medically Necessary. This does not apply to preventive or other health care services specifically covered under the Group Policy that are not required to preserve the health of the Member.
8. confinement, treatment, services or supplies not recommended and approved by a Physician.
9. confinement, treatment, services or supplies received while not under the care and treatment of a Physician or other provider.
10. treatment which is not available in the United States.
11. charges for Injury or Sickness for which the Member is entitled to payment under any workers' compensation or similar law.
12. Injury or Sickness for which the law requires the Member to maintain alternative insurance, bonding, or third party coverage.
13. Injury or Sickness arising out of or in the course of past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.
14. Injury or Sickness contracted while on duty with any military, naval, or air force of any country or international organization.
15. treatment of infertility except as specified in the Benefits section.
16. treatment, services, or supplies provided by the Insured Employee's spouse; child or parent.
17. confinement, treatment, services or supplies received where care is provided at government expense. This does not apply if: a) there is a legal obligation for the Member to pay for such treatment or service in the absence of coverage; or b) payment is required by law.
18. dental care and dental x-rays, including but not limited to: dental services following accidental Injury to teeth; dental implants; dental appliances; orthodontia; and dental services associated with medical treatment, including surgery on the jawbone and radiation therapy, except as otherwise required to provide Orthodontic Services. This exclusion does not include visits for repairs or treatment of accidental injury to sound natural teeth when performed or rendered within 6 months following the accident.
19. cosmetic services, including plastic surgery or other services that: a) are indicated primarily to improve the Member's appearance; and b) will not result in significant improvement in physical function. This does not apply to services that: a) will correct significant disfigurement resulting from a non-congenital Injury or surgery; or b) are incidental to a covered mastectomy.
20. orthotic devices, except as specifically set forth as a Covered Service.
21. nonprescription drugs or medicines, vitamins, nutrients and food supplements, even if prescribed or administered by a Physician, except as a limited benefit as set forth under the Preventive Services provisions of the BENEFITS section.
22. sterilization reversals.
23. treatments, procedures, drugs or medicines which KPIC determines are experimental or investigational. This means that one or more of the following is true:
    a. the device, drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished.

b. reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase, I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard of treatment or diagnosis.
c. eligible evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, its efficacy, or its efficacy as compared with the standard of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

24. special education and related counseling or therapy; or care for learning deficiencies or behavioral problems. This applies whether or not associated with manifest mental illness or other disturbances. This exclusion will not apply to nutritional counseling for Covered Persons diagnosed with an eating disorder.
25. services or supplies rendered for treatment of obesity or for weight reduction. This includes any surgical procedures or reversal thereof.
26. treatment of craniomandibular and temporomandibular joint disorders.
27. confinement, treatment, services or supplies that are required; a) only by a court of law (except when Medically Necessary); or b) only for insurance, travel, employment, camp, government licensing, or similar purposes.
28. personal comfort items such as telephone, radio, television, or barber services.
29. 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.
30. care in an intermediate care facility. This is care for which a Physician determines the facilities and services of an acute care general Hospital or the Extended Care services of a Skilled Nursing Facility are not Medically Necessary.
31. routine foot care such as trimming of corns and calluses; or treatment of flat feet or partial dislocations in the feet.
32. confinement or treatment that is not completed in accordance with the attending Physician's orders, beginning on the date the orders are not followed. Confinement or treatment in accordance with the attending Physician's orders will be considered to be an eligible expense through the day prior to the date the orders are no longer being followed.
33. hearing therapy; or hearing aids.
34. private duty nursing.
35. acupuncture.
36. alternative medical services not accepted by standard allopathic medical practices including but not limited to hypnotherapy, behavior testing, sleep therapy, massage therapy, naturopathy, rest cure, aroma therapy, biofeedback or hypnotherapy.
37. health education, including but is not limited to: a) stress reduction; b) weight reduction; or d) the services of a dietitian.
38. living expenses or transportation except as provided under Covered Services.
39. eye exams for contact lenses for the correction of vision.
40. radial keratotomies or photo refractive keratotomies.
41. long term rehabilitation and maintenance therapies.
42. any state or local sales tax.
43. prosthetics, drugs, injectables or equipment related to the treatment of sexual dysfunction.
44. manual manipulation of the spine unless specifically covered under a separate Rider attached to the Group Policy.
45. outpatient drugs and medicines, other than chemotherapy, unless otherwise stated in this Certificate or specifically covered under a separate Rider attached to the Group Policy.

46. non-surgically implanted prosthetic devices and orthotics unless specifically covered under a separate Rider attached to the Group Policy.external prosthetics and braces, except as specifically set forth in this Certificate or covered under a separate Rider attached to the Group Policy.
47. eye glasses and contact lenses and their fitting, unless specifically covered under a separate Rider attached to the Group Policy.
48. convenience and luxury items.
49. experimental or research devices and appliances.
50. the cost of equipment and the collection, storage, and processing of sperm for artificial insemination or in-vitro fertilization.
51. in vitro fertilization for Members who have had voluntary surgically induced sterility.
52. conception by artificial means, other than artificial insemination and in-vitro fertilization, including but not limited to: ovum transplants; gamete intrafallopian transfer(GIFT) and zygote intrafallopian transfer (ZIFT).
53. cardiac rehabilitation programs.
54. transplants, including acquisition and/or donor costs.
55. take home supplies, including but not limited to disposable supplies such as bandages, gauze, tape, and antiseptics.
56. Services in connection with a Surrogacy Arrangement, except for otherwise-Covered Services provided to a Covered Person who is a surrogate.

GENERAL PROVISIONS

Time Effective

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

Incontestability

Any statement made by the Policyholder or an Insured Employee in applying for insurance under the Group Policy will be considered a representation and not a warranty. After the Group Policy has been in force for 2 years, its validity cannot be contested except for nonpayment of premiums or fraudulent misstatement as determined by a court of competent jurisdiction. After an insured Employee's insurance has been in force for 2 years during his or her lifetime, its validity cannot be contested due to misstatement other than a fraudulent misstatement. Only statements that are in writing and signed by the Insured Employee can be used in a contest.

Misstatement Of Age

If the age of any person insured under the Group Policy 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).

Exam And Autopsy

When reasonably necessary, KPIC, at its own expense, may require medical exams of the person for whom claim is made or perform an autopsy if not forbidden by law.

Money Payable

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

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and You or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, You must reimburse Us for Covered Services You receive related to conception, pregnancy, deliver, or postpartum care in connection with that arrangement ("Surrogacy Health Services").

