guide to
YOUR BENEFITS AND SERVICES

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YOUR GROUP AGREEMENT

This plan has Excellent Accreditation from the NCQA.
See 2015 NCQA Guide for more information on Accreditation.

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

EOC-COVER (1/05)

Wrap

KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic, States, Inc.
2101 East Jefferson Street, Rockville, Maryland 20853

GROUP AGREEMENT
FACE SHEET

INTRODUCTION: This Group Agreement consisting of the Group Agreement and Group Evidence of Coverage as supplemented by this Face Sheet, has been entered into between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., (hereinafter "Health Plan"), and the organization (hereinafter "Group.")

GROUP: LITHOGR & PHOTO/LOCAL 285 (3TP)

GROUP NO.: 005238–0050

COVERAGE: KGT / ASN / X / ZBC / LOH / RZ / ZBC / BO /

AGREEMENT EFFECTIVE DATE: 03/01/2015

DEPENDENT LIMITING AGE (S): 26 / 26

OPEN ENROLLMENT PERIOD: Applications made during the Open Enrollment Period from 02/01 to 02/28 provide coverage effective 03/01/2015.

RIDERS: **Prescription Drug**
Extended Infertility Services

MONTHLY DUES:

1. Base Dues (For non-Medicare Subscribers and TEFRA "Working Aged" Subscribers with Medicare)

COMPOSITE	$1,154.24

ADDITIONAL CHARGE: For non-TEFRA eligible Members age 65 or older who are not entitled to benefits under Medicare, or entitled to benefits under Medicare but have not assigned such benefits to Health Plan. The following additional charge shall be added to the Base Dues per member. $228.69

The Group Agreement, Group Evidence of Coverage and Face Sheet are executed at the Administrative Offices of Health Plan located in Rockville, Maryland, to take effect as of 03/01/2015.

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

By: _____

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

Group

_____

Authorized Group Representative

Please return a signed copy of this Face Sheet to the Health Plan and retain one copy for your records. Any payment made by Group of amounts owed to Health Plan in accord with the Group Agreement will be deemed to constitute Group's acceptance of this Agreement.

DC-GRP-HMO-FACE(03/10)

KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic, States, Inc.
2101 East Jefferson Street, Rockville, Maryland 20853

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Mark Ruszczyk
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Group

_____

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DC-GRP-HMO-FACE(03/10)

TABLE OF CONTENTS

Introduction

This Group Agreement (Agreement), including the Evidence of Coverage (EOC), all of which are incorporated herein by reference, constitutes the contract between the Group and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan).

Health Plan is responsible for fulfilling its obligations under this Agreement with respect to itself and its product(s) described in the EOC.

Pursuant to this Agreement, Health Plan will provide covered Services and items to Members in accord with the EOC.

Group acknowledges acceptance of this Agreement by signing the Face Sheet and returning it to Health Plan. If Group does not return it to Health Plan, Group will be deemed as having accepted this Agreement if Group pays Health Plan any amount toward Premiums or enrolls a person under this Agreement.

SECTION 1 - Term of Agreement

This Agreement is effective from the date specified on the Face Sheet for 12 consecutive months, unless terminated as set forth in the "Termination of Agreement" section.

Unless this Agreement terminates pursuant to the "Termination of Agreement" section, Health Plan will either extend the term of this Agreement pursuant to the "Amendment of Agreement" section, or offer Group a new agreement to become effective immediately after termination of this Agreement.

Except as expressively provided in the EOC, all rights to benefits under this Agreement end at 11:59 p.m. Eastern Time on the termination date.

SECTION 2 - Amendment of Agreement

Upon 45 days prior written notice to Group, Health Plan may amend this Agreement with regard to Premiums, benefits, limitations, exclusions, or conditions, to be effective on the Anniversary Date.

In addition, Health Plan may, subject to government approval, amend this Agreement at any time by giving 45 days prior written notice to Group in order to (a) comply with applicable law, (b) reduce or expand Health Plan Service Area, or (c) increase any benefits of any Medicare product approved by HCFA, if applicable to this Agreement.

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of non-acceptance at least 15 days before the effective date of the amendment, in which event this Agreement terminates the date before the effective date of the amendment.

SECTION 3 - Termination of Agreement

This Agreement will terminate under any of the conditions listed below.

Within 5 business days of issuing written notice to Group of termination, Health Plan will mail to each Subscriber a legible copy of the notice.

Termination on Notice
Group may terminate this Agreement effective the day before any Anniversary Date by giving at least 90 days prior written notice to Health Plan.

Health Plan will extend benefits for covered Services to Members, with premium, as defined in the "Extension of Benefits" section of the EOC.

Termination for Non-Payment of Premium
Health Plan may terminate this Agreement for non-payment of Premium. Upon nonpayment of Premium, Health Plan will notify the group of the past-due amount and the effective date of termination, which will be 15 days from the date of the written notice.

The 15 days from the written notice by Health Plan to the termination date will constitute a grace period. This Agreement will remain in full force and effect throughout the grace period. If Health Plan receives full payment within the grace period, this Agreement will continue in effect according to the terms and conditions in the Agreement.

If Health Plan does not receive full payment by the end of the grace period, this Agreement will be terminated without further extension or consideration. Group will be liable for all unpaid amounts due through the date of termination.

Termination for Fraud, Intentionally Furnishing Incorrect or Incomplete Information, Violation of Contribution or Participation Requirements
If Group fails to (a) adhere to Health Plan's contribution or participation requirements, including those listed in the "Eligibility and Enrollment of Members" section, or (b) performs an act that constitutes fraud or intentional misrepresentation of material information to Health Plan under the terms of coverage, Health Plan will terminate this Agreement with 31 days prior written notice to Group.

Termination for Movement Outside the Service Area
Health Plan may terminate this Agreement upon 31-days prior written notice to Group if no eligible person lives, resides, or works in Health Plan's Service Area as described in the EOC.

Discontinuance of Product or All Products within a Market
Health Plan may terminate a particular product or all products offered in a small or large group market as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If Health Plan discontinues offering a particular product, Health Plan may terminate this Agreement upon 90 days written notice prior to the date of nonrenewal to each affected policyholder, plan sponsor, participant and beneficiary.

Health Plan shall offer Group another product then offered to groups in its respective market. Health Plan shall act uniformly without regard to the claims experience of any affected plan sponsor, or any health status-related factor of any affected individual.

Health status-related factor means a factor related to (i) health status; (ii) medical condition; (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information; (vii) evidence of insurability including conditions arising out of acts of domestic violence; or (viii) disability.

If Health Plan discontinues offering all products to small and/or large group markets, Health Plan may terminate this Agreement upon 180 days written notice to Group. And, upon at least 30 working days before that notice shall give notice, to the Commissioner, and, may not write new business for groups in the state for a 5-year period beginning on the date of notice to the commissioner, and, no other product will be offered to Group. For purposes of this Section, a "product" is a combination of benefits and Services provided to Members, each such product being defined by a distinct disclosure form or evidence of coverage.

SECTION 4 – Premium and Payments

Group shall pay to Health Plan for each Subscriber and his or her Family Dependents the Premium specified on the Face Sheet for each month on or before the agreed upon date in the preceding month. These amounts are called the "Base Premiums." "Base Premiums" means 100 percent of monthly Premiums for each enrolled Member, as set forth in this section.

A grace period of 15 days will be granted for the payment of each premium falling due after the 1st premium, during which grace period the policy shall continue in force.

Premium Payments for New Members
Premiums are payable for new Members for the entire month regardless of the membership effective date. Group shall continue to pay the Premium for each Subscriber and his or her Family Dependents covered under this Agreement until Group provides written notice to Health Plan to terminate such coverage.

Premium Payments for Terminating Members
Premiums are payable for Members for the entire month regardless of the membership termination date. Group shall continue to pay the Premium for each Subscriber and his or her Family Dependents covered under this Agreement until Group provides written notice to Health Plan to terminate such coverage.

Health Plan will not terminate coverage until it has received Group's written notice. The effective date of termination will be the date the written notice is received by Health Plan.

Premium Increase Due to Tax or Other Charge
If a government agency or other taxing authority imposes or increases a tax or other charge (excluding a tax on or measured by net income) upon Health Plan or any of its contracting providers (or any of their activities), then beginning on the effective date of that tax or charge, Health Plan may calculate Group's Premium to include Group's share of the new or increased tax or charge, subject to regulatory approval where required. Group's share is determined by dividing the number of Members enrolled through Group by the total number of Members enrolled in the applicable Service Area.

Premium Rebates
If state or federal law requires Health Plan to rebate Premiums from this or any earlier contract year and Health Plan rebates Premiums to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act, the Affordable Care Act, and the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

Clerical Errors
If a clerical or administrative error made by Group or Health Plan results in an eligible person being incorrectly enrolled or not enrolled, then such error will be rectified by Group and Health Plan within 90 days of the error being found.

If Group's written notice to add an eligible person is received more than 90-days from the eligible person's effective date, Health Plan will only enroll the eligible person a maximum of 90-days retroactively from the date Health Plan received the written notice from Group. Refunds or payments will be made accordingly by Health Plan or Group, whichever is applicable.

Cost Shares
Members must pay or arrange for payment of amounts they owe Health Plan, Plan Hospitals or Medical Group. The Cost Share is the amount of Allowable Charge for a covered Service and is due at the time the Member receives a Service.

Limit on Cost Shares
There are limits to the total amount of Cost Shares paid by a Member in a contract year for certain Services covered under this EOC. The Copayment Maximum and the Out-of-Pocket Maximum, if applicable, are provided in the EOC's Summary of Services and Cost Shares.

SECTION 5 - Eligibility and Enrollment

No change in Group's eligible or participation requirements is effective for purposes of this Agreement unless Health Plan consents in writing.

Group must:

(1) Hold an Open Enrollment Period at least once a year during which all eligible persons may enroll in Health Plan or in any other health care plan available through Group;

(2) Offer enrollment in Health Plan to all eligible persons on conditions no less favorable than those for any other health care plan available through Group;

(3) Contribute to all health care plans available through Group on a basis that does not financially discriminate against Health Plan or against eligible persons who choose to enroll in Health Plan. In no case will Group's contribution be less than one-half the rate required for a single Subscriber for the plan in which the Subscriber is enrolled.

SECTION 6 - Miscellaneous Provisions

Assignment
Health Plan may assign this Agreement.

Group may not assign this Agreement or any of the rights, interests, claims for money due, benefits, or obligations hereunder without prior written consent of Health Plan.

This Agreement shall be binding on the successors and permitted assignees of Health Plan and Group.

Attorney Fees and Costs
If Health Plan or Group institutes legal action against the other to collect any sums owed under this Agreement, the party that substantially prevails will be reimbursed for its reasonable litigation expenses, including attorneys' fees, by the other party.

Delegation of Claims Review Authority
Health Plan is a named fiduciary to review claims under this Agreement. Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this Agreement. In making these determinations, Health Plan has the authority to review claims in accord with the procedures contained herein and to construe this Agreement to determine whether the Member is entitled to benefits.

Governing Law
Except as preempted by federal law, this Agreement will be governed in accordance with the laws of the District of Columbia where Health Plan is licensed. Any provision required to be in this Agreement by state or federal law shall bind Group and Health Plan whether or not set forth herein.

Indemnification
Health Plan will indemnify and hold harmless Group and its agents, officers, and employees acting in their capacity as agents of Group (collectively, "Group Parties") against any claims, actions, costs (including reasonable attorneys' fees), damages, or judgments, to the extent that they arise out of Health Plan's acts or omissions under this Agreement.

Group will give Health Plan written notice of any claim that Group at any time contends is subject to this provision within 30 days after receiving notice of the claim, and will tender to Health Plan the opportunity, at Health Plan's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If Health Plan accepts the tender, then Health Plan will have no obligation to Group Parties with respect to attorneys' fees incurred by Group Parties. Upon request, Group Parties will give Health Plan all information and assistance reasonably

necessary for defense of the claim. The foregoing indemnification applies only to claims or actions against Group Parties by third parties, including Members, and does not apply to any claim or action by Health Plan that seeks to enforce Health Plan's rights under this Agreement.

Group will indemnify and hold harmless Health Plan and its agents, officers, and employees acting in their capacity as agents of Health Plan (collectively, Health Plan Parties) against any claims, actions, costs (including reasonable attorneys' fees), damages, or judgments, to the extent that they arise out of Group's acts or omissions under this Agreement.

Health Plan will give Group written notice of any claim that Health Plan at any time contends is subject to this provision within 30 days after receiving notice of the claim, and will tender to Group the opportunity, at Group's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If Group accepts the tender, then Group will have no obligation to Health Plan Parities with respect to attorneys' fees incurred by Health Plan Parties.

Upon request, Health Plan Parties will give Group all information and assistance reasonably necessary for defense of the claim. The foregoing indemnification applies only to claims or actions against Health Plan Parties by third parties, including Members, and does not apply to any claim or action by Group that seeks to enforce Group's rights under this Agreement.

Legal Action
No action at law or in equity shall be brought to recover on this contract (a) prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this contract or (b) after the expiration of (3) years after the time written proof of loss is required to be furnished.

Member Information
Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates. If Health Plan gives Group any information that is material to Members, Group will disseminate that information to Subscribers by the next regular communication to them, but in no event no later than 30 days after Group receives the information. For purposes of this paragraph, "material" means information that a reasonable person would consider important in determining action to be taken.

Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that Health Plan will provide SBCs to Members who make a request to Health Plan.

No Waiver
Health Plan's failure to enforce any provision of this Agreement will not constitute a waiver of that or any other provision, or impair Health Plan's right thereafter to require Group's strict performance of any provision.

Notices
Notices from Health Plan to Group or from Group to Health Plan must be delivered in writing, except that Health Plan and Group may each change its notice address by given written notice to the other. Notices are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

If to Health Plan:
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
P. O. Box 6831
2010 East Jefferson Street
Rockville, Maryland 20849-6831
(301) 468-6000

If to Group:
To the address indicated on the Face Sheet

If to Member:
To the latest address provided to Health Plan by the Member.

Other Group Coverages that Cover EHBs
For each non-grandfathered non-Medicare Health Plan coverage, except for any retiree-only coverage, Group must do all of the following if Group provides Health Plan Members with other medical or dental coverage (for example, separate pharmacy coverage) that covers any Essential Health Benefits (EHBs) that the Health Plan coverage does not cover:

- Notify Health Plan of the out-of-pocket maximum (OOPM) that applies to those Essential Health Benefits in each of the other medical or dental coverages.
- Ensure that the sum of the OOPM in Health Plan's coverage plus the OOPMs that apply to those Essential Health Benefits in all of the other medical and dental coverages does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

Right to Examine Records
Under reasonable notice, Health Plan may examine Group's records with respect to eligibility and payments provided under this Agreement.

Representation Regarding Waiting Periods
By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on its employees who meet Group's substantive eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

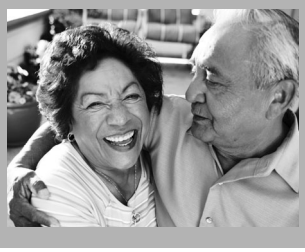
By:_____
Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

Notes

Notes

Notes

JOE SEARS
LITHOGR & PHOTO/LOCAL 285 (3TP)
911 RIDGEBROOK RD
SPARKS GLENCO, MD 21152-9459



guide to

YOUR 2015 BENEFITS AND SERVICES

kaiserpermanente.org

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

GROUP
EVIDENCE OF COVERAGE

DISTRICT OF COLUMBIA

SIGNATURE CARE DELIVERY SYSTEM

This plan has Excellent accreditation from the NCQA
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KAISER PERMANENTE®

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of the Mid-Atlantic States, Inc.
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Table of Contents

SECTION 1 – Introduction

This Evidence of Coverage (EOC) describes "Kaiser Permanente Signature[SM]," health care coverage provided under the Agreement between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and your Group. In this EOC, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is sometimes referred to as "Health Plan", "we", or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this EOC, please see the "Definitions" section of this EOC for terms you should know.

The term of this EOC is based on your Group's contract year and your effective date of coverage. Your Group's benefits administrator can confirm that this EOC is still in effect.

Health Plan provides health care Services directly to its Members through an integrated medical care system, rather than reimburse expenses on a fee-for-service basis. The EOC should be read with this direct-service nature in mind.

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this EOC. Also, as named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

Please note that Health Plan is subject to the regulations of the District of Columbia Department of Insurance, Securities and Banking ("DISB").