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

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

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee associated with the arrangement
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Surrogacy Health Services the baby (or babies) receive, including names,

addresses, and telephone numbers for any health insurance that will cover Surrogacy Health Services that the baby (or babies) receive
- A signed copy of any contracts and other documents that explain the arrangement
- Any other information We request to satisfy Our rights

You must send this information to:

Optum
Kaiser Permanente-Northern California
P.O. BOX 36380
Louisville, KY 40233

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

If Your estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, Your estate, parent, guardian, or conservator shall be subject to Our liens and Our rights to the same extent as if You had asserted the claim against the third part. We may assign Our rights to enforce Our liens and other rights.

If You have questions about Your obligation under this provision, please contact Optum Customer Service at 1-800-288-1576.

COORDINATION OF BENEFITS

Application: This coordination of benefits provision applies when the Member 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.
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. **Nondependent/Dependent:** The benefits of the Plan which covers the person as an employee, member, 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 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 are actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a noncustodial 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 Employee:** The primary Plan is the Plan which covers the person as an employee 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 employee (or as that employee'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 an employee, member, or subscriber the longer time. The secondary Plan is the Plan which covered that person the shorter time.

The Effect Of No-Fault Auto Coverage: No-fault auto coverage is considered the primary Plan.

Effect Of Medicare: This plan will not pay secondary to Medicare coverage. Any member who is eligible for Medicare as Primary payor, whether or not enrolled, will not be eligible for coverage under this policy.

COORDINATION OF BENEFITS

Medicare is Primary for retirees age 65 and over, the dependent spouse of a retiree age 65 and over, employees of a group with less than 20 employees, and for totally disabled dependents covered by Social Security Disability.

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.

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

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

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

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

Definitions

Allowable Expenses: 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 member.

Coordination Of Benefits: the way benefits are payable under more than one medical or dental plan. Under coordination of benefits, the member will not receive more than the Allowable Expenses for a loss.
Plan: any of the following which provides medical or dental benefits or services:
1. this Group Policy.
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 trusteed plan or a union welfare plan.
6. an employer or multi-employer plan or employee benefit plan.
7. a government program.
8. insurance required or provided by statute, except for coverage under Health Reinsurance Association for Connecticut residents.
9. group, group-type and individual automobile "no fault" and traditional automobile "fault" type coverage.

Plan does not include any:
1. individual or family policies or contracts, except no-fault auto coverage.
2. public medical assistance programs.
3. group or group-type hospital indemnity benefits of $100 per day or less.
4. school accident-type coverages.

COORDINATION OF BENEFITS

For purposes of this Coordination of Benefit provision, Health Plan is not a separate plan and there shall be no Coordination of Benefits between the benefits provided by Health Plan under the Added Choice Service Agreement/Group Agreement and the benefits provided under this Group Policy. The benefits provided by a Plan include those that would have been provided if a claim had been duly made.

Primary Plan/Secondary Plan: 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 Tier Two and Tier Three of your Kaiser Permanente Point of Service health coverage plan. For Claims and Appeals decisions regarding benefit claims under Tier One of Your Kaiser Permanente Point of Service health coverage plan, please refer to Your Evidence of Coverage.

This section contains the following:

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

A. Definitions Related to Claims and Appeals Procedures

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

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

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

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

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

Proof of Loss means sufficient information to allow KPIC or Our Administrator to decide if a claim is payable under the terms of the Group Policy. The information needed to make this determination may

include but is not limited to: reports of investigations concerning fraud and misrepresentation, necessary consent forms, releases and assignments, medical records, information regarding provider services, information regarding medical necessity or other necessary information requested by KPIC.

Language and Translation Assistance

If We send You an Adverse Benefit Determination at an address in a county where a federally mandated threshold language applies, then Your notice of Adverse Benefit Determination will include a notice of language assistance (oral translation) in that threshold language. A threshold language applies to a county if at least, 10% of the population is literate only in the same federally mandated non-English language. You may request language assistance with Your Claim and/or Appeal by calling 1 800-392-8649.

SPANISH (Español): Para obtener asistencia en Español, llame al. 1- 800-966-5955 (TTY: 711).

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-966-9555 (TTY: 711).

CHINESE (中文): 如果需要中文的帮助,请拨打这个号码 1-800-966-5955 (TTY: 711).

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-966-5955 (TTY: 711).

Appoint a Representative

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

Reviewing Information Regarding Your Claim

If You want to review the information that We have collected regarding Your Claim, You may request, and We will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of Your Claim. To make a request, You should contact the Department address listed in the adverse determination notice you received.

B. The Claims Process

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

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

Please refer to the subsection **C. The Internal Appeals Process** provision under this section for a detailed explanation regarding the mandatory appeal rights. Likewise, Our Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding the mandatory appeal rights, including external review, that may be available to You.
In addition, there are separate Appeals procedures for Adverse Benefit Determinations due to a retroactive termination of coverage (rescission). Please refer to the subsection **6) Appeals of retroactive coverage termination (rescission)** provision under this section for a **detailed** explanation.

Questions about claims: For assistance with questions regarding claims filed with KPIC, please contact the number listed on the back of your -ID Card -, or You may write to the address to the Department address listed in the adverse determination notice you received.

CLAIMS AND APPEALS PROCEDURES

1) Post-service Claims

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

All Post Service Claims under this Policy will be administered by:

Kaiser Foundation Health Plan, Inc.
ATTN: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813
Phone: 1-800-238-5742
Fax: 866-240-9384

Here are the procedures for filing a Post-Service Claim:

- **Post-service Claim**

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

    Kaiser Foundation Health Plan, Inc.
    ATTN: Regional Appeals Office
    711 Kapiolani Blvd.
    Honolulu, HI 96813
    Phone: 1-800-238-5742
    Fax: 866-240-9384

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

We will review Your Claim, and if We have all the information We need We will send You a written decision within 30 days after We receive Your Claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond Our control delay Our decision, if We notify You within 30 days after We receive Your Claim. If We tell You We need more information, We will ask You for the information before the end of the initial 30 day decision period ends, and We will give You 45 days to send Us the information. We will make a decision within 15 days after We receive the first piece of information (including documents) We requested. We encourage You to send all the

- requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within 45 days after We send Our request, We will make a decision based on the information We have within 15 days following the end of the 45 day period.