Kaiser Permanente Signature[SM]

Kaiser Permanente Signature[SM] provides health care Services to Members using Plan Providers located in our Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area, which is described in the "Definitions" section of this EOC.

To make your health care easily accessible, Health Plan provides conveniently located Plan Medical Centers and medical offices throughout the Washington and Baltimore metropolitan areas. We have placed an integrated team of specialists, nurses, and technicians alongside our physicians, all working together at our state-of-the-art Plan Medical Centers. In addition, we have added pharmacy, optical, laboratory, and x-ray facilities at most of our Plan Medical Centers.

You must receive care from Plan Providers within our Service Area, except for:

- Emergency Services
- Urgent Care Services outside our Service Area
- Authorized Referrals
- Covered Services received in other Kaiser Permanente Regions and Group Health Cooperative service areas

Through our medical care system, you have convenient access to all of the covered health care Services you may need, such as routine care with your own Plan Physician, hospital care, nurses, laboratory and pharmacy Services, and other benefits described in the "Benefits" section.

Who is Eligible

General

To be eligible to enroll and to remain enrolled, you must meet the following requirements:

A. You must meet your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements) and meet the Subscriber or Dependent eligibility requirements below.

B. You must live or work in our Service Area (our Service Area is described in the "Definitions" section).

   However, you or your Spouse's eligible children who live outside our Service Area may be eligible to enroll if you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO).

   Please note that coverage is only limited to Emergency Services and Urgent Care Services provided outside of our Service Area, unless you elect to bring the Dependent within our Service Area to receive covered Services from Plan Providers.

C. Neither you nor any member of your family may enroll under this EOC if you or any Dependent have ever had entitlement to Services through Health Plan terminated for:

   (1) If you or any Dependent have ever had entitlement to receive Services through us terminated for any of the reasons listed under "Termination for Cause" in the "Termination of Membership" section, neither you nor any member of your family is eligible to enroll under this EOC.

   (2) You may not enroll under this EOC until you pay all amounts owed by you and your Dependents if you were ever a Subscriber in

this or any other plan who had entitlement to receive Services through us terminated for:

(a) failure of you or your Dependent to pay any amounts owed to us, Kaiser Foundation Hospitals, or Medical Group; or

(b) failure to pay your Cost Share to any Plan Provider; or

(c) failure to pay non-group Premiums.

Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements that we have approved (for example, an employee of your Group who works at least the number of hours specified in those requirements).

Dependents

If you are a Subscriber and if your Group allows enrollment of Dependents, the following persons may be eligible to enroll as your Dependents:

A. Your Spouse;

B. Your or your Spouse's children (including adopted children or children placed with you for adoption) who are under the age limit specified on the Summary of Services and Cost Shares section of the Appendix;

C. Other Dependent persons who are under the age limit specified on the Summary of Services and Cost Shares section of the Appendix, (but not including foster children) who:

(1) are in the court-ordered custody of you or your Spouse; or

(2) you or your Spouse have received a court or administrative order; or

(3) are under testamentary or court-appointed guardianship.

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

You or your Spouse's currently enrolled Dependents who meet the Dependent eligibility requirements except for the age limit, may be eligible as a disabled Dependent if they meet all the following requirements:

A. They are incapable of self-sustaining employment because of a mentally- or physically-disabling injury, illness, or condition that occurred prior to reaching the age limit for Dependents;

B. They receive 50 percent or more of their support and maintenance from you or your Spouse; and

C. You give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent Certification" below in this section).

Disabled Dependent Certification

A Dependent who meets the Dependent eligibility requirements except for the age limit may be eligible as a disabled Dependent as described above. You must provide us documentation of your Dependent's incapacity and dependency as follows:

A. If your Dependent is a Member, we will send you a notice of his or her membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. Your Dependent's membership will terminate as described in our notice unless you provide us documentation of his or her incapacity and dependency within 60 days of receipt of our notice and we determine that he or she is eligible as a disabled Dependent.

If you provide us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination.

B. If we determine that your Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify you that he or she is not eligible and let you know the membership termination date.

If we determine that your Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.

C. If your Dependent is not a Member and you are requesting enrollment, you must provide us documentation of his or her incapacity and dependency within 60 days after we request it so that we can determine if he or she is eligible to enroll as a disabled Dependent.

If we determine that your Dependent is eligible as a disabled Dependent, you must provide us

documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled Dependent.

Genetic Information

Note: We will not use, require or request a genetic test, the results of a genetic test, genetic information, or genetic Services for the purpose of rejecting, limiting, canceling or refusing to renew a health insurance policy or contract. In addition, genetic information or the request for such information shall not be used to increase the rates of, affect the terms or conditions of, or otherwise affect a Member's coverage.

We will not release identifiable genetic information or the results of a genetic test to any person who is not an employee of Health Plan or a Plan Provider who is active in the Member's health care, without prior written authorization from the Member from whom the test results or genetic information was obtained.

Enrollment and Effective Date of Coverage

Membership begins at 12:00 a.m. on the membership effective date. Eligible people may enroll as follows:

New Employees and Their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible (you should check with your Group to see when new employees become eligible). Your memberships will become effective as determined by your Group.

Special Enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during Open Enrollment as described below, unless one of the following is true:

A. You become eligible as described in this "Special Enrollment" section.

B. You did not enroll in any coverage through your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to New Dependents

Subscribers may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within 31 days after:

- Marriage; or
- birth, adoption, or placement for adoption, by submitting to your Group a Health Plan-approved enrollment application.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.

The effective date of an enrollment as the result of other newly acquired Dependents will be:

A. For newborn children, the moment of birth.

   If payment of additional Premium is required to provide coverage for the newborn child then, in order for coverage to continue beyond 31 days from the date of birth, notification of birth and payment of additional Premium must be provided within 31 days of the date of birth, otherwise coverage for the newborn will terminate 31 days from the date of birth.

B. For newly adopted children (including children newly placed for adoption), the "date of adoption."

   The "date of adoption" means the earlier of: (1) a judicial decree of adoption, or (2) the assumption of custody, pending adoption of a prospective adoptive child by a prospective adoptive parent.

   If payment of additional Premium is required to provide coverage for the child then, in order for coverage to continue beyond 31 days from the date of adoption, notification of adoption and payment of additional Premium must be provided within 31 days of the date of adoption, otherwise coverage for the newly adopted child will terminate 31 days from the date of adoption.

   Once coverage is in effect, it will continue according to the terms of this EOC, unless the placement is disrupted prior to a final decree of adoption and the child is removed from placement with the Subscriber. In such case, coverage will terminate on the date the child is removed from placement.

C. For children who are newly eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.

If payment of additional Premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time but, payment of Premium must be provided within 31 days of the enrollment of the child, otherwise, enrollment of the child terminates 31 days from the date of court or testamentary appointment.

Special Enrollment Due to Court or Administrative Order

Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

If the Subscriber fails to enroll a child under a court or administrative order, the child's other parent or the Department of Social Services may apply for coverage. A Dependent child enrolled under this provision may not be disenrolled unless we receive satisfactory written proof that: (a) the court or administrative order is no longer in effect; and (b) the child is or will be enrolled in comparable health coverage that will take effect not later than the effective date of termination under this EOC; or (c) family coverage has been eliminated under this EOC.

Your Group will determine the effective date of an enrollment resulting from a court or administrative order, except that the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

Special Enrollment Due to Loss of Other Coverage

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if all of the following are true:

A. The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group;

B. The loss of the other coverage is due to one of the following:

   (1) exhaustion of COBRA coverage;

   (2) termination of employer contributions for non-COBRA coverage;

   (3) loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for Dependent children, or the Subscriber's death, termination of employment, or reduction in hours of employment;

   (4) loss of eligibility for Medicaid coverage or Child Health Insurance Program (CHIP) coverage, but not termination for cause; or

   (5) reaching a lifetime maximum on all benefits.

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 31 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid or CHIP coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to Reemployment After Military Service

If you terminated your health care coverage because you were called to active duty in the military service, you may be able to be reenrolled in your Group's health plan if required by state or federal law. Please ask your Group for more information.

Special Enrollment Due to Eligibility for Premium Assistance Under Medicaid or CHIP

You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Health Plan-approved enrollment or change of enrollment application to your Group within 60 days after the Subscriber or Dependent is determined eligible for premium assistance.

The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the Open Enrollment period begins and ends and your membership effective date.

Premium

Members are entitled to health care coverage only for the period for which we have received the appropriate Premium from your Group. You are responsible for the Member contribution to the Premium. Your Group will tell you the amount and how you will pay it to your Group (through payroll deduction, for example).

SECTION 2 – How to Obtain Services

To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed for any Services we provide at Allowable Charges and claims for Emergency or Urgent Care Services from non-Plan Providers will be denied.

As a Member, you are selecting our medical care delivery system to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- Emergency Services, in the "Benefits" section
- Urgent Care Outside our Service Area, in the "Benefits" section
- Getting a Referral, in this section
- Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas, in this section

Your Primary Care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your health care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician when you enroll. Each member of your family should have his or her own primary care Plan Physician. If you do not select a primary care Plan Physician upon enrollment, we will assign you one near your home.

You may select any primary care Plan Physician, who is available to accept new Members, from the following areas: internal medicine, family practice and pediatrics. A listing of all primary care Plan Physicians is provided to you on an annual basis.

You may also access our *Provider Directory* online at the following website address:

www.kp.org

To learn how to choose or change your primary care Plan Physician, please call our Member Services Department at:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 879-6380

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 9:00 p.m.

Getting a Referral

Plan Providers offer primary medical, pediatric, and obstetrics/gynecology care as well as specialty care in areas such as general surgery, orthopedic surgery, dermatology, and other medical specialties. If your primary care Plan Physician decides that you require covered Services from a specialist, you will be referred (as further described in this EOC) to a Plan Provider in your Signature provider network who is a specialist that can provide the care you need. All referrals will be subject to review and approval (authorization) in accordance with the terms of this EOC. We will notify you when our review is complete.

Our facilities include Plan Medical Centers and specialty facilities, such as imaging centers, located within our Service Area. You will receive most of the covered Services that you routinely need at these facilities unless you have an approved referral to another Plan Provider.

When you need covered Services (that are authorized) at a Plan Hospital, you will be referred to a Plan Hospital. We may direct that you receive covered hospital Services at a particular Plan Hospital so that we may better coordinate your care using Medical Group Plan Physicians and our electronic medical record system.

There are specific Services that do not require a referral from your primary care Plan Physician. However, you must obtain the care from a Plan Provider. These Services include the following:

(1) The initial consultation for treatment of mental illness, emotional disorders, drug or alcohol abuse provided by a Plan Provider. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance with arranging for and scheduling of covered Services. The Behavioral Health Access Unit may be reached at 1-866-530-8778.
(2) Obstetrical or gynecological care, for females, from a Plan Provider who specializes in obstetrics or gynecology.
(3) Optometry Services.
(4) Urgent Care Services provided within our Service Area.

Although a referral or prior authorization is not required to receive care from these providers, the provider may have to get prior authorization for certain Services.

For the most up-to-date list of Plan Medical Centers and other Plan Providers, visit our website at www.kp.org. To request a *Provider Directory*, please call our Member Services Department at the number listed on your Health Plan identification card.

Standing Referrals to Specialists

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your primary care Plan Physician may determine, in consultation with you and the specialist, that your needs would be best served through the continued care of a specialist. In such instances, your primary care Plan Physician will issue a standing referral to the specialist.

Standing referrals will be made in accordance with a written treatment plan developed by the primary care Plan Physician, specialist, and the Member. The treatment plan may limit the number of visits to the specialist or the period of time in which visits to the specialist are authorized. We retain the right to require the specialist to provide the primary care Plan Physician with ongoing communication about your treatment and health status.

Second Opinions

You may receive a second medical opinion from a Plan Physician upon request.

Getting the Care You Need; Emergency Services, Urgent Care and Advice Nurses

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or non-Plan Providers anywhere in the world, as long as the Services would have been covered under the "Benefits" section (subject to the "Exclusions, Limitations, and Reductions" section) if you had received them from Plan Providers.

Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

Getting Assistance from our Advice Nurses

If you are not sure whether you are experiencing an Emergency Medical Condition, or may require Urgent Care Services (for example, a sudden rash, high fever, severe vomiting, ear infection, or a sprain), you may call our advice nurses at:

Inside the Washington, D.C. Metropolitan Area
(703) 359-7878
TTY (703) 359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY at 1-800-700-4901

After office hours, call: 1-800-677-1112. You can call this number from anywhere in the United States, Canada, Puerto Rico, or the Virgin Islands.

Our advice nurses are registered nurses (RNs) specially trained to help assess medical problems and provide medical advice. They can help solve a problem over the phone and instruct you on self-care at home if appropriate. If the problem is more severe and you need an appointment, they will help you get one.

Making Appointments

When scheduling appointments it is important to have your identification card handy. If your primary care Plan Physician is located in a Plan Medical Center, please call:

Inside the Washington, D.C. Metropolitan Area
(703) 359-7878
TTY (703) 359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY at 1-800-700-4901

If your primary care Plan Physician is not located in a Plan Medical Center, please call his or her office directly. You will find his or her telephone number on the front of your identification card.

Missed Appointment Fee

If you cannot keep a scheduled medical appointment, please notify your health care professional's office at least one day prior to the appointment. If you fail to cancel your appointment, you may be responsible for the payment of an administrative fee for the missed appointment. The fee for a missed appointment at a Plan Medical Center is shown in the Appendix - Summary of Services and Cost Shares section of this EOC. The fee will not count toward your Deductible or Out of Pocket Maximum.

Using Your Identification Card

Each Member has a Health Plan ID card with a Medical Record Number on it to use when you call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify your medical records and

membership information. You should always have the same Medical Record Number. If you need to replace your card, or if we ever inadvertently issue you more than one Medical Record Number, please let us know by calling our Member Services Department in the Washington, D.C., Metropolitan area at (301) 468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is (301) 879-6380.

Your ID card is for identification only. You will be issued a Health Plan ID card that will serve as evidence of your membership status. In addition to your Health Plan ID card, you may be asked to show a valid photo ID at your medical appointments. Allowing another person to use your card will result in forfeiture of your membership card and may result in termination of your membership.

Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas

If you visit a different Kaiser Permanente or Group Health Cooperative service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. The covered Services, Copayments, Coinsurance and Deductibles may differ from those in this Service Area, and are governed by the Kaiser Permanente program for visiting members. This program does not cover certain Services, such as transplant Services or infertility Services. Also, except for out-of-Plan Emergency Services, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area. The 90-day limit on visiting member care does not apply to a Member who attends an accredited college or accredited vocational school.

To receive more information about visiting member Services, including facility locations across the United States, you may call our Member Services Department at:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 816-6380

Outside the Washington, D.C. Metropolitan Area
1-800-777-7902

Service areas and facilities where you may obtain visiting member care may change at any time.

The following visiting member care is covered when it is provided or arranged by a Plan Physician in the visited service area. The benefits may not be the same as those you receive in your home service area.

Hospital Inpatient Care:
- Physician Services
- Room and board
- Necessary Services and supplies
- Maternity Services
- Prescription drugs

Outpatient Care:
- Office visits
- Outpatient surgery
- Physical, speech and occupational therapy (up to 20 visits for physical therapy per incident; up to two months for occupational and speech therapy)
- Allergy tests and allergy injections
- Dialysis care

Laboratory and X-Ray:
- Covered in or out of the hospital

Outpatient Prescription Drugs:
- Covered only if you have an outpatient prescription drug benefit (regular home Service Area Copayments, Coinsurance, Deductibles, exclusions and limitations apply)

Mental Health Services Other than for Emergency or Urgent Care services:
- Outpatient visits and inpatient hospital days

Substance Abuse Treatment Other than for Emergency or Urgent Care services:
- Inpatient and outpatient medical detoxification and other outpatient visits

Skilled Nursing Facility Care:
- Up to 100 days per calendar year

Home Health Care:
- Home health care Services inside the visited service area

Hospice Care:
- Home-based hospice care inside the visited service area

Pre-Authorization Required for Certain Services
The following Services require preauthorization from your home Service Area while you are visiting another Kaiser Permanente or Group Health Cooperative service area:
- Inpatient physical rehabilitation
- Any other Service that would require pre-authorization in your home Service Area

In addition, some Services require pre-authorization from the visited region or service area. Please contact Member Services in the other Kaiser Permanente region or Group Health Cooperative (GHC) service area, once you have obtained pre-

authorization from your home region or GHC service area.