- If We deny Your Claim (if We do not agree to provide or pay for extending the ongoing course of treatment), please refer to subsection **C. The Internal Appeals Process** provision under this section for a detailed provision regarding the mandatory appeal rights. Likewise, Our Adverse

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

Participating Provider Claims

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

CLAIMS AND APPEALS PROCEDURES

Notice of Claims

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

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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

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

Time for Payment of Benefits

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

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

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

Contested Claims

If KPIC is unable to pay Your claim after receiving proper Proof of Loss, KPIC will notify You of any contest to or denial of the claim within 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 **C. The Internal Appeals Process** provision under this section for specific provisions for filing an appeal for each type of Claim (Pre-service; Concurrent, Urgent and Post Service) in cases of any Adverse Benefit Determination.

Legal Action

No action may be brought more than three (3) years after the date written Proof of Loss is given to Us.

Time Limitations

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

Overpayment

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

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

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

2) Pre-Service Claims

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

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

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

- **Pre-Service Claim**
  - Send Your request in writing to Us that You want to make a Claim for Us to pre-certify a benefit or treatment You have not yet received. Your request and any related documents You give Us constitute Your Claim. You must either mail Your Claim to Us or, fax Your Claim to Us at

Permanente Advantage Appeals Department
8954 Rio San Diego Dr, 4th Floor, Ste 406
San Diego, CA 92108
Phone: 1-888-525-1553

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

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

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

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

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

3) Concurrent Care Claims

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

If We either (a) deny Your request to extend Your current authorized ongoing care (Your concurrent care Claim) or (b) inform You that authorized care that You are currently receiving is going to end early and You Appeal Our Adverse Benefit Determination at least 24 hours before Your ongoing course of covered treatment will end, then during the time that We are considering Your Appeal, You may continue to receive the authorized Covered Services. If You continue to receive these Covered Services while We consider Your Appeal and Your Appeal does not result in Our approval of Your concurrent care Claim, then You will have to pay for the services that We decide are not covered.

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

Here are the procedures for filing a Concurrent Care Claim.

- **Concurrent Care Claim**

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

    Permanente Advantage Appeals Department
    8954 Rio San Diego Dr, 4th Floor, Ste 406
    San Diego, CA 92108
    Phone: 1-888-525-1553

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

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

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

  - If We consider Your concurrent Claim on an urgent basis, We will notify You of Our decision orally or in writing as soon as Your clinical condition requires, but not later than 24 hours after We

received Your Appeal. If We notify You of Our decision orally, We will send You written confirmation within 3 days after receiving Your Claim.

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

C. The Internal Appeals Process

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

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

As a member of a group with health coverage insured by KPIC, Your internal review process includes a single mandatory level of appeal.

<u>One Level of Appeal</u>

If We deny Your Claim (Post Service, Pre-Service or Concurrent Claims), in whole or in part you have the right to request an Appeal of such decision. Our Adverse Benefit Determination notice will tell You why We denied Your claim and will include information regarding the mandatory appeal rights, including external review, that may be available to You.

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

Our decision of Your one level of appeal is the final decision and You may be deemed to have exhausted all Your internal appeal rights. If You disagree with Our decision, You may have the right to request an external review. For a detailed provision of the external review process, please refer to **D. External Review** under this section. You must either mail Your Appeal to Us, or fax Your Appeal to Us at:

Permanente Advantage Appeals Department
8954 Rio San Diego Dr, 4th Floor, Ste 406
San Diego, CA 92108
Phone: 1-888-525-1553

Providing Additional Information Regarding Your Claim

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

Kaiser Foundation Health Plan, Inc.
ATTN: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813
Phone: 1-800-238-5742
Fax: 1-866-240-9384

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

Kaiser Foundation Health Plan, Inc.
ATTN: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813
Phone: 1-800-238-5742
Fax: 1-866-240-9384

To arrange to give testimony by telephone, You should contact Kaiser Permanente Appeals Department at 1-877-847-7572.

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

Sharing Additional Information That We Collect

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

Time frame for Resolving Your Appeal

There are several types of Claims, and each has a time frame in resolving your Appeal.

- Post-Service Claims
- Pre-Service Claims (urgent and non-urgent)
- Concurrent Care Claims (urgent and non-urgent)

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

1) Post-Service Appeal

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

  For Medical Claims:

  Kaiser Foundation Health Plan, Inc.
  ATTN: Regional Appeals Office
  711 Kapiolani Blvd.
  Honolulu, HI 96813
  Phone: 1-800-238-5742
  Fax:1-866-240-9384

  For Optional Prescription Drug:

  Kaiser Foundation Health Plan, Inc.
  ATTN: Regional Appeals Office
  711 Kapiolani Blvd.
  Honolulu, HI 96813
  Phone: 1-800-238-5742
  Fax: 1-866-240-9384

- We will review your appeal as follows:
  - For Appeals involving medical claims - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 60 days from the date that we receive your request for our review unless we inform you otherwise in advance.
  - For Appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive your request for our review unless we inform you otherwise in advance.
- If We deny Your Appeal, Our Adverse Benefit Determination notice will tell You why We denied Your Appeal and will include information regarding any further process, including external review, that may be available to You.

2) Non-Urgent Pre-Service Appeal

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

  Permanente Advantage Appeals Department
  8954 Rio San Diego Dr, 4th Floor, Ste 406
  San Diego, CA 92108
  Phone: 1-888-525-1553

- We will review your appeal as follows:
  - For Appeals involving medical claims - Because you have not yet received the services or equipment that You requested, we will review Your Appeal and send you a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive your request for our review unless we inform you otherwise in advance.
  - For appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive your request for our review unless we inform you otherwise in advance.

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

3) Urgent Pre-Service Appeal

- Tell Us that You want to urgently Appeal Our Adverse Benefit Determination regarding Your pre-service Claim. Please include the following: (1) Your name and Medical Record Number, (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 Dr, 4th Floor, Ste 406
  San Diego, CA 92108
  Phone: 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 pre-service Claim qualifies as urgent. If You do not request simultaneous external review in Your Appeal, then You may be able to request external review after We make Our decision regarding Your Appeal (see **D. External Review** provision under this section), if Our internal appeal decision is not in Your favor.

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

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

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

4) Non-Urgent Concurrent Care Appeal

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

  Permanente Advantage Appeals Department
  8954 Rio San Diego Dr, 4th Floor, Ste 406
  San Diego, CA 92108
  Phone: 1-888-525-1553

- We will review your appeal as follows:

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

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

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

  The notification will include the following information:

  1. The specific reason or reasons for the Denial;
  2. Reference to the specific provisions in the Group Policy on which the Denial was based;
  3. Your right to obtain reasonable access to, and copies of, all documents, records and other information relevant to Your Claim for Benefits;
  4. An explanation of any procedures for You to follow to request a voluntary level of appeal, if applicable;
  5. A statement of Your rights under section 502(a) of ERISA following a Denial on Your appeal;
  6. If any internal rule, guideline, protocol or other similar criterion was relied upon in making the Denial, an offer to provide the rule, guideline, protocol or similar criterion;
  7. If the Denial was based upon Medical Necessity, experimental treatment or similar exclusions or limitations, an offer to provide the specific basis for the Denial.

5) Urgent Concurrent Care Appeal

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

  Permanente Advantage Appeals Department
  8954 Rio San Diego Dr, 4th Floor, Ste 406
  San Diego, CA 92108
  Phone: 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 Appeal qualifies as urgent. If You do not request simultaneous external review in Your Appeal, then You may be able to request external review after We make Our decision regarding Your Appeal (see **D. External Review** provision under this section), if Our internal appeal decision is not in Your favor.

- We will decide whether Your Appeal is urgent or non-urgent unless Your attending health care provider tells Us Your Appeal is urgent. If We determine that Your Appeal is not urgent, We will treat Your Appeal as non-urgent. Generally, an Appeal is urgent only if using the procedure for

non-urgent Appeals (a) could seriously jeopardize Your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of Your medical condition, subject You to severe pain that cannot be adequately managed without continuing Your course of covered treatment.

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

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

6) Appeals of retroactive coverage termination (rescission)

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

-

Kaiser Foundation Health Plan, Inc.
ATTN: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813
Phone: 1-800-238-5742
Fax: 866-240-9384

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. Your must send Your Appeal to:

Kaiser Foundation Health Plan, Inc.
ATTN: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813
Phone: 1-800-238-5742
Fax: 866-240-9384

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

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

D. External Review

If You are dissatisfied with Our final Adverse Benefit Determination, you may request an external appeal with an independent review organization (IRO). The process is available for decisions about medical judgment including one based on Our requirements for Medical Necessity, appropriateness, health care setting, level of care of effectiveness of a covered service, or Our determination that the requested care or service is experimental or investigational. If our Adverse Benefit Determination does not involve medical judgment or medical information, then Your request is not eligible for external review through the Hawaii state process.

An IRO is independent from Kaiser Permanente Insurance Company (KPIC) and has the authority to overturn Our denial of coverage or payment. The IRO that is responsible for conducting Your external appeal is based on Your KPIC plan.

Our Adverse Benefit Determination notice will contain information about the IRO that applies to You and instructions on filing an external appeal with the IRO. You may also be able to simultaneously request external review as permitted under federal law in connection with an expedited internal appeal.

If You are covered by a state or county employee plan, certain employee disability or a qualified church plan, or an employee health plan subject to ERISA (the Employee Retirement Income Security Act), then You may have the right to request external review by the Insurance Division of the State of Hawaii. You, Your appointed representative, or treating provider may file the request for review. Requests for external review must be submitted to the Insurance Division within one hundred thirty (130) days of your receipt of KPIC's final adverse decision. Requests for external review may be filed at the address below or by facsimile to 808-587-5379. You can reach the Health Insurance Branch of the Hawaii Insurance Division by calling 808-586-2804.

State of Hawaii DCCA
Insurance Division - External Appeals
335 Merchant St. 2nd Floor.
Honolulu, HI 96813

If the request is determined eligible for external review, the Insurance Division will assign the case to an IRO approved by the Insurance Division within three business days. Once assigned, the IRO will notify You and KPIC within five (5) business days that the external appeal has been opened for review. We must submit to the IRO within five (5) business days of Our receipt of the notice from the IRO all the documents and information that we considered during our internal review of Your request. You or your authorized representative may submit additional written information to the IRO within five (5) business days of Your receipt of the notice from the IRO.

The IRO will perform the external review by considering the information noted above and the terms of your KPIC as well as your medical records, any recommendations from your attending health care professional, additional consulting reports from appropriate health care professionals, the medical necessity statute defined under Hawaii law (Hawaii Revised Statutes chapter 432E-1), the most appropriate practice guidelines, any applicable clinical review criteria developed and used by KPIC, and the opinion of the IRO's clinical reviewer. The IRO will not be bound by our initial and appeal adverse decisions in deciding your external appeal. The IRO will send you its decision in writing within 45 days of receiving your external review request. In the event the IRO reverses our adverse decision, we must immediately cover or pay for the service or item that you are requesting.

Expedited External Review

Expedited review may be requested from the Insurance Division by You, Your authorized representative, or health care provider if processing under the standard timeframe would result in serious jeopardy to Your life or health, seriously affect Your ability to regain maximum function, or subject You to severe pain that cannot be adequately managed without the care or treatment You are requesting. Expedited review

may also be requested if Your appeal involves admission to a facility for health care services, the availability of care or a continued stay at a facility for health care services, or a health care service that You are receiving during an emergency visit before You are discharged from the facility where the emergency services are being obtained. If Your request qualifies for expedited processing at the time You receive our initial adverse benefit determination or file your internal appeal, You have the right to simultaneously request expedited review with the Insurance Division. The expedited process does not apply to services or items that You have already received.

If the request is determined eligible for expedited external review, the Insurance Division will immediately assign the case to an IRO approved by the Insurance Division and provide KPIC with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that We considered during Our internal review of Your request.

The IRO will perform the external review by considering the same types of information as noted earlier under the standard process. The IRO will not be bound by Our initial and appeal adverse decisions in deciding Your external expedited appeal. The IRO will notify You of its decision as expeditiously as Your medical condition or the circumstances require, but in no event more than 72 hours of its receipt of Your eligible expedited request. If its decision was provided verbally at first, then the IRO must send written confirmation within 48 hours of its verbal notice. In the event the IRO reverses Our adverse decision, We must immediately cover or pay for the service or item that You are requesting.

External review requests for experimental or investigational services or treatments
Additional procedures apply to a request involving an experimental or investigational service or treatment. You or Your authorized representative may make an oral request for expedited review if Your treating physician certifies in writing that the service or treatment You are requesting would be significantly less effective if it was not initiated promptly. This certification must be filed promptly with the Insurance Division following Your oral request for review. If You or Your authorized representative request expedited review in writing rather than orally, You must include Your treating physician's written certification with the written request. If Your request is determined eligible for expedited review, the Insurance Division must immediately assign the case to an IRO approved by the Insurance Division and provide KPIC with the name of the IRO. We must transmit to the IRO in an expeditious manner all the documents and information that We considered during our internal review of Your request.