Visiting Member Service Exclusions
The following Services are not covered under your visiting member benefits. ("Services" include equipment and supplies.) However, some of these Services, such as Emergency Services, may be covered under your home Service Area benefits, and applicable Copayments, Coinsurance and/or Deductibles will apply. For coverage information, refer to the "Benefits" section of this EOC.

- Services that are not Medically Necessary
- Physical examinations and related Services for insurance, employment, or licensing
- Drugs for the treatment of sexual dysfunction disorders
- Dental care and dental X-rays
- Services to reverse voluntary infertility
- Infertility Services
- Services related to conception by artificial means, such as IVF and GIFT
- Experimental Services and all clinical trials
- Cosmetic surgery or other Services primarily to change appearance
- Custodial care and care provided in an intermediate care facility
- Services related to sexual reassignment
- Transplants and related care
- Complementary and alternative medicine Services, such as chiropractic Services
- Services received as a result of a written referral from a Plan provider in your home service area
- Emergency Services, including emergency ambulance Services
- Services that are excluded or limited in your home Service Area

Moving to Another Kaiser Permanente or Group Health Cooperative Service Area

If you move to another Kaiser Permanente or Group Health Cooperative service area, you may be able to transfer your Group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premium, Copayments, Coinsurance and Deductibles may not be the same in the other service area. You should contact your Group's employee benefits coordinator before you move.

Value Added Services

Health Plan makes available a variety of value added services to its Members in order to aid Members in their quest for better health by providing access to additional services, which may not be covered under this plan. Examples may include discounted eyewear, non-covered health education classes and publications, discounted fitness club memberships, health promotion and wellness programs and rewards for participating in those programs. Some of these value added services are available to all Members and others may be available only to Members enrolled in certain groups and/or plans. To take advantage of these services, a Member need only identify himself/herself as a Health Plan Member by showing his/her ID card and paying the fee, if any, at the time of service. Because these value added services are not covered Services, any fees you pay will not accrue to any coverage calculations, such as deductibles and out-of-pocket maximum calculations.

For information concerning these services, including which ones are available to you, you may contact our Member Services Department at:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 879-6380

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 9:00 p.m.

These value added services are neither offered nor guaranteed under your Health Plan coverage. Some of these services may be provided by entities other than the Health Plan. We may change or discontinue some or all of these services at any time.

These value added services are not offered as an inducement to purchase a health care plan from Health Plan. Although they are not covered Services, we may include their costs in the calculation of your Premium.

Health Plan does not endorse or make any representations regarding the quality of such services or their medical efficacy, nor the financial integrity of the entities providing the value added services. The Health Plan expressly disclaims any liability for these services provided by these entities. If you have a dispute regarding these products or services, you must resolve it with the entity offering the product or service. Although we have no obligation to assist with such resolution, should a problem arise with any of these products or services, you may call the Member Services Call Center, and the Health Plan may try to assist in getting the issue resolved.

SECTION 3 – Benefits

The Services described in this "Benefits" section are covered only if all of the following conditions are met:

- You are a Member on the date the Services are rendered;
- The Services are provided:
  - by a Plan Provider; or
  - by a non-Plan Provider ,subject to an approved referral as described in Section 2; and
  - in accordance with the terms and conditions of this EOC including but not limited to the requirements, if any, for prior approval (authorization);
- The Services are Medically Necessary; and
- You receive the Services from a Plan Provider except as described in this EOC.

You must receive all covered Services from Plan Providers inside our Service Area, except for:

- Emergency Services
- Urgent Care outside our Service Area
- Authorized referrals to non-Plan Providers (as described in Section 2)
- Visiting Member Services as described in Section 2

Exclusions and Limitations:
Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that affect all benefits are described in the "Exclusions, Limitations, and Reductions" section of this EOC.

Note: The "Summary of Services and Cost Shares" Appendix lists the Copayments, Coinsurances and Deductibles that apply to the following covered Services. Your Cost Share will be based on the type and place of Service.

A. Outpatient Care

We cover the following outpatient care:

- Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology Services (refer to "Preventive Health Care Services" for coverage of preventive care Services);
- Specialty care visits (refer to "Referrals to Plan Providers" in the "How to Obtain Services" section for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel;
- Diagnostic testing for care or treatment of an illness; or to screen for a disease for which you have been determined to be at high risk for contracting. This includes, but is not limited to:
  - Diagnostic exams, including digital rectal exams and prostate antigen (PSA) tests provided:
    - to persons age 40 and over; who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society;
  - Colorectal cancer screening, specifically: screening with an annual fecal occult blood test; flexible sigmoidoscopy or colonoscopy; or, when appropriate, radiologic imaging, for persons, who are at high risk of cancer. High risk is determined based on the most recently published guidelines of the American College of Gastroenterology, in consultation with the American Cancer Society;
  - Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A "qualified individual" means:
    - an estrogen deficient person at clinical risk for osteoporosis;
    - a person with a specific sign suggestive of spinal osteoporosis. This includes: roentgeno-graphic osteopenia or roentgenographic evidence suggestive of collapse; wedging; or ballooning of one or more thoracic or lumbar vertebral bodies; and who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
    - a person receiving long-term gluco-corticoid (steroid) therapy;
    - a person with primary hyper-parathyroidsm; or
    - a person being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;

  (Refer to "Preventive Health Services" for coverage of preventive care tests and screening Services);
- Outpatient surgery;
- Anesthesia; including Services of an anesthesiologist;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Medical social Services;

- House calls when care can best be provided in your home as determined by a Plan Provider;
- After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services.

Additional outpatient Services are covered, but only as described in this "Benefits" section, subject to all the limits and exclusions for that Service.

B. Hospital Inpatient Care

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by an acute care general hospital in our Service Area:

- Room and board (includes bed, meals and special diets), including private room when deemed Medically Necessary;
- Specialized care and critical care units;
- General and special nursing care;
- Operating and recovery room;
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists;
- Anesthesia, including Services of an anesthesiologist;
- Medical supplies;
- Chemotherapy and radiation therapy;
- Respiratory therapy; and
- Medical social Services and discharge planning.

Additional inpatient Services are covered, but only as described in this "Benefits" section, subject to all the limits and exclusions for that Service:

C. Accidental Dental Injury Services

We cover restorative Services necessary to promptly repair, but not replace, Sound Natural Teeth that have been injured as the result of an external force. Coverage is provided when all of the following conditions have been met:

- The accident has been reported to your primary care Plan Physician within 72 hours of the accident.
- A Plan Provider provides the restorative dental Services.
- The injury occurred as the result of an external force. "External force" is defined as violent contact with an external object; not force incurred while chewing.
- The injury was sustained to Sound Natural Teeth.
- The covered Services must be requested within 60 days of the injury.
- The covered Services are provided during the 12 consecutive month period commencing from the date that the injury occurred.

Coverage under this benefit is provided for the most cost-effective procedure available that, in the opinion of the Plan Provider, would produce the most satisfactory result.

For the purposes of this benefit, Sound Natural Teeth are defined as a tooth or teeth that (a) have not been weakened by existing dental pathology such as decay or periodontal disease, or (b) have not been previously restored by a crown, inlay, onlay, porcelain restoration, or treatment by endodontics.

Accidental Dental Injury Services Exclusions:

- Services provided by non-Plan Providers.
- Services provided after 12 months from the date the injury occurred.
- Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Plan Provider, restoration is impossible.

D. Allergy Services

We cover the following allergy Services:

- Evaluations, and treatment
- Injections and serum

E. Ambulance Services

We cover licensed ambulance Services only if your medical condition requires: (1) the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services, including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

Ambulance transportation from an emergency room to a Plan Facility or from a hospital to a Plan Facility that is both Medically Necessary and ordered by a Plan Provider is covered at no charge.

We also cover medically appropriate non-emergent transportation Services provided by select transport carriers when ordered by a Plan Provider at no charge.

We cover licensed ambulance and non-emergent transportation Services ordered by a Plan Provider only inside our Service Area, except as covered under the "Emergency Services" provision in this section of the EOC.

Ambulance Services Exclusions:

- Except for select non-emergent transportation ordered by a Plan Provider, we do not cover transportation by car, taxi, bus, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider.
- Non-emergent transportation Services that are not medically appropriate and that have not been ordered by a Plan Provider.

F. Anesthesia for Dental Services

We cover general anesthesia and associated hospital or ambulatory surgical center Services for dental care provided to Members:

- Who are 7 years of age or younger or are developmentally disabled;
- For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and
- For whom a superior result can be expected from dental care provided under general anesthesia; or
- Who are 17 years of age or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and
- Whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity; or
- For adults age 17 and older when the Member's medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory surgical center charges will be covered only for dental care that is provided by:

- A fully accredited specialist in pediatric dentistry; or
- A fully accredited specialist in oral and maxillofacial surgery; and
- For whom hospital privileges has been granted.

Anesthesia for Dental Services Exclusions:

- The dentist's or specialist's professional Services.
- Anesthesia and related facility charges for dental care for temporomandibular joint (TMJ) disorders.

G. Blood, Blood Products and their Administration

We cover; blood, blood products, both derivatives and components, including the collection and storage of autologous blood for elective surgery; cord blood procurement and storage for approved Medically Necessary care, when authorized by a Plan Provider; and the administration of prescribed whole blood and blood products.

In addition, benefits shall be provided for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

Blood, Blood Products and their Administration Limitations:

- Member recipients must be designated at the time of procurement of cord blood.

Blood, Blood Products and their Administration Exclusions:

- Directed blood donations.

H. Chemical Dependency and Mental Health Services

We cover the treatment of treatable mental illnesses, emotional disorders, drug abuse and alcohol abuse for conditions that, in the opinion of a Plan Provider, would be responsive to therapeutic management.

For the purposes of this benefit provision:

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

While you are in a hospital, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Plan Provider including:

- Individual therapy
- Group therapy
- Shock therapy
- Drug therapy
- Education
- Psychiatric nursing care
- Appropriate hospital Services

Medical Services for detoxification are limited to the removal of the toxic substance or substances from the system. Detoxification will be covered for a minimum of 12 days annually.

We cover Medically Necessary treatment in a licensed or certified residential treatment center.

Partial hospitalization is defined as the provision of medically directed intensive or intermediate short term treatment for mental illness, emotional disorders, drug and alcohol abuse for a period of less than 24 hours but more than 4 hours in a day in a licensed or certified facility or program.

In an outpatient setting, we cover all necessary Services of physicians and other health care professionals as performed, prescribed, or directed by a physician including, but not limited to:

- Evaluations
- Crisis intervention
- Individual therapy
- Group therapy
- Psychological testing
- Medical treatment for withdrawal symptoms
- Visits for the purpose of monitoring drug therapy

Chemical Dependency and Mental Health Services Exclusions:

- Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse, or drug addiction, except as described above.
- Services provided in a psychiatric residential treatment facility, except as described above.
- Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes.
- Applied Behavior Analysis (ABA).
- Cognitive Behavior Therapy (CBT).
- Psychological testing for ability, aptitude, intelligence, or interest.
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be Medically Necessary.
- Evaluations that are primarily for legal or administrative purposes, and are not Medically Necessary.

I. Cleft Lip, Cleft Palate or Both

We cover inpatient and outpatient Services arising from orthodontics, oral surgery and otologic, audiological and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.

J. Clinical Trials

We cover the routine patient care costs you may incur as an eligible participant in an approved clinical trial undertaken for the purposes of: the prevention, early detection, treatment; or monitoring of cancer, chronic disease, or life-threatening illness.

For the purposes of this benefit, an approved clinical trial means:

(a) A clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
- The National Institutes of Health;
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare and Medicaid Services;
- A bona fide clinical trial cooperative group, including: the National Cancer Institute Clinical Trials Cooperative Group; the National Cancer Institute Community Clinical Oncology Program; the AIDS Clinical Trials Group; and the Community Programs for Clinical Research in AIDS; or
- The Department of Defense, the Department of Veterans Affairs, or the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant;

(b) A study or investigation approved by the Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or

(c) An investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

"Routine patient care costs" mean:

(a) Items, drugs, and Services that are typically provided absent a clinical trial;

(b) Items, drugs, and Services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and

(c) Items, drugs, and Services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Clinical Trials Exclusions:

Routine patient care costs shall not include:

- The cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or items, drugs, or Services provided

solely to satisfy data collection and analysis needs; or
- Items, drugs, or Services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

Note: Coverage will not be restricted solely because the Member received the Service outside the Service Area or the Service was provided by a non-Plan Provider.

Off-Label use of Drugs or Devices. We also cover Patient Costs incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor or provider of that drug or device.

K. Diabetic Equipment, Supplies, and Self-Management

We cover diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and educational Services, including medical nutrition therapy, when prescribed by a Plan Provider and purchased from a Plan Provider, for the treatment of:
- insulin-using diabetes;
- insulin-dependent diabetes;
- non-insulin using diabetes; or
- elevated blood glucose levels induced by pregnancy, including gestational diabetes.

Note: Insulin is not covered under this benefit. Refer to the "Outpatient Prescription Drug Rider," if applicable.

Diabetic Equipment and Supplies Limitation:
Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply: (1) was prescribed by a Plan Provider; and (2) (a) there is no equivalent preferred equipment or supply available, or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. "Health Plan preferred equipment and supplies" are those purchased from a Plan preferred vendor.

L. Dialysis

If the following criteria are met, we cover dialysis Services related to acute renal failure and chronic (end-stage) renal disease:
- You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis;
- The facility (when not provided in the home) is certified by Medicare; and
- A Plan Provider provides a written referral for care at the facility.

We cover the following renal dialysis Services:
- Outpatient maintenance dialysis treatments in a Plan dialysis facility. Coverage includes the cost of lab tests, equipment, supplies and other Services associated with your treatment.
- Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis.
- Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:
- Training for self-dialysis including the instructions for a person who will assist you with self-dialysis.
- Services of the Plan Provider who is conducting your self-dialysis training.
- Retraining for use of new equipment for self-dialysis.

We cover home dialysis, which includes:
- Hemodialysis;
- Home intermittent peritoneal dialysis (IPD);
- Home continuous cycling peritoneal dialysis (CCPD); and
- Home continuous ambulatory peritoneal dialysis (CAPD).

M. Drugs, Supplies, and Supplements

Administered Drugs, Supplies and Supplements
We cover the following during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office or during home visits:
- Oral infused or injected drugs, and radioactive materials used for therapeutic purposes, including chemotherapy;
- Injectable devices;
- The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
- Medical and surgical supplies including: dressings; splints; casts; hypodermic needles; syringes; or any other Medically Necessary supplies provided at the time of treatment;
- Vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA)

that are not considered part of routine preventive care.

Note: Additional Services that require administration or observation by medical personnel are covered. See the "Outpatient Prescription Drugs Rider," if applicable, for coverage of self-administered outpatient prescription drugs; "Preventive Health Care Services" for coverage of vaccines and immunizations that are part of routine preventive care; "Allergy Services" for coverage of allergy test and treatment materials; and "Family Planning Services" for the insertion and removal of contraceptive drugs and devices, if applicable.

Drugs, Supplies and Supplements Exclusions:

- Drugs, supplies, and supplements that can be self-administered or do not require administration or observation by medical personnel.
- Drugs for which a prescription is not required by law.
- Drugs for the treatment of sexual dysfunction disorders.
- Drugs for the treatment of infertility.

N. Durable Medical Equipment

Durable Medical Equipment is defined as equipment that: (a) is intended for repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of illness or injury; and (d) meets Health Plan criteria for Medical Necessity.

Durable Medical Equipment does not include coverage for prosthetic devices, such as implants, artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to "Prosthetic Devices" for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis. Additional coverage for external prosthesis and orthotic devices is only covered if a Prosthetic and Orthotic Devices Rider is attached to this EOC.

Basic Durable Medical Equipment

We cover Durable Medical Equipment as prescribed by a Plan Provider for use in your home (or an institution used as your home). We also cover Durable Medical Equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Note: Diabetes equipment and supplies are not covered under this section (refer to "Diabetes Equipment, Supplies and Self-Management").

Supplemental Durable Medical Equipment

We cover the following Durable Medical Equipment for home use as separate benefits, and as indicated below.

1. Oxygen and Equipment

We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for being Medically Necessary. A Plan Provider must certify the continued medical need for oxygen and equipment every 30 days.

2. Positive Airway Pressure Equipment

We cover continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for being Medically Necessary. A Plan Provider must certify the continued medical need every 30 days.

3. Apnea Monitors

We cover apnea monitors for infants who are under age 3, for a period not to exceed 6 months.