Within three business days after being assigned to perform the external review, the IRO will select one or more clinical reviewers who are experts in the treatment of the condition and knowledgeable about the service or treatment that is the subject of the request. Each clinical reviewer must provide an opinion regarding whether the service or treatment should be covered. This opinion must be provided to the IRO orally or in writing as expeditiously as Your condition requires but in no event more than five calendar days after the reviewer was selected. If the opinion was provided orally, then the reviewer must provide a written report to the IRO within 48 hours following the date the oral opinion was provided. The IRO must provide You, Your authorized representative, and KPIC with its decision either orally or in writing within 48 hours after it receives the opinion. If its decision was provided orally, then the IRO must send its decision in writing within 48 hours of the oral notice. If a majority of the clinical reviewers recommend that the service or treatment should be covered, then the IRO must reverse KPIC's adverse decision. If a majority of the reviewers recommend that the service or treatment should not be covered, then the IRO will make a decision to uphold KPIC's adverse decision. If the reviewers are evenly split as to whether the service or treatment should be covered, then the IRO must obtain the opinion of another clinical reviewer. The processing timeframes are not extended if the IRO needs to obtain the opinion of an additional reviewer.

For non-expedited requests involving an experimental or investigational service or treatment that are determined eligible for external review, the Insurance Division has three business days after the eligibility decision was made to assign the case to an IRO approved by the Insurance Division and provide KPIC with the name of the IRO. We must submit to the IRO within five business days of Our receipt of the name of the IRO all the documents and information that We considered during Our internal review of Your request. You or Your authorized representative may submit additional written information to the IRO within five business days of Your receipt of the notice that Your case was assigned to an IRO. The IRO

must select one or more clinical reviewers within three business days after it was assigned to perform the external review. Each reviewer must provide its opinion to the IRO in writing within 20 days of the date the IRO was assigned to perform the review. The IRO must then provide its written decision to You, Your authorized representative, and KPIC within 20 days after the opinions were received. The IRO must decide to reverse or uphold KPIC's adverse decision in the same manner discussed earlier based on a majority of the clinical reviewers' recommendations.

Procedures applicable to all requests for external review

The IRO's decision is binding on You and KPIC except for any additional remedies that may be available to You or KPIC under applicable federal or state law. You or Your authorized representative may not file a subsequent request for external review involving the same adverse decision for which You already received an external decision.

When filing any request for external review, You must include a copy of KPIC's final ABD with Your request, unless You are seeking simultaneous expedited external review or we have substantially failed to comply with Our internal appeals procedure. You or Your authorized representative will also be required to authorize the release of Your medical records that need to be reviewed for the external appeal, as well as provide written disclosure that permits the Insurance Division to perform a conflict of interest evaluation as part of the selection process for an appropriate IRO. You can find forms that meet each requirement on Our website at kp.org or by calling our Customer Service Center at 808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor Islands). Lastly, a $15 filing fee must be included with the external appeal request. The filing fee will be refunded if KPIC's adverse determination is reversed through the external review or the Insurance Division waives the fee because it poses an undue hardship on You. Your request will be considered incomplete and the external review delayed if You do not to submit all the required information with the request.

When You submit a request for external review, the Insurance Division will inform Kaiser Permanente about Your request. We will be responsible for notifying the Insurance Division and You or Your authorized representative in writing whether the request is complete and eligible for external review. If We believe Your request is not eligible for external review, You may file an appeal with the Insurance Division. Our notice of ineligibility will include information on requesting this appeal.

You must exhaust Kaiser Permanente's internal claims and appeals process before You may request external review, except 1) when external review is permitted to occur simultaneously for requests that qualify for expedited review, or 2) we have failed to comply with applicable claims and appeals requirements under federal or state law. You may have certain additional rights if You remain dissatisfied after You have exhausted our internal claims and appeals procedures and external review. If You are enrolled through a plan that is subject to ERISA, you may file a civil action under section 502(a) of ERISA. 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 1-866-444-3272. 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.

Different procedures apply to the following plans: Kaiser Permanente Senior Advantage, Kaiser Permanente Medicare Cost, Kaiser Permanente QUEST, the Federal Employees Health Benefits Program, and Kaiser Permanente Individuals and Families. Members on these plans should consult their respective Evidence of Coverage, handbook, or brochure for a description of the independent external review procedures that apply to them.

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

BENEFIT RIDER

This Rider is issued and made part of the Group Policy/Certificate to which it is attached. This Rider is issued in consideration of the application and receipt of any applicable premium payments. By attachment of this Rider, the Group Policy/Certificate is amended as follows:

OUTPATIENT PRESCRIPTION DRUGS

Subject to all provisions of the Policy, benefits will be payable for Expenses Incurred for the Covered Services shown below. The Percentage Payable for such Expenses Incurred will be 80 percent of the Maximum Allowable Charge. In no event, however, will the Member's per prescription coinsurance be less than $3 for each Generic Maintenance drug; $15 for each Generic drug; $50 for Brand-name and $200 for Specialty drug. Benefits payable for outpatient prescription drugs are limited to a 30-day supply per prescription or refill. Charges for outpatient prescription drugs are not subject to the Calendar Year Deductible. Coinsurance amounts paid in connection with outpatient prescription drugs are subject to, and contribute toward, satisfaction of the Out-of-Pocket Maximum.

Definitions:

"Generic drugs" are drugs approved by the U.S. Food and Drug Administration (FDA), have the same active ingredient of the brand-name drugs, are produced and sold under their generic names after the patent of the brand-name drug expires, and are on the KPIC formulary.

"Maintenance drugs" are those which are used to treat chronic conditions, such as asthma, hypertension, diabetes, hyperlipidemia, cardiovascular disease, and mental health.

"Generic Maintenance drugs" are specific generic drugs used for the treatment of chronic conditions. However, not all generic drugs used for the treatment of chronic conditions are considered generic "Maintenance" drugs.

"Brand-name drugs" are drugs approved by the U.S. Food and Drug Administration (FDA), produced and sold under the original manufacturer's brand name, and listed on the KPIC formulary.

"Specialty drugs" are very high-cost drugs approved by the U.S. Food and Drug Administration (FDA) that are on the KPIC formulary.

Covered Services:

The following when filled at designated pharmacies:

1. Formulary outpatient drugs and medicines, limited to those lawfully obtainable only upon a Physician's written prescription. A pharmacy may substitute a chemical or Generic equivalent to a Brand-name drug, unless prohibited by the Physician. If a Member requests a Brand-name form of the prescribed or authorized drug, the Member must pay any difference in price between the chemical or Generic equivalent drug prescribed or authorized by the Physician and the requested Brand-name form. A copy of the KPIC formulary list is available upon request from KPIC's Administrator.