4. Asthma Equipment

We cover the following asthma equipment for pediatric and adult asthmatics when purchased from a Plan Provider:

- Spacers
- Peak-flow meters
- Nebulizers

5. Bilirubin Lights

We cover bilirubin lights for infants, who are under age 3, for a period not to exceed 6 months.

Durable Medical Equipment Exclusions:

- Comfort, convenience, or luxury equipment or features.
- Exercise or hygiene equipment.
- Non-medical items such as sauna baths or elevators.
- Modifications to your home or car.
- Devices for testing blood or other body substances (except as covered under "Diabetes Equipment, Supplies and Self-Management").
- Electronic monitors of the heart or lungs, except infant apnea monitors.
- Services not preauthorized by Health Plan.

O. Emergency Services

As described below you are covered for Emergency Services if you experience an Emergency Medical Condition anywhere in the world.

If you experience an Emergency Medical Condition you should contact 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, not to exceed 48 hours or the next business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room visit was not due to an "Emergency Medical Condition," as defined in the "Definitions" Appendix of this EOC, and was not authorized by Health Plan, you will be responsible for all charges.

We cover Emergency Services as follows:

Inside our Service Area:
We cover reasonable charges for Emergency Services provided within our Service Area by a Plan Provider or a non-Plan provider. Coverage provided by a non-Plan Provider is limited to Emergency Services required before you can, without medically harmful consequences, be transported to a Plan Hospital or your primary care Plan Physician's office.

Outside our Service Area:
We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside our Service Area.

We do not cover Services for conditions that, before leaving the Service Area, you should have known might require Services while you are away, such as: dialysis for end-stage renal disease; post-operative care following surgery; and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

Continuing Treatment Following Emergency Services

Inside our Service Area
After Emergency Services have been received inside the Service Area, all continuing or follow-up treatment must be provided or coordinated by your primary care Plan Physician.

Inside another Kaiser Permanente Region:
If you have received Emergency Services while you are temporarily in another Kaiser Permanente Region, continuing or follow-up treatment is available from physicians contracting with that Kaiser Permanente plan.

Outside our Service Area:
All other continuing or follow-up care for Emergency Services received outside our Service Area must be authorized by us, until you can safely return to the Service Area.

Transport to a Service Area
If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan Region, we will cover necessary ambulance Services or other special transportation arrangements medically required to transport you to a Plan Hospital or Medical Office in our Service Area, or in the nearest Kaiser Foundation Health Plan Region, for continuing or follow-up treatment. **Note**: All ambulance transportation is covered under the "Ambulatory Services" benefit in this section.

Continued Care in Non-Plan Facility Limitation
If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of 48 hours of any hospital admission, or on the first working day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, of if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services
Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within six months of the date of the Service, or as soon as reasonably possible in order to assure payment.

Emergency Services HIV Screening Test

We cover the cost of a voluntary HIV screening test performed on a Member while the Member is receiving emergency medical Services, other than HIV screening, at a hospital emergency room. The test is covered whether or not the HIV screening test is necessary for the treatment of the medical emergency which caused the member to seek Emergency Services.

Covered Services include:

- The costs of administering such a test;
- All lab costs to analyze the test; and
- The costs of telling the Member the results of the test; and any applicable follow-up instructions for obtaining health care and supportive Services.

Other than the Cost Share shown in the Summary of Services and Cost Shares for Emergency Services, no additional Cost Share will be imposed for these Services.

Emergency Services Limitations:

- **Notification:** If you receive care at a hospital emergency room or are admitted to a non-Plan Hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours or the next business day, whichever is later, of the emergency room visit or hospital admission, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the emergency room visit, or hospital care you receive after transfer would have been possible.
- **Continuing or Follow-up Treatment**: Except as provided for under "Continuing Treatment Following Emergency Surgery," we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.
- **Hospital Observation**: Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.

P. Family Planning Services

We cover the following:

- Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control.
- Insertion and removal, and any Medically Necessary exams associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered only under an "Outpatient Prescription Drug Rider", if applicable.
- Tubal ligations.
- Vasectomies.
- Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.

  Voluntary termination of pregnancy limitations:

  - We cover up to a maximum of two (2) voluntary terminations of pregnancy during a contract year.

Note: Diagnostic procedures are covered, but not under this section (see "X-ray, Laboratory and Special Procedures").

Q. Habilitative Services

We cover Medically Necessary Services, including speech therapy, occupational therapy and physical therapy, for children under the age of 21 years with a congenital or genetic birth defect, to enhance the child's ability to function. Medically Necessary habilitative Services are those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without effecting a cure. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defect means a defect existing at or from birth, including a hereditary defect. The term "congenital or genetic birth defect includes: (1) autism or an autism spectrum disorder and (2) cerebral palsy.

Habilitative Services Exclusions:

- Assistive technology Services and devices.
- Services provided through federal, state or local early intervention programs, including school programs.
- Services not preauthorized by Health Plan.

R. Hearing Services

We cover hearing tests to determine the need for hearing correction. (Refer to Preventive Health Care Services for coverage for newborn hearing screenings.)

Hearing Services Exclusions:

- Tests to determine an appropriate hearing aid; and
- Hearing aids or tests to determine their efficacy.

S. Home Health Care

Except as provided for Visiting Member Services, we cover the following Home Health Care only within our Service Area, only if you are substantially confined to your home, and only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home:

- Skilled nursing care
- Home health aide Services

- Medical social Services

Home Health Care is Medically Necessary health Services that can be safely and effectively provided in your home by health care personnel and are directed by a Plan Provider. They include visits by registered nurses, practical nurses or home health aides who work under the supervision or direction of a registered nurse or medical doctor.

We also cover any other outpatient Services, as described in this "Benefits" section, that have been authorized by your Plan Physician as Medically Necessary and appropriately rendered in a home setting.

Home Health Visits Following Mastectomy or Removal of Testicle

Members undergoing a mastectomy or removal of a testicle on an outpatient basis, as well as those who receive less than 48 hours of inpatient hospitalization following the surgery, are entitled to the following:

- One home visit scheduled to occur within 24 hours following his or her discharge; and
- One additional home visit, when prescribed by the patient's attending physician.

Home Health Care Limitations:

- Home Health Care visits shall be limited to two (2) hours per visit. Intermittent care shall not exceed three (3) visits in one day.

Note: If a visit lasts longer than two hours, then each two-hour increment counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

Additional limitations may be stated in the "Summary of Services and Cost Shares."

Home Health Care Exclusions:

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Reductions" section of this EOC).
- Routine administration of oral medications, eye drops, ointments.
- General maintenance care of colostomy, ileostomy, and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids, and orthopedic devices.
- Homemaker Services.
- Care that a Plan Provider determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, and we provide or offer to provide that care in one of these facilities.
- Services not preauthorized by Health Plan.
- Transportation and delivery service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

T. Hospice Care

Hospice Care is for terminally ill Members. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is 6 months or less, you can choose Hospice Care through home or inpatient care instead of traditional Services otherwise provided for your illness. We cover Hospice Care in the home if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

We cover Hospice Care within our Service Area and only when provided by a Plan Provider. Hospice Care includes the following:

- Nursing care;
- Physical, occupational, speech, and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Homemaker Services;
- Medical supplies and appliances;
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- General hospice inpatient Services for acute symptom management including pain management;
- Respite Care that may be limited to 5 consecutive days for any one inpatient stay up to 4 times in any contract year;
- Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member's Family for a period of one year after the Member's death; and
- Services of hospice volunteers.

Definitions:

Family Member means a relative by blood, marriage, domestic partnership, civil union, or adoption who lives with or regularly participates in the care of the terminally ill Member.

Hospice Care means a coordinated, inter-disciplinary program of hospice care for meeting the special physical, psychological, spiritual, and social needs of

terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health Services through home or inpatient care during the illness and bereavement counseling following the death of the Member.

Respite Care means temporary care provided to the terminally ill Member to relieve the Member's Caregiver from the daily care of the Member.

Caregiver means an individual primarily responsible for the day to day care of the Member during the period in which the Member receives Hospice Care.

U. Infertility Services

We cover the following:

- Services for diagnosis and treatment of involuntary infertility for females and males; and
- Artificial insemination.

Notes:

- Involuntary infertility means the inability to conceive after 1 year of unprotected vaginal intercourse.
- Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider are covered under this provision. Refer to the Prescription Drug Rider, if applicable, for coverage of outpatient infertility drugs.

Infertility Services Exclusions:

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Assisted reproductive procedures and any related testing or service that includes the use of donor sperm, donor eggs or donor embryos.
- Any charges associated with obtaining donor eggs, donor sperm or donor embryos.
- Infertility Services when the member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive Endocrinology.
- Services not preauthorized by Health Plan.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies (ART) and procedures, including, but not limited to: in vitro fertilization; gamete intrafallopian transfers (GIFT); zygote interafallopian transfers (ZIFT); assisted hatching; and prescription drugs related to such procedures.

V. Maternity Services

We cover obstetrical Services for routine global maternity care; care for conditions that existed prior to pregnancy; care for high-risk conditions that develop during pregnancy; and non-routine obstetrical care.

"Routine global maternity" means care provided after the first visit where pregnancy is confirmed, and includes all of the following Services, subject to a Cost Share: (a) the normal series of regularly scheduled preventive prenatal care exams; (b) physician charges for labor and delivery, including cesarean section; and (c) routine postpartum follow-up consultations and exams.

Services for pre-existing conditions care related to the development of a high risk condition(s) during pregnancy, and non-routine obstetrical care are covered subject to applicable Cost Share for specialty, diagnostic, and/or treatment Services.

We cover inpatient hospitalization Services for you and your enrolled newborn child for a minimum stay of at least 48 hours following an uncomplicated vaginal delivery; and at least 96 hours following an uncomplicated cesarean section. We also cover postpartum home care visits upon release, when prescribed by the attending provider.

In consultation with your physician, you may request a shorter length of stay. In such cases, we will cover one home health visit scheduled to occur within 24 hours after discharge, and an additional home visit if prescribed by the attending provider.

Up to 4 days of additional hospitalization for the newborn is covered if you are required to remain hospitalized after childbirth for medical reasons.

W. Medical Foods

We cover medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry for which the State screens newborn babies. Coverage is provided if the medical foods and low protein food products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Plan Provider.

Medical foods are intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed or administered enterally (i.e. by tube directly into the stomach or small intestines) under the direction of a Plan Provider.

Low protein modified foods are food products that are (a) specially formulated to have less than one gram of

protein per serving, and (b) intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

Medical Foods Exclusions:

- Medical food for treatment of any conditions other than an inherited metabolic disease.

X. Morbid Obesity

We cover diagnosis and treatment of morbid obesity including gastric bypass surgery or other surgical method that is recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity, and is consistent with criteria approved by the National Institutes of Health.

Morbid obesity is defined as:

- A weight that is at least 100 pounds over or twice the ideal weight for a patients frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
- A body mass index (BMI) that is equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
- A BMI of 40 kilograms per meter squared without such comorbidity.

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

Morbid Obesity Services Exclusions

- Services not preauthorized by Health Plan.

Y. Oral Surgery

We cover treatment of tumors where a biopsy is needed for pathological reasons.

We also cover treatment of significant congenital defects, causing functional impairment, found in the oral cavity or jaw area which are similar to disease or which occur in other parts of the body, including Medically Necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses.

For the purposes of this benefit, coverage for diseases and injuries of the jaw include:

- fractures of the jaw or facial bones;
- removal of cysts of non-dental origin or tumors, including any associated lab fees prior to removal; and
- surgical correction of malformation of the jaw when the malformation creates significant impairment in the Member's speech and nutrition, and when such impairments are demonstrated through examination and consultation with appropriate Plan Providers.

For the purposes of this benefit, coverage of significant congenital defects causing functional impairment must be:

- evidenced through documented medical records showing significant impairment in speech or a nutritional deficit; and
- based on examination of the Member by a Plan Provider.

Functional impairment refers to an anatomical function as opposed to a psychological function.

Health Plan provides coverage for cleft lip and cleft palate under a separate benefit. Please see the "Cleft Lip, Cleft Palate, or Both" section of this EOC for coverage.

Oral Surgery Exclusions:

- Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
- Lab fees associated with cysts that are considered dental under our standards.
- Medical and dental Services for treatment of the condition commonly referred to as TMJ (temporomandibular joint syndrome).
- Orthodontic Services.
- Dental appliances.

Z. Preventive Health Care Services

We cover medically appropriate preventive health care Services based on your age, sex, or other factors, as determined by your primary care Plan Physician pursuant to national preventive health care standards.

These Services include the exam, screening tests and interpretation for:

- Preventive care exams, including:
  - routine physical examinations and health screening tests appropriate to your age and sex;
  - well-woman examinations; and
  - well child care examinations;
- Routine and Medically Necessary immunizations (excluding travel immunizations) for children and adults in accordance with Plan guidelines. Childhood immunizations include diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella and other immunizations as may be prescribed by the Commissioner of Health;
- An annual pap smear, including coverage for any FDA-approved gynecologic cytology screening technology;

- Low dose screening mammograms to determine the presence of breast disease is covered as follows: (i) one mammogram for persons age 35 through 39; (ii) one mammogram biennially for persons age 40 through 49; and (iii) one mammogram annually for person 50 and over;
- Bone mass measurement to determine risk for osteoporosis;
- Prostate Cancer screening including diagnostic examinations, digital rectal examinations, and prostate antigen (PSA) tests provided to men who are age 40 or older;
- Colorectal cancer screening in accordance with screening guidelines issued by the American Cancer Society including fecal occult blood tests, flexible sigmoidoscopy, and screening colonoscopy;
- Cholesterol test (lipid profile);
- Diabetes screening (fasting blood glucose test);
- Sexually Transmitted Disease (STD) tests (including chlamydia, gonorrhea, syphilis and HPS), subject to the following:
    - Annual chlamydia screening is covered for (1) women under the age of 20, if they are sexually active; and (2) women 20 years of age or older, and men of any age, who have multiple risk factors, which include: (i) a prior history of sexually transmitted diseases; (ii) new or multiple sex partners; (iii) inconsistent use of barrier contraceptives; or (iv) cervical ectopy;
    - Human Papillomavirus Screening (HPS) as recommended for cervical cytology screening by the American College of Obstetricians and Gynecologists;
- HIV tests;
- TB tests;
- Newborn hearing screenings that include follow up audiological examinations, as recommended by a physician or audiologist, and performed by a licensed audiologist to confirm the existence or absence of hearing loss when ordered by a Plan Provider;
- Associated preventive care radiological and lab tests not listed above; and
- BRCA counseling and genetic testing is covered a no Cost Share. Any follow up Medically Necessary treatment is covered at the applicable Cost Share based upon type and place of Service.

Preventive Health Services Limitation:
While treatment may be provided in the following situations, the following Services are not considered Preventive Care Services. Applicable Cost Shares will apply.

- Monitoring a chronic disease;
- Follow-up Services after you have been diagnosed with a disease;
- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting based on factors determined by national standards;
- Services provided when you show signs or symptoms of a specific disease or disease process;
- Non-routine gynecological visits; and
- Treatment of a medical condition or problem identified during the course of a preventive screening exam.

Note: Refer to "Outpatient Services" for coverage of non-preventive diagnostic tests and other covered Outpatient Services.

AA. Prosthetic Devices

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

Internally Implanted Devices
We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, monofocal intraocular lens implants, artificial hips and joints, breast implants following mastectomy (see "Reconstructive Surgery" following mastectomy below), and cochlear implants that are approved by the Federal Food and Drug Administration for general use.

Ostomy and Urological Supplies
We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets Health Plan's criteria for Medical Necessity.

Breast Prosthetics
We cover breast prostheses and mastectomy bras following a Medically Necessary mastectomy. Coverage includes custom-made internal and external breast prostheses, regardless of when the mastectomy was performed. Coverage also includes breast prostheses for the non-diseased breast to achieve symmetry.

Breast Prosthetics Limitation:

- Coverage for mastectomy bras is limited to a maximum of two (2) per contract year.

Prosthetic Devices Exclusions:

- Services not preauthorized by Health Plan.
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this Section under "Cleft-Lip, Cleft Palate, or Both", "Hearing Services", or as provided under a "Prosthetic and Orthotic Devices Rider", if applicable.
- Repair or replacement of prosthetics devices due to loss or misuse.
- Hair Prostheses.
- Microprocessor and robotic controlled external prosthetics and orthotics that does not meet Health Plan criteria for Medical Necessity.
- Multifocal intraocular lens implants.

BB. Reconstructive Surgery

We cover reconstructive surgery. This shall include plastic, cosmetic and related procedures required to: (a) to correct significant disfigurement resulting from an injury or Medically Necessary surgery, (b) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (c) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger.

Following mastectomy, we also cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Mastectomy is the surgical removal of all or part of a breast as a result of breast cancer. Reconstructive breast surgery is surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Reconstructive Surgery Exclusions:

- Cosmetic surgery, plastic surgery, or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance, or are not likely to result in significant improvement in physical function, and are not Medically Necessary. Examples of excluded cosmetic dermatology services are:
  - Removal of moles or other benign skin growths for appearance only.
  - Chemical Peels.
  - Pierced earlobe repairs, except for the repair of an acute bleeding laceration.

CC. Skilled Nursing Facility Care

We cover skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required.

We cover the following Services:

- Room and board;
- Physician and nursing care;
- Medical social Services;
- Medical and biological supplies; and
- Respiratory therapy.

Note: The following Services are covered, but not under this section:

- Blood (see "Blood, Blood Products and Their Administration);
- Drugs (see "Drugs, Supplies and Supplements");
- Durable Medical Equipment ordinarily furnished by a Skilled Nursing Facility, including oxygen dispensing equipment and oxygen (see "Durable Medical Equipment");
- Physical, occupational, and speech therapy (see "Therapy and Rehabilitation Services"); and
- X-ray, laboratory, and special procedures (see "X-ray, Laboratory and Special Procedures").

Skilled Nursing Facility Care Exclusions:

- Custodial care (see definition under "Exclusions" in the "Exclusions, Limitations, and Reductions" section of this EOC).
- Domiciliary care.

DD. Therapy and Rehabilitation Services

Physical, Occupational, and Speech Therapy Services

If, in the judgment of a Plan Provider, significant improvement is achievable within a two-month period, we cover physical, occupational and speech therapy:

1. while you are confined in Plan Hospital; and
2. for up to 90 consecutive days of treatment per injury, incident or condition for each therapy in a Plan Medical Center, a Plan Provider's medical office, or a Skilled Nursing Facility, or as part of home health care. This limit does not apply to necessary treatment of cleft lip or cleft palate.

Physical, Occupational, and Speech Therapy Services Limitations:

- Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical

function, except as provided for under "Habilitative Services" in this section.
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.

Multidisciplinary Rehabilitation
If, in the judgment of a Plan Provider, significant improvement is achievable within a two-month period, we cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider's medical office, or a Skilled Nursing Facility. Coverage is limited to a maximum of two consecutive months of treatment per injury, incident or condition.

Multidisciplinary rehabilitation Service programs mean inpatient or outpatient day programs that incorporate more than one therapy at a time in the rehabilitation treatment.

Multidisciplinary Rehabilitation Limitations:
- The limitations listed above for physical, occupation and speech therapy also applies to those Services when provided within a multidisciplinary program.

Cardiac Rehabilitation Services
We cover outpatient cardiac rehabilitation Services that is Medically Necessary following coronary surgery or a myocardial infarction, for up to 12 weeks, or 36 sessions, whichever occurs first.

Cardiac rehabilitation Services must be provided or coordinated by a facility approved by Health Plan, and that offers exercise stress testing, rehabilitative exercises and education and counseling.

Therapy and Rehabilitation Services Exclusions:
- Long-term rehabilitative therapy.

EE. Telemedicine Services

We cover telemedicine Services that would otherwise be covered under this Benefits section when provided by on a face-to-face basis.

Telemedicine Services means the delivery of healthcare Services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment.

Telemedicine Services Exclusion*:*
- Services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions.

FF. Transplant Services

If the following criteria are met, we cover stem cell rescue and transplants of organs, tissue, or bone marrow:
- You satisfy all medical criteria developed by Medical Group and by the facility providing the transplant;
- The facility is certified by Medicare; and
- A Plan Provider provides a written referral for care at the facility.

After the referral to a transplant facility, the following applies:
- Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.
- Health Plan, Plan Hospitals, Medical Group and Plan Providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor.
- We cover reasonable medical and hospital expenses as long as these expenses are directly related to a covered transplant for a donor, or an individual identified by Medical Group as a potential donor even if not a Member.

Transplant Services Exclusions:
- Services related to non-human or artificial organs and their implantation.

GG. Urgent Care

As described below you are covered for Urgent Care Services anywhere in the world. "Urgent Care Services" are defined as Services required as the result of a sudden illness or injury, which requires prompt attention, but is not of an emergent nature." Your Copayment or Coinsurance will be determined by the place of Service (i.e., at a Provider's office or at an after hours urgent care center, as shown in the Summary of Services and Cost Shares section.

Inside our Service Area

We will cover reasonable charges for Urgent Care Services received from Plan Providers and Plan Facilities within the Service Area.

If you require Urgent Care Services please call your primary care Plan Provider as follows:

If your primary care Plan Physician is located at a Plan Medical Office please call:

Inside the Washington, D.C. Metropolitan Area
(703) 359-7878
TTY (703) 359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY 1-800-700-4901

If your primary care Plan Physician is located in our network of Plan Providers, please call his or her office directly. You will find his or her telephone number on the front of your identification card.

Outside our Service Area

If you are injured or become ill while temporarily outside the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. All follow-up care must be provided by a Plan Provider or Plan Facility.

If you obtain prior approval from Health Plan, covered benefits include the cost of necessary ambulance or other special transportation Services medically required to transport you to a Plan Hospital or Plan Medical Office in the Service Area, or in the nearest Kaiser Foundation Health Plan Region for continuing or follow-up treatment.

Urgent Care Limitations:

We do not cover Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of an extreme personal emergency.

Urgent Care Exclusions:

- Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

HH. Vision Services

Medical Treatment

We will provide coverage for Medically Necessary treatment for diseases of or injuries to the eye. Such treatment shall be covered to the same extent as for other Medically Necessary treatments for illness or injury.

Eye Exams

We cover routine and necessary eye exams, including:

- Routine tests such as eye health and glaucoma tests; and
- Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

Pediatric Eye Exams

We cover the following for children under age 19 at no charge:

- One routine eye exam per year, including:
  - Routine tests such as eye health and glaucoma tests; and
  - Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses.

Pediatric Lenses and Frames

We cover the following for children under age 19 at no charge:

- One pair of lenses per year;
- One pair of frames per year from a select group of frames;
- Regular contact lenses (in lieu of lenses and frames) for the first regular supply for that contact lens per year; or
- Medically Necessary contact lenses up to two pair per eye per year.

In addition, we cover the following Services:

Eyeglass Lenses

We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye.

Frames

We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment.

Contact Lenses

We provide a discount on the initial fitting for contact lenses, when purchased at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following Services:

- Fitting of contact lenses;
- Initial pair of diagnostic lenses (to assure proper fit);
- Insertion and removal of contact lens training; and
- Three (3) months of follow-up visits.

You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time. Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.

Vision Exclusions:

- Industrial and athletic safety frames.
- Eyeglass lenses and contact lenses with no refractive value.
  - Sunglasses without corrective lenses unless Medically Necessary.
  - Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia), and astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
  - Eye exercises.
  - Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
  - Replacement of lost, broken, or damaged lenses frames and contact lenses.
  - Plano lenses.
  - Lens adornment, such as engraving, faceting, or jewelling.
  - Low-vision devices.
  - Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
  - Orthoptic (eye training) therapy.

II. X-ray, Laboratory, and Special Procedures

We cover the following Services only when prescribed as part of care covered in other parts of this "Benefits" section (for example, diagnostic imaging and laboratory tests are covered for outpatient Services only to the extent the outpatient Services are covered under "Outpatient Care"):

- Diagnostic imaging;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures, such as electrocardiograms and electroencephalograms;
- Sleep lab and sleep studies; and
- Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies; and interventional radiology.

SECTION 4 – Exclusions, Limitations, and Reductions

The following section provides you with information on what Services Health Plan will not pay for regardless of whether the Service is medically necessary or not.

It also provides information on how your benefits may be coordinated with other types of coverage.

Exclusions

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits" section. When a Service is excluded, all Services related to the excluded Service are also excluded, even if they would otherwise be covered under this EOC.

Alternative Medical Services
Chiropractic and acupuncture Services and any Services of a Chiropractor, Acupuncturist, Naturopath, and Massage Therapist, unless otherwise covered under a Rider attached to this EOC.

Certain Exams and Services
Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs; or (b) required for insurance or licensing or disability determinations; or (c) on court-order or required for parole or probation.

Cosmetic Services
Services that are intended primarily to improve your appearance and that are not likely to result in significant improvement in physical function, except for Services covered under "Reconstructive Surgery" or "Cleft Lip, Cleft Palate or Both" in the "Benefits" section.

Custodial Care
Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine),or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

Dental Care
Dental care and dental x-rays, including dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporal mandibular joint (TMJ) pain dysfunction syndrome, unless otherwise covered under a Rider attached to this EOC. This exclusion does not apply to medically necessary dental care covered under "Accidental Dental Injury Services", "Cleft-Lip, Cleft-Palate or Both", or "Oral Surgery" in the "Benefits" section.

Disposable Supplies
Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices, not specifically listed as covered in the "Benefits" section.

Durable Medical Equipment
Except for Services covered under "Durable Medical Equipment" in the "Benefits" section.

Employer or Government Responsibility
Financial responsibility for Services that an employer or government agency is required by law to provide.

Experimental or Investigational Services
Except as covered under "Clinical Trials" section of the "Benefits" section, a Service is experimental or investigational for your condition if any of the following statements apply to it as of the time the Service is or will be provided to you:

- It cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
- It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
- It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.

In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

- your medical records;
- the written protocols or other documents pursuant to which the Service has been or will be provided;
- any consent documents you or your representative has executed or will be asked to execute, to receive the Service;
- the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
- the published authoritative medical or scientific literature regarding the service, as applied to your illness or injury; and
- regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

External Prosthetic and Orthotic Devices
Services and supplies for external prosthetic and orthotic devices, except as specifically covered under the "Benefits" section of this EOC, or unless otherwise covered under a Rider attached to this EOC.

Prohibited Referrals
Payment of any claim, bill, or other demand or request for payment for covered services determined to be furnished as the result of a referral prohibited by law.

Routine Foot Care Services
Routine foot care Services that are not medically necessary. This exclusion does not exclude Services when you are under active treatment for a metabolic or peripheral vascular disease.

Services for Members in the Custody of Law Enforcement Officers
Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as Out-of-Plan Emergency Services.

Surrogacy Arrangements
Services related to conception, pregnancy or delivery in connection with a surrogacy arrangement. A surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Travel and Lodging Expenses
Travel and lodging expenses, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.

Travel Immunizations
All Services related to immunization in anticipation of traveling outside the country.

Vision Services
Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures.

Workers' Compensation or Employer's Liability
Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to a "Financial Benefit"), is provided under any workers' compensation or employer's liability law. We will provide Services even if it is unclear whether you are entitled to a Financial Benefit; but we may recover the value of any covered Services from the following sources:

- Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
- You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employers' liability law.

Limitations

We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services such as major disaster, epidemic, war, terrorist activity, riot, civil insurrection, disability of a large share of personnel of a Plan Hospital or Plan Medical Center, complete

or partial destruction of facilities, and labor disputes not involving Health Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services, except to the extent prescribed by the Commissioner of Insurance of the District of Columbia.

Reductions

Injury or Illness Caused by Third Party
Except for any covered Services that would be (a) payable under Personal Injury Protection (PIP) coverage, and/or (b) payable under any capitation agreement Health Plan has with a Participating Provider, if you become ill or injured through the fault of a third party and you collect any money from the third party or from his or her insurance company for medical expenses, Health Plan will be subrogated for any Service provided by or arranged as a result of the occurrence that gave rise to the cause of action as follows: (a) per Health Plan's fee schedule for Services provided or arranged by Medical Group, or (b) any actual expenses that were made for Services provided by Participating Providers.

Except for any covered Services that would be (a) payable under Personal Injury Protection (PIP) coverage, and/or (b) payable under any capitation agreement Health Plan has with a Participating Provider, when you recover for medical expenses in a cause of action, Health Plan has the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. Health Plan will also be subrogated as of the time it mails or delivers a written notice of its exercise of this option to you or to your attorney as follows: (a) per Health Plan's fee schedule for services provided by Medical Group at one of our Medical Offices, or (b) any actual expenses that were made for Services provided by a Participating Provider. The subrogated amount will be reduced by any court costs and attorney's fees.

To secure Health Plan's rights, the Health Plan will have a lien on the proceeds of any judgment or settlement you obtain against a third party for covered medical expenses, in accordance with the first paragraph of this section. The Health Plan's recovery shall be made only to the extent that the Health Plan provided covered Services or made payments for covered Services as a result of the occurrence that gave rise to the cause of action. The proceeds of any judgment or settlement that the Member or Health Plan obtains shall first be applied to satisfy Health Plan's lien, regardless of whether the total amount of recovery is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against the third party, you must send written notice of the claim or legal action to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Other Party Liability & Recovery Dept.
2101 East Jefferson Street
Rockville, Maryland 20852

In order for Health Plan to determine the existence of any rights we may have and to satisfy those rights, you must complete and send Health Plan all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay Health Plan directly. You must not take any action prejudicial to Health Plan's rights.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to Health Plan's liens and other rights to the same extent as if you had asserted the claim against the third party. Health Plan may assign its rights to enforce its liens and other rights.

If you are enrolled in Medicare, Medicare law may apply with respect to Services covered by Medicare.

Medicare and TRICARE Benefits

Your benefits are reduced by any benefits for which you are enrolled and receiving under Medicare Part A and/or Part B, except for Members whose Medicare benefits are secondary by law. TRICARE benefits are secondary by law.

Coordination of Benefits (COB)
If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage. The Plan that pays first (Primary Plan) is determined by using National Association of Insurance Commissioners (NAIC) and Medicare Secondary Payer (MSP) Order of Benefits Guidelines.

1. The Primary Plan then provides benefits as it would in the absence of any other coverage.
2. The Plan that pays benefits second (Secondary Plan) coordinates with the Primary Plan, and pays the difference between what the Primary Plan paid, or the value of any benefit or service provided, and the maximum liability of the Secondary Plan, not to exceed 100 percent of total Allowable Expenses. The Secondary Plan is never liable for more expenses than it would cover if it had been Primary.

If you have any questions about COB, please call our Member Services Call Center.
Inside the Washington, D.C., Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
1-800-777-7902
TTY (301) 816-6344

Order of Benefit Determination Rules
Coordination of Benefits ("COB") applies when a Member has health care coverage under more than one Plan. "Plan" and "Health Plan" are defined below.

1. The Order of Benefit Determination Rules will be used to determine which Plan is the Primary Plan. The other Plans will be Secondary Plan(s).
2. If the Health Plan is the Primary Plan, it will provide or pay its benefits without considering the other Plan(s) benefits.
3. If the Health Plan is a Secondary Plan, the benefits or services provided under this Agreement will be coordinated with the Primary Plan so the total of benefits paid, or the reasonable cash value of the services provided, between the Primary Plan and the Secondary Plan(s) do not exceed 100% of the total Allowable Expenses.

Definitions
"Plan": Any of the following that provides benefits or services for, or because of, medical care or treatment: Individual or group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage. “Plan” does not include an individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy that does not provide benefits on an expense-incurred basis.

"Health Plan": Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing services or benefits for health care. Health Plan is a Plan.

"Allowable Expense": means a health care service or expense, including Deductibles, Coinsurance or Copayments that is covered in full or in part by any of the Plans covering the Member. This means that an expense or healthcare service or a portion of an expense or health care service that is not covered by any of the Plans is not an allowable expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense. "Allowable Expense does not include coverage for dental care except as provided under "Accidental Dental Injuries" in the "benefits" section.