2. Insulin.
3. Diabetes supplies.
4. Certain drugs that do not require a prescription, as listed on the KPIC formulary.
5. Birth control pills and devices.

Exclusions:

In addition to the General Limitations and Exclusions of the Policy/Certificate, the following additional exclusions apply to this Benefit Rider. Benefits will not be payable for:

1. Drugs for which a prescription is not required by law including condoms, contraceptive foams, creams or other non-prescription substances used individually or in conjunction with any other prescribed drug or device, except insulin is covered. This exclusion does not apply to tobacco cessation drugs and products covered under the Preventive Services section of the Policy/Certificate.
2. Drugs and their associated dosage strengths and forms in the same therapeutic category as a non-prescription drug that have the same indication as the non-prescription drug. Prescribed drugs that are necessary for or associated with services excluded or not covered under the Policy/Certificate.
3. Drugs not included on the KPIC formulary, unless a non-formulary drug has been specifically prescribed and authorized by the licensed Physician.
4. Drugs to shorten the duration of the common cold.
5. Drugs related to enhancing athletic performance (including weight training and body building).
6. Any packaging other than the dispensing pharmacy's standard packaging.
7. Replacement of lost, stolen or damaged drugs.
8. Travel immunizations.
9. Prescribed drugs that are used to treat erectile dysfunction.
10. Drugs and medicines obtained from a non-designated pharmacy.
11. Medical supplies such as dressings and antiseptics.
12. Reusable devices such as blood sugar testing meters and finger stick lancet cartridges.
13. Drugs and medicines that are necessary for services excluded under the Policy/Certificate.

UTILIZATION MANAGEMENT PROGRAM

Quantity Limits

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

Age Limits

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

Step Therapy Process

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

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

Prior Authorization

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

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

If a drug requires prior authorization, Your prescribing Physician or authorized provider must work with Us to authorize the drug for Your use. Drugs requiring prior authorization have specific clinical criteria that You must meet in order for the prescription to be eligible for coverage. Refer to the formulary for a complete list of medications requiring prior authorization. The most current formulary can be obtained by visiting https://choiceproducts-hawaii.kaiserpermanente.org/added-choice/member-information/pharmacy/#option2. If you have questions about prior authorization or about the outpatient prescription drugs covered under Your plan, You can call 1-800-788-2949 or 711 (TTY), 24 hours a day, 7 days a week (closed holidays).

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

1. You, Your prescribing Physician, or authorized provider can begin the prior authorization process by calling 1-800-788-2949;
2. Following completion of the prior authorization intake process as set forth in item 1 above, We will notify the requestor within 72 hours for non-urgent requests and within 24 hours when exigent circumstances exist, that:
    a. The request is approved; or
    b. The request is disapproved due to:
        i. Not Medically Necessary; or

ii. Missing material information required to determine Medical Necessity; or
iii. The patient is no longer eligible for coverage.

3. If We fail to respond within 72 hours for non-urgent requests or within 24 hours when exigent circumstances exist, the request shall be deemed to have been approved.
4. In the event the prior authorization request is disapproved:
   a. The notice of disapproval will contain an accurate and clear written explanation of the specific reasons for disapproving the request.
   b. If the disapproval is due to missing material information required to determine Medical Necessity, the notice of disapproval will contain an accurate and clear explanation that specifically identifies the missing material information.
5. The prior authorization request shall be deemed approved if the notice of disapproval is not sent to the requestor within 72 hours for non-urgent request or within 24 hours when exigent circumstances exist.
6. Notices required to be sent the requestor shall be delivered by Us in the same manner the request was submitted to Us or by any other mutually agreeable accessible method of notification.

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

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

"Authorized 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 prescribing Physician or authorized provider may request an exception to the prior authorization and step therapy processes described above if You are already being treated for a medical condition and are currently under medication of a drug subject to prior authorization or step therapy, provided the drug is appropriately prescribed and is considered safe and effective for your condition. However, further prior authorization may be required for the continued coverage of a outpatient prescription drug prescribed under a prior insurance policy or health insurance plan.

To request a waiver please call MedImpact at: 1-800-788-2949

If Your request for an exception to the prior authorization or step therapy processes 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 of Your Certificate of Insurance for details regarding the grievance and appeals process and the **YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW** section for Your right to an Independent Medical Review.

This Rider does not change, waive or extend any part of the Group Policy/Certificate other than as set forth above. This Rider is subject to all the provisions of the Group Policy/Certificate that are not in conflict with this Rider. In the event this Rider creates a duplication of benefits, duplicate benefits will not be paid, but the higher of the applicable benefits will apply. This Rider is effective on the later of the Group Policy Effective Date or the Group Policy Anniversary Date corresponding with

this Rider's issuance. This Rider terminates on the same date as the Group Policy, unless otherwise terminated upon renewal of the Group Policy.

Charles P. Bevilacqua
President

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

NO SURPRISES ACT AMENDMENT

This Amendment issued and made part of the Group Policy/Certificate to which it is attached and becomes effective on January 1, 2022. By attachment of this Amendment, the Group Policy/Certificate to which it is attached is amended is amended as described below.

I. The Definitions section is amended by the addition of the following terms that are being added to the and apply only to the provisions in this Amendment:

Air Ambulance Service means medical transport by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605, for patients.

Ancillary Services means:

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

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

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

1. is undergoing a course of treatment for a serious and complex condition from the provider or facility;
2. is undergoing a course of institutional or inpatient care from the provider or facility;
3. is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

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

Emergency Medical Condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd, or as would be required under such section if such section applied to an Independent Freestanding Emergency Department) that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate 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 section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished); and
3. Except as provided in item 4. below, Covered Services that are furnished by a Non-Participating Provider or nonparticipating Emergency Facility after the individual is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the services described in item 1. above are furnished.
4. The Covered Services described in item 3. above are not included as Emergency Services if all of the following conditions are met:

    a. The attending emergency physician or treating provider determines that the individual is able to travel using nonmedical transportation or non-emergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into account the individual's medical condition;
    b. The provider or facility furnishing such additional items and services satisfies the notice and consent criteria of 45 C.F.R § 149.420(c) through (g) with respect to such items and services, provided that the written notice additionally satisfies items 4.b.i. and ii. below, as applicable;

        i. In the case of a Participating Emergency Facility and a Non-Participating Provider, the written notice must also include a list of any Participating providers at the facility who are able to furnish such items and services involved and notification that the participant, beneficiary, or Member may be referred, at their option, to such a Participating Provider.

        ii. In the case of a Non-Participating Emergency Facility, the written notice must include the good faith estimated amount that the individual may be charged for items or services furnished by the Non-Participating Emergency Facility or by Non-Participating Providers with respect to the visit at such facility (including any item or

service that is reasonably expected to be furnished by the Non-Participating Emergency Facility or Non-Participating Providers in conjunction with such items or services);

c. The individual (or an Authorized Representative of such individual) is in a condition to receive the information described in item b. above, as determined by the attending emergency physician or treating provider using appropriate medical judgment, and to provide informed consent in accordance with applicable State law; and

d. The Covered Services are not rendered by an on-call physician or a hospital-based physician who has obtained an assignment of benefits from the Covered Person.