"Claim Determination Period": A calendar year. However, it does not include any part of a year during which a person has no Health Plan coverage, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules
1. If another Plan does not have a COB provision, that Plan is the Primary Plan.
2. If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:
   a. Subscriber/Dependent. A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a dependent.
   b. Dependent Child/Parents Not Separated, Divorced, or whose Domestic Partnership or Legal Partnership is Not Terminated. Except as stated in subparagraph (b)(iii) below, when Health Plan and another Plan cover the same child as a dependent of different persons, called "parents":
      i. The Plan of the parent whose birthday falls earlier in the year is Primary to the Plan of the parent whose birthday falls later in the year; but
      ii. If both parents have the same birthday, the Plan that covered a parent longer is Primary; or
      iii. If the rules in (i) or (ii) do not apply to the rules provided in the other Plan, then the rules in the other Plan will be used to determine the order of benefits.
   c. Dependent Child/Separated or Divorced Parents, or whose Domestic Partnership or Legal Partnership is Terminated. If two or more Plans cover a person as a dependent child of divorced or separated parents, or as a dependent of parents whose Domestic Partnership or Legal Partnership has

terminated, benefits for the child are determined in this order:

i. First, the Plan of the parent with custody of the child;
ii. Then, the Plan of the spouse, Domestic Partner, or Legal Partner of the parent with custody of the child;
iii. Finally, the Plan of the parent not having custody of the child.
iv. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph (iv) does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

d. Active/Inactive Employee. A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's dependent) is Primary to a Plan that covers that person as a laid off or retired employee (or as such an employee's dependent).
e. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the Plan that has covered a Subscriber longer is Primary to the Plan which has covered the Subscriber for the shorter time.

Effect of COB on the Benefits of this Plan

When Health Plan is the Primary Plan, COB has no effect on the benefits or services provided under this Agreement. When Health Plan is a Secondary Plan as to one or more other Plans, its benefits may be coordinated with the Primary Plan carrier using the guidelines below. COB shall in no way restrict or impede the rendering of services provided by Health Plan. At the Member's request, Health Plan will provider or arrange for covered services and then seek coordination with a Primary Plan.

1. Coordination with This Plan's Benefits. Health Plan may coordinate benefits payable or may recover the reasonable cash value of services it has provided when the sum of:
   a. The benefits that would be payable for, or the reasonable cash value of, the services provided as Allowable Expenses by Health Plan in the absence of this COB provision; and
   b. The benefits that would be payable for Allowable Expenses under one or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim thereon is made; exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any services provided by Health Plan may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.
2. Right to Reserve and Release Needed Information. Certain information is needed to apply these COB rules. Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under Health Plan must give Health Plan any information it needs.
3. Facility of Payment. If a payment made or service provided under another Plan includes an amount that should have been paid or provided by or through Health Plan, Health Plan may pay that amount to the organization that made the payment. The amount paid will be treated as if it was a benefit paid by Health Plan.
4. Right of Recovery. If the amount of payments by Health Plan is more than it should have paid under this COB provision, or if it has provided services that should have been paid by the Primary Plan, Health Plan may recover the excess or the reasonable cash value of the services, as applicable, from one or more of:
   a. The persons it has paid or for whom it has paid;
   b. Insurance companies; or
   c. Other organizations.
5. Benefit Reserve Account. When Health Plan does not have to pay full benefits, or recovers the reasonable cash value of the services provided because of COB, the savings will be credited to the Member in a Benefit Reserve Account. These savings can be used by the Member for any unpaid Covered Expense during the calendar year. A Member may request detailed information concerning the Benefits Reserve Account from Health Plan's Patient Accounting Department.

Military Services
For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

SECTION 5 – Getting Assistance, Filing Claims, and the Appeals Procedure

Getting Assistance

Member Services representatives are available at our Plan Medical Offices and through our Call Center to answer any questions you have about your benefits, available services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace an ID card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside our Service Area (see Post-Service Claims) or to initiate an appeal for any unresolved problem.

We want you to be satisfied with your health care. Please discuss any problems with your primary care plan provider or other health care professionals treating you. If you are not satisfied with your primary care plan provider, you can request a different plan provider by calling our Member Services Department.

Who to Contact

By Telephone

Member Services Department telephone numbers:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

TDD **(301) 879-6380**

In Writing

To contact us in writing, mail your correspondence to:

Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852

For a claim, send it to the attention of:
Member Services Department

For an appeal, send it to the attention of:
Member Services Appeals Unit

By Facsimile

To fax us your correspondence, send it to:
(301) 816-6192

Definitions

Adverse Decision: Any determination by Health Plan that (a) that an admission, availability of care, continued stay, or other Service is or is not a covered benefit; or if it is a covered benefit, that such service has been reviewed and does not meet the Health Plan's requirements for medical necessity, appropriateness, health care settings, level of care or effectiveness, and therefore payment is not provided or made by Health Plan, for the service, thereby making the Member responsible in whole, or in part; or (b) cancels or terminates a Member's membership retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.

Authorized Representative: An individual authorized by the Member in writing or otherwise authorized by state law to act on the Member's behalf to file claims and to submit Appeals. Authorized Representative shall also include a Health Care Provider acting on behalf of a Member with the Member's express written consent, or without the Member's express consent in an Emergency situation. With respect to claims and appeals, the term "Member" or "you", or "your" shall include an Authorized Representative.

Concurrent Care Claim: A request that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either (a) the course of treatment prescribed will expire, or (b) the course of treatment prescribed will be shortened.

Pre-Service Claim: A request that Health Plan provide or pay for a Service that you have not yet received.

Post-Service Claim: **A** request for payment for Services you have already received, including but not limited to, claims for Out-of-Plan emergency services.

Urgent Medical Condition: As used in this Section 5, a medical condition for which care has not been rendered, and which if not treated within 24 hours:

1. could reasonably be expected to result in:
   a. placing your life or health in serious jeopardy;
   b. serious impairment to bodily function; or
   c. serious dysfunction of any bodily organ or part; or
2. would, in the opinion of a physician with knowledge of your medical condition, subject the Member to severe pain that cannot be adequately managed without the Services which are the subject of the claim.

Procedure for Filing a Claim and Initial Claim Decisions

Health Plan will review claims that you make for Services or payment, and we may use medical experts to help us review claims and appeals. You may file a claim or an appeal on your own behalf or through an Authorized Representative. As used with respect to Pre-Service, Concurrent Care, or Post-Service Claims and appeals related thereto, the term "Member" "you" or "your" shall include an Authorized Representative, as defined above.

If you miss a deadline for filing a claim or appeal, we may decline to review it. If your health benefits are provided through an "ERISA" covered employer group, you can file a demand for arbitration or civil action under ERISA §502(a)1)(B), but you must meet any deadlines and exhaust the claims and appeals procedures as described in this Section before you can do so. If you are not sure if your group is an "ERISA" group, you should contact your employer.

We do not charge you for filing claims or appeals, but you must bear the cost of anyone you hire to represent or help you. You may also contact the Managed Care Ombudsman (contact information is set forth below) to obtain assistance.

A. Pre-Service Claims

Pre-Service claims are requests that Health Plan provide or pay for a Service that you have not yet received. We will decide if your claim involves an Urgent Medical Condition or not. If you receive any of the Services you are requesting before we make our decision, your claim or appeal will become a Post-Service Claim with respect to those Services. If you have any questions about Pre-Service Claims, please contact our Member Services Department at the numbers listed above.

Procedure for Making a Non-Urgent Pre-Service Claim

1. Tell the Member Services Department that you want to make a claim for Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.

2. We will review your claim, and if we have all the information we need we will send you a written decision within 15 days after we receive your claim.

If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within 15 days of receipt of your claim.

You will have 45 days to send us the requested information. 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. We will send you our written decision within 15 days after receipt of the requested information. If we do not receive any of the requested information (including documents) within 45 days after our request, we will make a decision based on the information we have and send you a written decision within 15 days after the end of the 45 days.

3. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

Expedited Procedure for an Urgent Medical Condition

1. Tell the Member Services Department you want to make an urgent claim for Health Plan to provide or pay for a Service that you have not yet received. Your written or oral request and any related documents you give us constitute your claim.

2. If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.

3. We will review your claim and if we have all the information we need we will notify you orally or in writing of our decision, as soon as possible taking into account your medical condition, but no later than 24 hours after receiving your claim. If we notified you orally, we will send a written confirmation within three days after that. If we do not have all the information we need, we may ask for more information within 24 hours of receipt of your claim. If we do not receive the requested information (including documents) within 48 hours after our request, we will make our decision based on the information we have.

4. We shall notify you by telephone within 1 working day of making the decision, and shall provide written notice of our decision within three days after that.

5. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

6. When you or your Authorized Representative sends an appeal, you or your Authorized Representative may also request simultaneous

external review of our initial adverse decision. If you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative's appeal must tell us this. You will be eligible for the simultaneous external review only if your Pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, than you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See the section entitled, External Appeal Procedures for additional information about filing an external appeal.

B. Concurrent Care Claims

Concurrent care claims are requests that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either (a) the course of treatment prescribed will expire, or (b) the course of treatment prescribed will be shortened. We will decide if your claim involves an Urgent Medical Condition or not. If you have any questions about Concurrent Care Claims, please contact the Member Service Department at the phone numbers listed above.

Procedure for Making a Non-Urgent Concurrent Care Claim When Your Course of Treatment Will Expire

1. We will review your claim, and if we have all the information we need we will send you a written decision within 15 days after we receive your claim.

If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within 15 days of receipt of your claim.

You will have 45 days to send us the requested information. 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. We will send you our written decision within 15 days after receipt of the requested information. If we do not receive any of the requested information (including documents) within 45 days after our request, we will make a decision based on the information we have and send you a written decision within 15 days after the end of the 45 days.

2. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

3. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can appeal.

Procedure for Making a Concurrent Care Claim When Your Course of Treatment for an Urgent Medical Condition Will Expire

1. At least 24 hours before the expiration of the Services or before your shortened course of care ends, you should call or write the Member Services Department that you have an Urgent Medical Condition or your course of treatment has been terminated early and that you want to continue your course of care. Your written or oral request and any related document you give us constitute your claim. Call or write the Member Service Department at the address and telephone numbers listed above.

2. If you filed a request for additional services at least 24 hours before the end of an approved course of treatment, you may continue to receive those services during the time your claim is under consideration. If your claim is then denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, Health Plan will decide your request for review within a reasonable period of time appropriate to the circumstances but, in no event, later than 30 calendar days from the date on which the claim was received.

3. If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as non-urgent Concurrent Care Claim.

4. We will review your claim and notify you of our decision orally or in writing within 24 hours after we receive your claim. If we notify you orally, we will send you a written decision within 3 days (2 business days if an Adverse Decision could result) after that.

5. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can appeal.

6. When you or your Authorized Representative sends the appeal, you or your Authorized Representative may also request simultaneous external review of our adverse decision. If you want simultaneous external review, your or your Authorized Representative's appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review only if your Concurrent Care Claim qualifies as urgent. If you or your Authorized Representative do not request simultaneous external review in the appeal, then you

or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See the section entitled, External Appeal Procedures for additional information about filing an external appeal.

C. Post-Service Claims

Post-service claims are requests for payment for Services you have already received, including claims for Emergency Services and Urgent Care Services rendered outside our Service Area. If you have any questions about Post-service claims or appeals, please call the Member Services Department at the address and telephone numbers listed above.

Procedure for Making a Post-Service Claim

Claims for Emergency Services or Urgent Care Services rendered outside our Service Area or other Services received from non-Plan Providers must be filed on forms provided by Health Plan; such forms may be obtained by calling or writing to the Member Services Department.

1. You must send the completed claim form to us at the address listed on the claim form within 180 days, or as soon as reasonably possible after the Services are rendered. You should attach itemized bills along with receipts if you have paid the bills. Incomplete claim forms will be returned to you. This will delay any payments which may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payors.

2. 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. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we tell you we need more time and ask you for more information, you will have 45 days to provide the requested information. 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, we will make a decision based on the information we have. We will issue our decision within 15 days of the deadline for receiving the information.

3. If we deny your claim or if we do not pay for all the Services you requested, our written decision will tell you why we denied your claim and how you can appeal.

Internal Appeal Procedures

The appeal procedures are designed by Health Plan to assure that Member concerns are fairly and properly heard and resolved.

These procedures apply to a request for reconsideration of an Adverse Decision rendered by the Health Plan regarding any aspect of the Health Plan's health care Service.

A Member or a Member's Authorized Representative may request an informal or formal appeal by contacting the Member Services Department.

In addition, you or your Authorized Representative, as applicable, may review (without charge) the information on which Health Plan made its decision. You may also send additional information including comments, documents or additional medical records supporting your claim.

Additional information may be sent to:

Member Services Appeals Unit
Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20852
By fax: (301) 816-6192

If Health Plan had asked for additional information before and you did not provide it, you may still submit the additional information with your appeal. In addition, you may also provide testimony in writing or by telephone. Written testimony may be sent along with your appeal to the address listed above. To arrange to give testimony by telephone, you may contact the Member Services Appeals Unit. Health Plan will add all additional information to your claim file and will review all new information without regard to whether this information was submitted and/or considered in its initial decision.

In addition, prior to Health Plan rendering its final decision, it will provide you, without charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) Health Plan in connection with your appeal.

If during the Health Plan's review of your appeal, it determines that an adverse decision can be made based on a new or additional rationale, the Health Plan will provide you with this new information prior to issuing its final adverse decision and will explain how you can respond to the information if you choose to do so. The additional information will be provided to you as soon as possible and sufficiently before the deadline to give you a reasonable opportunity to respond to the new information.

Wherever the term "Member" or "you" or "your" is used in this section, it shall include the Member's Authorized Representative.

Member Service Representatives are available by telephone each day during business hours to describe to Members how appeals are processed and resolved and to assist the Member with filing an appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 AM to 5:30 PM at (301) 468-6000, if calling within the local area, or (301) 816-6344 TDD (Telephonic Device for the Deaf).

Informal Appeal

Step 1 - Telephone number: If you do not agree with an Adverse Decision, you may request the opportunity to discuss and review the decision with appropriate clinical staff. When requesting an informal appeal, the Member must include a telephone number where he/she may be contacted to discuss the case.

Step 2 – Sufficient Information: Before accepting a request for an informal review, Health Plan will determine if it has sufficient information readily available to reach a decision within the required time frame. If additional information is needed, Health Plan will notify the Member to immediately proceed to initiate a formal appeal.

Step 3 – Discussion: All requests for informal appeals will be acted upon immediately. Health Plan may have to contact the Member by telephone to discuss and review the Adverse Decision. When relevant, Health Plan may arrange for the Member or the Member's Representative to discuss the adverse decision with appropriate clinical staff.

Step 4 – Decision: Health Plan must conclude the informal appeal as soon as possible, but no later than 14 business days after the request for an informal appeal was filed. Health Plan will provide a written explanation of the appeal decision to the Member or Member's Representative within five (5) business days from the date of the decision.

In the case of an adverse appeal decision, the written explanation shall inform the Member or Member's Representative of the right to request a formal appeal of the informal appeal decision.

Formal Appeal

This procedure applies to decisions regarding non-urgent Pre-Service Claims and Concurrent Claims as well as for Post-Service Claims.

Initiating a Formal Appeal
You may initiate a formal appeal by submitting a written request, including all supporting documentation that relates to the appeal to:

Member Services Appeals Unit
Kaiser Permanente
2101 East Jefferson Street
Rockville, MD 20849
(301) 816-6192 (FAX)

The appeal must be filed in writing within 180 days from the date of receipt of the original denial notice**. If the appeal is filed after the 180 days, Health Plan will send a letter denying any further review due to lack of timely filing.**

Each request for a formal appeal will be acknowledged by Health Plan, in writing, within 10 business days of receipt.

If Health Plan does not have sufficient information to complete its internal appeal process, the acknowledgement letter will:

a. notify the Member that it cannot proceed with reviewing the appeal unless additional information is provided;
b. specify all additional information required to be filed; and
c. assist in gathering the necessary information without further delay.

Appeal Review
Each formal appeal will be reviewed by a health care professional selected by Health Plan based upon the specific issued presented in the appeal, and who was not involved in the initial Adverse Decision.
If the review requires medical expertise, the reviewer or panel will include at least one medical reviewer in the same specialty as the matter at issue.

Each medical reviewer shall be a physician or an advanced practice registered nurse or other health care provider possessing a non-restricted license to practice or provide care anywhere in the United States, and have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

Formal Appeal Decisions
Each formal appeal will be concluded as soon as possible after receipt of all necessary documentation by Health Plan, but not later than 30 calendar days after the date the appeal was received.

Health Plan will notify you of its decision verbally or in writing. If the Service is approved, Health Plan will provide assistance in arranging the authorized Service. If the Service is denied, written notice will be sent to you within three days after a verbal decision has been communicated.

Extension of Review Period
The time frame for concluding our formal appeal decision may only be extended by written request to the Member. If the Member does not agree to an extension, the appeal will move forward to be completed by end of the original time frame. Any agreement to extend the appeal decision shall be documented in writing.

Expedited Appeals

If you are appealing an Adverse Decision that involves an Urgent Medical Condition, you may request an expedited decision by contacting Health Plan:

During Regular Business Hours
Monday through Friday from 7:30am – 5:30pm – The Member should contact the Member Services Department.

Inside the Washington, D.C. Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
1-800-777-7902.

During Non-Business Hours
The Member should call the Advice/Appointment Line.

Inside the Washington, D.C. Metropolitan area
(703) 359-7878

Outside the Washington, D.C. Metropolitan area
1-800-777-7904

Once an expedited appeal is initiated, clinical review will determine if the appeal involves an Urgent Medical Condition. If the appeal does not meet the criteria for an expedited appeal, the request will be managed as a formal appeal, as described above. If such a decision is made, Health Plan will call the Member within 24 hours.

If the request for appeal meets the criteria for an expedited appeal, the appeal will be reviewed by a Plan Physician who is board certified or eligible in the same specialty as the treatment under review, and who is not the individual (or the individual's subordinate) who made the initial adverse decision. If additional information is needed to proceed with the review, the Member or the Authorized Representative will be contacted by telephone or facsimile.

Expedited Appeal Decisions
An expedited appeal will be concluded as soon as possible after receipt of all necessary documentation by Health Plan, but not later than 24 hours after receipt of the request for appeal. Health plan will notify you of its decision immediately by telephone. If the Service is approved, Health Plan will provide assistance in arranging the authorized Service. If the Service is denied, written notice of its decision will be sent within one business day after that.

Notification of Adverse Appeal Decisions
If the review results in a denial, Health Plan will notify the Member and the Authorized Representative in writing. The notification shall include:

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

2. References to any specific criteria or standards, including interpretive guidelines, on which the decision was based (including reference to the specific plan provisions on which determination was based);

3. A statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member's medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized Representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized Representative's claim.

4. All pertinent instruction, including the telephone numbers and titles of persons to contact, any forms required to initiate an external review, and applicable time frames to request a formal external review of the decision; and

5. A statement of your rights under section 502(a) of ERISA, if applicable.

6. If we send you a notice of an adverse decision to an address in a county where a federally mandated threshold language applies, then you or your

Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10% of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services at 301-468-6000, if calling within the local area, or 301-816-6344 TTY (Telephonic Device for the Deaf).

External Appeal Procedures

If you receive an adverse decision on your appeal, you have a right to seek a formal external review of the decision within 30 business days after the decision.

If the appeal was denied because the Service was not considered medically necessary or appropriate, send your request for an external appeal to:

District of Columbia
Department of Health Care Finance
Office of the Health Care Ombudsman and
Bill of Rights
899 North Capital Street, N.E., 6th Floor
Washington, DC 20002
Phone number: 202-724-7491
Toll Free: 1-877-685-6391
Fax number: (202) 535-1216

If the appeal was denied for any other reason, send your request for an external appeal to:

Commissioner of Insurance
District of Columbia
Department of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
Phone number: (202)-727-8000
Fax number: (202)-535-1196

Exhaustion of Internal Appeal Process

You must exhaust Health Plan's Internal Appeal Process *before* you may file an external appeal with the Commissioner of Insurance except in the following circumstances:

1. Health Plan failed to comply with any deadline for completion of a formal internal review;

2. In the case of an Urgent Medical Condition, if the request demonstrates to the satisfaction of the Director a compelling reason to do so, including a showing that the potential delay in receipt of a Service until after the Member exhausts the internal grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill with symptoms that causes the Member to be a danger to self and others; or

3. Health Plan failed to make a decision for an Expedited Appeal within 24 hours after the appeal was filed.

SECTION 6 – Termination of Membership

We will inform you of the date your coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents' membership ends at the same time as the Subscriber's membership ends.

You will be charged non-Member rates for any health care services and supplies you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Extension of Benefits" in this "Termination of Membership" section.

This "Termination of Membership" section describes how your membership may end; and explains how you will be able to maintain Health Plan coverage without a break in coverage if your membership under this EOC ends.

Termination Due to Loss of Eligibility
If:

1. you meet the eligibility requirements described under "Who is Eligible" in the "Eligibility and Enrollment" section on the first day of a month; but
2. later in that month you no longer meet those eligibility requirements;

then your membership terminates on the last day of that month, unless your Group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your Group's benefits administrator to confirm your termination date.

Termination of Group Agreement
If your Group's Agreement with us terminates for any reason, your membership ends on the same date that your Group's Agreement terminates.

Termination for Cause
We may terminate the memberships of the Subscriber and all Dependents in your Family Unit by sending written notice to the Subscriber at least 31 days before the termination date if anyone in your Family Unit commits one of the following acts:

- You knowingly: (1) misrepresent membership status; or (2) present an invalid prescription or physician order; or (3) misuse (or let someone else misuse) a Member ID card; or (4) you commit other types of fraud in connection with your membership;
- You knowingly furnish incorrect or incomplete information to us or fail to notify us of changes in your family status that may affect your eligibility or benefits;
- You no longer live or work within Health Plan's Service Area; or
- Your behavior with respect to Health Plan staff or Medical Group providers is: (a) disruptive; (b) unruly; (c) abusive; or (d) uncooperative, to the extent that your continued enrollment under this EOC seriously impairs Health Plan's ability to furnish Services to you or to other Health Plan members.

Termination for Nonpayment
You are entitled to coverage only for the period for which we have received the appropriate Premium from your Group. If your Group fails to pay us the appropriate Premium for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

Extension of Benefits

In those instances when your coverage with us has terminated, we will extend benefits for covered services, subject to Premium payment, in the following instances:

1. If:
   a. you become Totally Disabled while enrolled under this Agreement; and
   b. you remain so at the time your coverage ends,

   then we will continue to provide benefits for covered services related to the condition causing the disability.

   Coverage will continue for:
   a. 180 days from the date of termination; or
   b. until you no longer qualify as being Totally Disabled; or
   c. until such time as a succeeding health plan elects to provide coverage to you without limitations,

   whichever comes first.

2. If you are a Health Plan approved inpatient in a Hospital or Skilled Nursing Facility at the time your coverage ends, we will continue to provide benefits for covered Services related to the condition for which you've been admitted.

   Coverage will continue for:
   a. 180 days from the date of termination; or
   b. until a determination is made by a Physician that care in the Hospital or Skilled Nursing Facility is no longer medically indicated; or
   c. the admission terminates,

   whichever comes first.

To assist us, if you believe you qualify under this "Extension of Benefits" provision, you must notify us in writing.

Limitation(s):
The "Extension of Benefits" section listed above does not apply to the following:

- Members' whose coverage ends because of failure to pay Premium;
- Members' whose coverage ends because of fraud or material misrepresentation by the Member;
- When coverage is provided by another health plan and that health plan's coverage:
  (a) is provided at a cost less than or equal to the cost of the extended benefit available under this EOC; and
  (b) will not result in an interruption of benefits to the Member.

Continuation of Group Coverage under Federal Law

(COBRA)

You or your Dependents may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility. Members are eligible for COBRA continuation coverage even if they live in another Kaiser Foundation Health Plan or allied plan service area. Please contact your Group if you want to know whether you or your Dependents are eligible for COBRA coverage, how to elect COBRA coverage, or how much you will have to pay your Group for it.

Continuation of Group Coverage under District of Columbia Law

Employers maintaining a health benefits plan for fewer than 20 employees must offer you and your Dependents who are eligible for state continuation coverage and who would otherwise lose coverage, uninterrupted coverage for a period of 15 continuous months, in compliance with applicable District of Columbia law, unless you:

(1) Are terminated for gross misconduct;
(2) Are eligible for an extension of coverage under federal COBRA law; or
(3) Fail to complete the appropriate election forms and provide proper payment in a timely manner.

Affected employers are required by District of Columbia law to provide employees whose coverage has terminated with written notification of the right to continue this group coverage within 15 days following the date coverage would otherwise have terminated.

You and any Dependents who want to continue coverage must elect coverage by transmitting the amount required to continue coverage no later than 45 days after the date coverage would otherwise terminate.

Continuation coverage continues only upon payment of applicable monthly charges, which may include an allowable reasonable administrative fee, and terminates on the earliest of the following:

(1) You establish residence outside Health Plan's service area;
(2) You fail to make timely payment of the required cost of coverage;
(3) You violate a material condition of this contract;
(4) You become covered under another group health benefits plan that does not contain any exclusion or limitation with respect to pre-existing conditions that affects the covered Member;
(5) You become entitled to Medicare; or
(6) Your employer no longer offers group health benefits coverage to any employee.

Your cost for continued coverage shall not exceed 102% of your group's premium charge.

If you elect to continue coverage under this provision, you must pay to your employer the amount required to continue coverage no later than 45 days after the date that coverage would otherwise have terminated.

If your employer, without interruption, replaces coverage with similar coverage under another health benefits plan, you shall have the right to continue coverage under the replacement health benefits plan for the balance of your continuation of coverage benefit period, so long as you continue to meet the requirements for continuation of coverage.

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Members are not ineligible for USERRA continuation coverage solely because they live in another Kaiser Foundation Health Plan or allied plan service area. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

Coverage Available on Termination

For information about non-group plans available through us with no waiting period or pre-existing condition limitations, visit our Website at: www.kp.org

Or call our Member Services Call Center at:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

SECTION 7 – Miscellaneous Provisions

Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Group Agreement and this EOC.

Advance Directives

The following legal forms help you control the kind of health care you will receive if you become very ill or unconscious:

- A *Durable Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your views on life support and other treatments.
- A *Living Will* and the *Natural Death Act Declaration to Physicians* lets you write down your wishes about receiving life support and other treatment.

For additional information about Advance Directives, including how to obtain forms and instructions, contact our Member Services Call Center.

Inside Washington, D.C., Metropolitan area
(301) 468-6000, or in the Baltimore, Maryland
TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, a revised EOC will be issued to you.

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

Assignment

You may not assign this EOC or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney Fees and Expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

Contracts with Plan Providers

Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call our Member Services Call Center in the Washington, D.C., Metropolitan area at (301) 468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is (301) 816-6344.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from Non-Plan Providers, except for Emergency Services or authorized referrals.

If our contract with any Plan Provider terminates, for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status, while you are under the care of that Plan Provider, you may continue to see that provider and we will retain financial responsibility for covered Services you receive, in excess of any applicable Copayments, Coinsurance or Deductibles for a period not to exceed 90 days from the date we have notified you of the Plan Provider's termination.

Governing Law

Except as preempted by federal law, this EOC will be covered in accord with law of the District of Columbia and any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

Groups and Members are not Health Plan's Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

Member Rights and Responsibilities: Our Commitment to Each Other

Kaiser Permanente is committed to providing you and your family with quality health care Services. In a spirit of partnership with you, here are the rights and responsibilities we share in the delivery of your health care Services.

MEMBER RIGHTS

As a member of Kaiser Permanente, you have the right to:

1. **Receive information that empowers you to be involved in health care decision making. This includes your right to:**
   a. Actively participate in discussions and decisions regarding your health care options.
   b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved - no matter what the cost is or what your benefits are.
   c. Receive relevant information and education that helps promote your safety in the course of treatment.
   d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.
   e. Refuse treatment, providing you accept the responsibility and consequences of your decision.
   f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a durable power of attorney for health, living will, or other health care treatment directive. You can rescind or modify these documents at any time.
   g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.
   h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on applicable state and federal law to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You, or your authorized representative, will be asked to provide written permission before your records are released, unless otherwise permitted by law.
2. **Receive information about Kaiser Permanente and your plan. This includes your right to:**
   a. Receive the information you need to choose or change your Primary Care Physician, including the name, professional level, and credentials of the doctors assisting or treating you.
   b. Receive information about Kaiser Permanente, our Services, our practitioners and providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente's member rights and responsibility policies.
   c. Receive information about financial arrangements with physicians that could affect the use of Services you might need.
   d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
   e. Receive covered urgently needed Services when traveling outside Kaiser Permanente's Service Area.
   f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for services that are not covered.
   g. File a complaint, grievance or appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.
3. **Receive professional care and service. This includes your right to:**
   a. See Plan Providers, get covered health care Services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner.
   b. Have your medical care, medical records and protected health information handled

confidentially and in a way that respects your privacy.
c. Be treated with respect and dignity.
d. Request that a staff member be present as a chaperone during medical appointments or tests.
e. Receive and exercise your rights and responsibilities without any discrimination based on age, gender, sexual orientation, race, ethnicity, religion, disability, medical condition, national origin, educational background, reading skills, ability to speak or read English, or economic or health status, including any mental or physical disability you may have.
f. Request interpreter services in your primary language at no charge.
g. Receive health care in facilities that are environmentally safe and accessible to all.

MEMBER RESPONSIBILITIES
As a Member of Kaiser Permanente, you have the responsibility to:

1. Promote your own good health:
a. Be active in your health care and engage in healthy habits.
b. Select a Primary Care Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Physician.
c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.
d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals.
e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.
f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.
g. Schedule the health care appointments your physician or health care professional recommends.
h. Keep scheduled appointments or cancel appointments with as much notice as possible.

2. Know and understand your plan and benefits:
a. Read about your health care benefits in this EOC and become familiar with them. Call us when you have questions or concerns.
b. Pay your plan premiums and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible.

3. Promote respect and safety for others:
a. Extend the same courtesy and respect to others that you expect when seeking health care Services.
b. Assure a safe environment for other Members, staff, and physicians by not threatening or harming others.
c. Let us know if you have any questions, concerns, problems or suggestions.

Named Fiduciary

Under our Agreement with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this EOC. Also, as a named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

No Waiver

Our failure to enforce any provision of this EOC will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate in our employment practices on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Notices

Our notices to you will be sent to the most recent address we have on file for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Services Call Center in the Washington, D.C., Metropolitan area at (301) 468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902 as soon as possible to give us their new address. Our TTY is (301) 816-6344.

Notice of Grandfathered Group Plan

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is "a grandfathered health plan" under the Patient

Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the PPACA.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause your Plan to change from grandfathered health plan status can be directed to your plan administrator. If your Plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov./ebsa/healthreform. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services, to the extent that if we have made payment to a health care provider, we may only retroactively deny reimbursement to the health care provider during the 6-month period after the date we paid the claim submitted by the health care provider.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, health research and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center (see below). You can also find the notice at your local Plan Facility or on our Web site at www.kp.org.

Inside Washington, D.C., Metropolitan area
(301) 468-6000, or in the Baltimore, Maryland
TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

By: 

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

APPENDICES

Definitions

The following terms, when capitalized and used in any part of this EOC, mean:

Allowable Charges (AC): means either:

- For Services provided by Health Plan or Medical Group, the amount in the Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members;
- For items obtained at a Plan Pharmacy, the "Member Standard Value" which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
- For all other Services,
  - the contracted amount;
  - the negotiated amount;
  - the amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or
  - the amount that the Health Plan pays for those Services.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as listed under "Copayments and Coinsurance" in the Summary of Services and Cost Shares section of the Appendix.

Cost Share: The amount of the Allowable Charge that you must pay for covered Services through Copayments.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements see "Who Is Eligible" in the "Eligibility and Enrollment" section.)

Emergency Medical Condition: A medical condition 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:

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

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

- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient

Essential Health Benefits: has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Family Unit: A Subscriber and all of his or her enrolled Dependents.

Fee Schedule: A listing of procedure-specific fees developed by Health Plan and for which the Plan Provider agrees to accept as payment in full for covered Services rendered.

Health Plan: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. This EOC sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Mid-Atlantic Permanente Medical Group, P.C. and Kaiser Foundation Hospitals.

Medical Group: The Mid-Atlantic Permanente Medical Group, P.C.

Medically Necessary: Medically Necessary means that the Service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and /or your provider; and (iv) the most appropriate level of Service which can safely be provided to you. 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. For purposes of this definition, "generally accepted

standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the Kaiser Permanente Medical Care Program; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service (described in this Section 3) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5.

Medicare: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

Member: A person who is eligible and enrolled under this EOC, and for whom we have received the applicable Premium. This EOC sometimes refers to Member as "you" or "your."

Participating Network Pharmacy: Any pharmacy with whom we have entered into an agreement to provide pharmaceutical Services to Members.

Plan: Kaiser Permanente.

Plan Facility: A Plan Medical Center, a Plan Hospital or another freestanding facility that (i) is operated by us or contracts to provide Services and supplies to Members, and (ii) is included in your Signature provider network.

Plan Hospital: A hospital that (i) contracts to provide inpatient and/or outpatient Services to Members and (ii) is included in your Signature provider network.