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.

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

Non-Participating Provider means a physician or other health care provider that has not contracted directly with Us or an entity contracting on behalf of Us to provide health care services to Our Members.

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

Out-of-Network Rate means, with respect to an item or service furnished by a Non-Participating Provider, Non-Participating Emergency Facility, or Non-Participating Provider of Air Ambulance Services:

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

Participating Emergency Facility means any Emergency Facility that has contracted directly with Us or an entity contracting on behalf of Us to provide health care services to Our Members. A single case agreement between an Emergency Facility and Us that is used to address unique

situations in which a Covered Person requires services that typically occur out-of-network constitutes a contractual relationship for purposes of this definition and is limited to the parties to the agreement.

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

Participating Provider means a physician or other health care provider that has contracted directly with Us or an entity contracting on behalf of Us to provide health care services to Our Members.

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

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

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

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

Stabilize with respect to an Emergency Medical Condition, means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability,

that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

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

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

II. The Benefits section is amended by the addition of the following provisions:

EMERGENCY SERVICES

Any provision of the contract that provides benefits with respect to services in an emergency department of a hospital or with respect to Emergency Services in an Independent Freestanding Emergency Department, is amended to provide Emergency Services:

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

COST-SHARING REQUIREMENTS, PAYMENT AND BALANCE BILLING PROTECTIONS FOR EMERGENCY SERVICES

1. If any copayment amount, coinsurance percentage, or other cost-sharing requirement described in the contract for Emergency Services is different for a service received from a Participating Provider or Participating Emergency Facility than for a service received from a Non-Participating Provider or Non-Participating Emergency Facility, the copayment amount, coinsurance percentage, and/or other cost-sharing requirement for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility is amended to be the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for Emergency Services provided by a participating provider or participating Emergency Facility;

2. If the contract has separate in-network and out-of-network deductibles or separate in- network and out-of-network out-of-pocket maximums, the contract is amended to provide that any cost-sharing payments made with respect to Emergency Services provided by a Non-Participating Provider or a nonparticipating Emergency Facility will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;
3. The contract is amended to provide that if Emergency Services are provided by a Non-Participating Provider or Nonparticipating Emergency Facility, any cost-sharing requirement will be calculated based on the recognized amount;
4. If Emergency Services are provided by a Non-Participating Provider or Non-Participating Emergency Facility, We will make payment for the covered Emergency Services directly to the Non-Participating Provider or Non-Participating Emergency Facility. The payment amount will be equal to the amount by which the out-of- network rate exceeds the cost-sharing amount for the services; and
5. Any provisions of the contract that describe the Member's responsibility for charges for Emergency Services furnished by Non-Participating Providers or Non-Participating Emergency Facilities are amended to provide that the Member will not be liable for an amount that exceeds the Member's cost-sharing requirement under this Amendment.

COST-SHARING REQUIREMENTS, PAYMENTS AND BALANCE BILLING PROTECTIONS FOR NON-EMERGENCY SERVICES PERFORMED BY NON-PARTICIPATING PROVIDERS AT PARTICIPATING FACILITIES, INCLUDING ANCILLARY SERVICES FOR UNFORSEEN URGENT MEDICAL NEEDS

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

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such items and services furnished by a Non-Participating Provider with respect to a visit in a participating facility is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for the items and services when provided by a participating provider;

2. Any cost-sharing requirement for the items and services will be calculated based on the recognized amount;

3. Any cost-sharing payments made with respect to the items and services will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;

4. We will make payment for the items and services directly to the Non-Participating Provider. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for the items and services; and

5. Any provisions of the contract that describe the Member's responsibility for charges for such items or services that exceed Our payment are amended to provide that the Member will not be liable for an amount that exceeds the Member's cost- sharing requirement under this Amendment.

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

1. Covered Services rendered by an on-call physician or a hospital-based physician who has obtained an assignment of benefits from the Member;

2. Ancillary Services; and

3. items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-Participating Provider satisfied the notice and consent criteria;

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

COST-SHARING REQUIREMENTS, PAYMENTS AND BALANCE BILLING PROTECTIONS FOR NON-PARTICIPATING PROVIDERS OF AIR AMBULANCE SERVICES

Any provision of the contract that provides benefits with respect to Air Ambulance Services is amended to provide the following when services are received from a Non-Participating Provider of Air Ambulance Services:

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for the Air Ambulance Service is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for Air Ambulance Services when provided by a participating provider of ambulance services;

2. Any cost-sharing requirement will be calculated based on the lesser of the Qualifying Payment Amount or the billed amount for the services;

3. Any cost-sharing payments made with respect to the Air Ambulance Service will be counted toward any applicable in-network deductible and in-network out-of-pocket maximum;

4. We will make payment for the Air Ambulance Services directly to the Non-Participating Provider of ambulance services. The payment amount will be equal to the amount by which the out-of-network rate exceeds the cost-sharing amount for Air Ambulance Services; and

5. Any provisions of the contract that describe the Member's responsibility for charges for covered Air Ambulance Services furnished by Non-Participating Providers are amended to provide that the Member will not be liable for an amount that exceeds the Member's cost- sharing requirement under this Amendment.

COST-SHARING AND BALANCE BILLING PROTECTIONS FOR SERVICES PROVIDED BASED ON RELIANCE ON INCORRECT NETWORK INFORMAITON

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

1. The copayment amount, coinsurance percentage, and/or other cost-sharing requirement for such item or service furnished by a Non-Participating Provider is the same as the copayment amount, coinsurance percentage, and/or other cost-sharing requirement listed in the contract for the item or service when provided by a participating provider; and

2. Any cost-sharing payments made with respect to the item or service will be counted toward

any applicable in-network deductible and in-network out-of-pocket maximum.

3. The Member will not be liable for an amount that exceeds the cost-sharing that would have applied to the Member if the provider was a participating provider.

CONTINUITY OF CARE

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

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

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

This Amendment does not change, waive, or extend any part of the Group Policy/Certificate other than as set forth above. This Amendment is subject to all the provisions of the Group Policy/Certificate that are not in conflict with this Amendment. In the event this Amendment creates a duplication of benefits, duplicate benefits will not be paid, but the higher of the applicable benefits will apply. This Amendment shall terminate on the same date as the Group Policy/Certificate to which it is attached.

Charles P. Bevilacqua
President

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

CIGNA PPO PROVIDER INTEGRATION AMENDMENT RIDER

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

The following provisions are in lieu of and replace any similar provisions in the above Certificates.

I. The CONTRACTED PROVIDER CARE/NON-CONTRACTED PROVIDER CARE section is hereby amended and replaced in its entirety with the following:

CONTRACTED PROVDER CARE/NON-CONTRACTED PROVDER CARE

PLEASE READ THE FOLLOWING INFORMATION. IT WILL HELP YOU UNDERSTAND HOW THE PROVIDER YOU SELECT CAN AFFECT THE DOLLAR AMOUNT YOU MUST PAY IN CONNECTION WITH RECEIVING COVERED SERVICES.

This section describes your access to your Out-of-Network Coverage including verification of current status of Contracted Providers and information on Contracted Provider directory.

KPIC pays for Covered Services and supplies under the Group Policy from either a Contracted Provider or Non-Contracted Provider. A Contracted Provider is a Hospital, Skilled Nursing Facility or any other medical or health related provider who has contracted with KPIC for the purpose of reducing health care costs by negotiating fees. A Non- Contracted Provider is a Hospital, Skilled Nursing Facility or any other medical or health related provider who has not contracted with KPIC to support the Added Choice product.

Contracted Providers within the Hawaii Added Choice Service Area

A list of Contracted Providers in the Added Choice Service Area will be given to you at the time your coverage becomes effective. Any changes to this list will be provided not less than annually. You may contact Member Services during regular business hours to receive current information on these providers.

Contracted Providers in the states of CA, CO, GA, MD, OR, VA, WA and the District of Columbia (hereafter referred to as KP States).

When a Member receives Covered Services in KP States, please refer to the Added Choice Service Agreement/ Group Agreement.

Contracted Providers outside the Hawaii Added Choice Service Area and the KP States

CIGNA INTEGRATION AMENDMENT RIDER

To verify the current participation status of a Contracted Provider, please call the toll-free number listed in the [Participating Provider directory.] You may visit KPIC's Contracted Provider available to you at : [https://any provider directory] for providers for all other states and [https://outside of the KP states.]. Additionally, a current printed listing of KPIC's Contracted Provider 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]

When a Member receives Covered Services, KPIC will pay, after satisfaction of the applicable calendar year deductible and Coinsurance, the Percentage Payable of the Maximum Allowable Charge. The Maximum Allowable Charge is the lesser of: 1) The Usual and Customary Charge; 2) the Negotiated Rate; or 3) the actual billed charge. Please refer to the Definitions section for a further explanation of the Maximum Allowable Charge.

When receiving Covered Services from a Contracted Provider, the Member is typically only responsible for the deductible and Coinsurance. If, however a Non-Contracted Provider is utilized, the Member is, except otherwise required by state and or federal law, responsible for the difference between the Maximum Allowable Charge and the amount the Non-Contracted-Provider actually charged, in addition to any applicable deductible and Coinsurance amounts due under the Group Policy.

II. The PRECERTIFICATION section is hereby amended by adding the following provision at the end of the Failure To Comply With The Precertification Procedures sub-section:

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.

This Rider does not change, waive or extend any part of the Group Policy/Certificate other than as set forth above. This Rider is subject to all the provisions of the Group Policy/Certificate that are not in conflict with this Rider. In the event this Rider creates a duplication of benefits, duplicate benefits will not be paid, but the higher of the applicable benefits will apply. This Rider is effective on the same date as the Group Policy to which it is attached, unless a different date is shown above. This Rider terminates on the same date as the Group Policy to which it is attached.

Chuck Bevilacqua
President

NONDISCRIMINATION NOTICE

Kaiser Permanente Insurance Company (KPIC) complies with applicable federal civil rights law and does not discriminate on the basis of race, color, national origin, age, disability, or sex. KPIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-238-5742** (TTY: **711**)

If you believe that Kaiser Permanente Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail or phone at: KPIC Civil Rights Coordinator, Grievance 1557, 8954 Rio San Diego Dr, 4th Floor, Ste 406 San Diego, CA 92108, telephone number 1-888-529-1533.

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

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-238-5742** (TTY: **711**).

Cebuano (Bisaya) ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad.
Tawag sa **1-800-238-5742** (TTY: **711**).

中文 **(Chinese)** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-238-5742**（TTY：**711**）。

Chuuk (Chukese) MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo.
Kori **1-800-238-5742** (TTY: **711**).

ʻŌlelo Hawaiʻi (Hawaiian) E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo Hawaiʻi, hiki iā ʻoe ke loaʻa i ke kōkua manuahi. E kelepona i ka helu **1-800-238-5742** (TTY: **711**).

Iloko (Ilocano) PAKDAAR: No agsasaoka iti Ilokano, dagiti awan bayadna a serbisio a para iti beddeng ti lengguahe ket sidadaan para kenka.
Awagan ti **1-800-238-5742** (TTY: **711**)

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-238-5742**（TTY: **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로이용하실 수 있습니다. **1-800-238-5742** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການ ບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-238-5742** (TTY: **711**).

Kajin Majōḷ (Marshallese) LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk **1-800-238-5742** (TTY: **711**).

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti’go Diné Bizaad, saad bee áká’ánída’áwo’dęę’, t’áá jiik’eh, éí ná hól ǫ́, koj į’ hódíílnih **1-800-238-5742** (TTY: **711**).

Lokaiahn Pohnpei (Pohnpeian) MEHN KAIR: Ma komw kin lokiaiahn Pohnpei, wasahn sawas en palien lokaia kak sawas ni sohte isais.
Koahl nempe **1-800-238-5742** (TTY: **711**).

Faa-Samoa (Samoan) MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoani, e fai fua e leai se totogi, mo oe, Telefoni mai: **1-800-238-5742** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-238-5742** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-238-5742** (TTY: **711**).

Lea Faka-Tonga (Tongan) FAKATOKANGA’I: Kapau ‘oku ke Lea Faka-Tonga, ko e kau tokoni fakatonu lea ‘oku nau fai atu ha tokoni ta’etotongi, pea teke lava ‘o ma’u ia. Telefoni mai **1-800-238-5742** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-238-5742** (TTY: **711**).