Plan Medical Center: Medical office and specialty care facilities such as imaging center**s** operated by us in which Medical Group and other health care providers including non-physician specialists employed by us provide primary care, specialty care, and ancillary care Services to Members.

Plan Pharmacy: Any pharmacy located at a Plan Medical Center.

Plan Physician: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who (1) contracts to provide Services and supplies to Members and (ii) is included in your Signature provider network.

Plan Provider: A Plan Physician, or other health care provider including but not limited to a non-physician specialist, and Plan Facility that (i) is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program, or (ii) contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

Premium: Periodic membership charges paid by Group.

Service Area: The areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, King George, Spotsylvania, Stafford, Loudoun, Prince William, and specific zip codes within Caroline, Culpeper, Fauquier, Hanover, Louisa, Orange and Westmoreland; the following Virginia cities – Alexandria, Falls Church, Fairfax, Fredericksburg, Manassas and Manassas Park; the following Maryland areas: the City of Baltimore; the following Maryland counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, and Prince George's, and specific zip codes within Calvert, Charles, and Frederick counties. A listing of these zip codes may be obtained from any Health Plan office.

Services: Health care Services or items.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation Services, or other related health care Services and is certified by Medicare. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Spouse: Your legal husband or wife. The term Spouse shall include your same-sex spouse if you were legally married in another jurisdiction, and the marriage is not expressly prohibited or deemed illegal under District of Columbia law.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status (unless coverage is provided under a continuation of coverage provision)

and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who is Eligible" in the "Eligibility and Enrollment" section).

Totally Disabled:

For Subscribers and Adult Dependents: In the judgment of a Medical Group Physician, a person is totally disabled by reason of injury or sickness if the Member is unable to perform each and every duty pertaining to his or her occupation during the first 52 weeks of the disability. After the first 52 weeks, a person is totally disabled if the Member is unable to perform each and every duty of any business or occupation for which the Member is reasonably fitted by education, training and experience.

For Dependent Children: In the judgment of a Medical Group Physician, an illness or injury which makes the child unable to substantially engage in any of the normal activities of children in good health and like age.

Urgent Care Services: Services required as the result of a sudden illness or injury, which require prompt attention, but are not of an emergent nature.

Summary of Services and Cost Shares

This summary does not describe benefits. For the description of a benefit, including any limitations or exclusions, please refer to the identical heading in the "Benefits" section (also refer to the "Exclusions, Limitations and Reductions" section, which applies to all benefits). **Note:** Additional benefits may also be covered under Riders attached to this EOC, and which follow this Summary of Services and Cost Shares.

DEPENDENT AGE LIMIT
Eligible Dependent children are covered from birth to age 26, as defined by your Group and approved by Health Plan.

MEMBER COST-SHARE
Your Cost Share is the amount of the Allowable Charge for a covered Service that you must pay through Copayments and Coinsurance. The Cost Share, if any, is listed below in the schedule for each Service in this "Summary of Services and Cost Shares." Allowable Charge is defined in the Definitions section of this EOC.

In addition to the monthly Premium, you may be required to pay a Cost Share for some Services. You are responsible for payment of all Cost Shares. Copayments are due at the time you receive a Service. You will be billed for any Deductible and Coinsurance you owe. Failure to pay your Cost Shares may result in termination of your Membership (refer to Section 6, Termination for Nonpayment).

Missed Appointment Fee

The amount you may be required to pay if you fail to keep a scheduled appointment and you do not notify us at least one day prior to the appointment.	$25 per missed appointment

Copayments and Coinsurance

Covered Service	You Pay
Outpatient Care	
Office visits (for other than preventive health care Services)	
Primary care office visits	
For adults	$10 per visit
For children under 5 years of age	No charge
For children 5 years of age or older	$10 per visit
Specialty care office visits	$20 per visit
Consultations and immunizations for foreign travel	$10 per visit
Outpatient surgery	$20 per visit
Anesthesia	No charge
Chemotherapy and radiation therapy	$20 per visit
Respiratory therapy	$20 per visit
Medical social Services	$10 per visit
House calls	No charge
Hospital Inpatient Care All charges incurred during a covered stay as an inpatient in a hospital	No charge
Accidental Dental Injury Services	Applicable Cost Shares will apply, based on type and place of Service

Copayments and Coinsurance

Covered Service	You Pay
Allergy Services	
Allergy evaluation and treatment	Applicable Cost Shares will apply, based on type and place of Service
Injection visit and serum	Applicable Cost Shares will apply, based on type and place of Service, not to exceed the cost of the serum plus administration
Ambulance Services	
By a licensed ambulance Service, per encounter	$100 per encounter
Non-emergent transportation Services	No charge; Deductible waived
Anesthesia for Dental Services	
Anesthesia and associated hospital or ambulatory Services for certain individuals only.	Applicable Cost Shares will apply, based on type and place of Service
Blood, Blood Products and Their Administration	No charge
Chemical Dependency and Mental Health Services	
Inpatient psychiatric and substance abuse care, including detoxification (minimum of 12 days of detoxification per contract year)	Applicable inpatient Cost Share will apply
Hospital alternative Services	
Intensive outpatient psychiatric treatment programs	$10 per visit
Partial hospitalization	$10 per visit
Outpatient psychiatric and substance abuse care	
• Individual therapy	$10 per visit
• Group therapy	$5 per visit
Medication management visits	$10 per visit
Residential treatment center	Applicable inpatient Cost Shares will apply
Cleft Lip, Cleft Palate, or Both	Applicable Cost Shares will apply, based on type and place of Service
Clinical Trials	Applicable Cost Shares will apply, based on type and place of Service
Diabetic Equipment, Supplies and Self-Management Training	
Diabetic equipment and supplies	No charge
Self-management training	Applicable Cost Shares will apply, based on place of Service
Dialysis	
Inpatient care	Applicable inpatient care Cost Shares will apply
Outpatient Care	$20 per visit

Copayments and Coinsurance

Covered Service	You Pay
Drugs, Supplies, and Supplements Administered by or under the supervision of a Plan Provider	No charge
Durable Medical Equipment (DME) – Outpatient	
Outpatient Basic Durable Medical Equipment	50% of AC*
Outpatient Supplemental Durable Medical Equipment	
• Oxygen and Equipment (Must be certified every 30 days)	50% of AC*
• Positive Airway Pressure Equipment (Must be certified every 30 days)	50% of AC*
• Apnea Monitors (Infants under 3, not to exceed a period of 6 months)	50% of AC*
• Asthma Equipment	50% of AC*
• Bilirubin Lights (Infants under 3, not to exceed a period of 6 months)	50% of AC*
Emergency Services	
Emergency Room Visits	
• Inside the Service Area	$75 per visit; Copayment waived if immediately admitted as an inpatient
• Outside the Service Area	$75 per visit; Copayment waived if immediately admitted as an inpatient Transfer to an observation bed or observation status does not qualify as an admission to a hospital and your emergency room visit copayment will not be waived.
Emergency Services HIV Screening Test	No charge
Family Planning	
Office visits	$20 per visit
Tubal ligation, Vasectomy, Voluntary termination of pregnancy	Applicable Cost Share will apply based on place of Service
Habilitative Services Limited to children up to age 21.	$20 per visit
Hearing Services Hearing tests (newborn hearing screening tests are covered under preventive health care Services at no charge)	Applicable office visit Cost Share will apply based on place of Service
Home Health Care See Section 3 for benefit limitations	No charge
Hospice Care	No charge

Copayments and Coinsurance

Covered Service	You Pay
Infertility Services	
Office visits	50% of AC*
Inpatient Hospital Care	50% of AC*
All other Services for treatment of infertility	50% of AC*
Maternity Services	
Routine global maternity care	No charge
Non-routine outpatient obstetrical care	$20 per visit
Post-partum home health visits	No charge
Inpatient obstetrical care and delivery, including cesarean section	No charge
Medical Foods	25% of AC*
Morbid Obesity Services	Applicable Cost Shares will apply based on type and place of Service.
Oral Surgery	Applicable Cost Shares will apply based on type and place of Service
Preventive Health Care Services	
Routine physical exams for adults	No charge
Routine preventive tests for adults	No charge
Well child care visits	No charge
Routine immunizations for children and adults conducted in a Lab or Radiology (No additional charge for immunization agent)	No charge
Prosthetic Devices	
Internally implanted devices	No charge
Ostomy and urological supplies	50% of AC*
Breast prosthetics	No charge
Reconstructive Surgery	Applicable Cost Shares will apply based on place and type of Service.
Skilled Nursing Facility Care Limited to a maximum benefit of 60 days per contract year	No charge
Telemedicine Services	No charge

Copayments and Coinsurance

Covered Service	You Pay
Therapy and Rehabilitation Services (Refer to Section 3 for benefit maximums)	
Inpatient Services	Applicable inpatient Cost Shares will apply
Outpatient Services	$20 per visit
Note: All Services received in one day for multidisciplinary rehabilitation Services at a day treatment program will be considered one visit.	
Transplants	Applicable Cost Shares will apply based on place and type of Service
Urgent Care	
Office visit during regular office hours	Applicable office visit Cost Share will apply
After-Hours Urgent Care or Urgent Care Center	$20 per visit
Vision Services	
Eye exams (for adults age 19 or older)	
• by an Optometrist	$10 per visit
• by an Ophthalmologist	$20 per visit
Eyeglass lenses and frames	You receive a 25% discount off retail price** for eyeglass lenses and for eyeglass frames
Contact lenses	You receive a 15% discount off retail price** on initial pair of contact lenses
Note: A child may select any pair of glasses in lieu of, or in addition to, the eyeglasses or contact lenses available at no charge under Vision Services for children below and receive the discount at any Plan Vision Center.	
Vision Services (for children under age 19)	
Eye exams	
• by an Optometrist	$10 per visit
• by an Ophthalmologist	$20 per visit
Eyeglass lenses and frames (Limited to a select group)	No charge for one pair per contract year
Contact lenses (Limited to a select group)	No charge for initial fit and first purchase per contract year
Medically Necessary contact lenses (Limited to a select group)	No charge
Low Vision Aids (Unlimited from available supply)	No charge

Copayments and Coinsurance	
Covered Service	**You Pay**
X-ray, Laboratory and Special Procedures	
Inpatient diagnostic imaging, interventional diagnostic tests, laboratory tests, specialty imaging and special procedures	Applicable inpatient Cost Shares will apply
Outpatient diagnostic imaging, interventional diagnostic tests, and laboratory tests	No charge
Outpatient specialty imaging (including CT, MRI, PET Scans, Nuclear Medicine and Interventional Radiology) and special procedures	$50 per test
Sleep lab	$50 per visit
Sleep studies	$20 per visit
Note: Charges for covered outpatient diagnostic and laboratory tests performed in a Plan Physician's office are included in the office visit Copayment.	

*AC means Allowable Charge

** "Retail price" means the price that would otherwise be charged for the lenses, frames or contacts at the KP Vision Care Center on the day purchased.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the limit to the total amount of Copayments and Coinsurance you must pay in a contract year for the Basic Health Services covered under this EOC as shown below. Once you or your Family Unit have met the Out-of-Pocket Maximum, you will not be required to pay any additional Cost Shares for these Basic Health Services for the rest of the contract year.

Family Out-of-Pocket Maximum If you have one or more Dependents covered under this EOC, the covered medical expenses incurred by, all Members of the Family Unit medical expenses together apply toward the family Out-of-Pocket Maximum shown below; however no one family member's medical expenses may contribute more than the individual Out-of-Pocket Maximum shown below. After one member of a Family Unit has met the Individual Coverage Out-of-Pocket Maximum, his or her Out-of-Pocket Maximum will be met for the rest of the contract year. Other family Members will continue to pay applicable Cost Shares until the Family Out-of-Pocket Maximum is met. After all Members of the Family Unit combined have met the Family Out-of-Pocket Maximum, the Out-of-Pocket Maximum will be met for all Members of the Family Unit for the rest of the contract year.

Except as excluded below, the following Services are considered "Basic Health Services" that apply toward the Out-of-Pocket Maximum:

- Inpatient and outpatient physician Services
- Inpatient hospital Services
- Outpatient medical Services
- Preventive health care Services
- Emergency Services
- Adult vision exams
- X-ray, laboratory and special procedures
- Inpatient and outpatient chemical dependency and mental health Services

Out-of-Pocket Maximum Exclusions:
The following Services, if covered, are ***not*** considered "Basic Health Services" and ***do not*** apply toward your Out-of-Pocket Maximum.

- Outpatient drugs, supplies and supplements, including blood, blood products, and medical foods
- Outpatient durable medical equipment and prosthetic and orthotic devices
- Inpatient and outpatient infertility Services
- Eyeglass lenses and frames, contact lenses available at a discount

Keep Your Receipts. When you pay a Cost Share, we will give you a receipt. Keep your receipts. If you have met your Out-of-Pocket Maximum, and we have not received and processed all of your claims, you can use your receipts to prove that you have met your Out-of-Pocket Maximum. You can also obtain a statement of the amounts that have been applied toward your Out-of-Pocket Maximum from our Member Services Department.

Notice of Out-of-Pocket Maximum. We will also keep accurate records of your out-of-pocket expenses and will notify you when you have reached the maximum. We will send you written notice no later than 30 days after we have received and processed your claims that the Copayment maximum is reached. If you have exceeded your Out-of-Pocket Maximum, we will promptly refund to you any Copayments or Coinsurance charged after the maximum was reached.

Annual Out-of-Pocket Maximum	
Combined total of allowable Copayments and Coinsurance	**Individual Out-of-Pocket Maximum** $1,500 per individual per contract year **Family Out-of-Pocket Maximum** $3,000 per Family Unit per contract year

KAISER FOUNDATION HEALTH PLAN
OF THE MID-ATLANTIC STATES, INC.

2101 East Jefferson Street
Rockville, Maryland 20852
301-816-2424

OUTPATIENT PRESCRIPTION DRUG RIDER

GROUP EVIDENCE OF COVERAGE

This Outpatient Prescription Drug Rider (Rider) is effective as of the date of your Group Agreement and Group Evidence of Coverage (EOC) This Rider shall end as of the date your Group Agreement and EOC terminate.

The following benefit, limitations, and exclusions are hereby added to the "Benefits" Section of your EOC in consideration of the application and payment of the additional Premium for such Services.

A. Definitions:

Allowable Charge: Has the same meaning as defined in your EOC. See "Appendices - Definitions."

Brand Name Drug: A prescription drug that has been patented and is produced by only one manufacturer.

Cost Share: Has the same meaning as defined in your EOC.

FDA: The United States Food and Drug Administration.

Generic Drug: A prescription drug that does not bear the trademark of a specific manufacturer. It is chemically the same as a Brand Name Drug.

Mail Service Delivery Program: A program operated by the Health Plan that distributes prescription drugs to Members via mail. Certain drugs that need special handling are not provided through the mail-delivery service. This includes, but is not limited to, drugs that are time or temperature sensitive, drugs that cannot legally be sent by U.S. mail, and drugs that need professional administration or observation.

Maintenance Medications: A covered drug that may be needed for six (6) months or more to treat a chronic condition.

Medical Literature: Scientific studies published in a peer-reviewed national professional medical journal.

Non-Preferred Brand Drug: A Brand Name Drug that is not on the Preferred Drug List.

Oral Anticancer Medication: An orally administered anticancer medication used to kill or slow the growth of cancerous cells.

Plan Pharmacy: A pharmacy that is owned and operated by Health Plan.

Preferred Brand Drugs: A Brand Name Drug that is on the Preferred Drug List.

Preferred Drug List: A list of prescription drugs and compounded drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. This Committee, which is made up of Plan Physicians and other Plan Providers, selects prescription drugs for inclusion in the Preferred Drug List based on a number of factors, including but not limited to safety and effectiveness as determined from a review of Medical Literature, Standard Reference Compendia, and research.

Prescription Drug ("Rx") Coinsurance: A percentage of the Allowable Charge that you must pay for each prescription or prescription refill.

Prescription Drug ("Rx") Copayment: The specific dollar amount that you must pay for each prescription or prescription refill.

Standard Manufacturer's Package Size: The volume or quantity of a drug or medication that is placed in a receptacle by the maker/distributor of the drug or medication, and is intended by the maker/distributor to be distributed in that volume or quantity.

Standard Reference Compendia: Any authoritative compendia as recognized from time to time by the federal Secretary of Health and Human Services or the Commissioner.

Tobacco Cessation Drugs: Over-the-Counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.

B. Benefit:

Except as provided in the Limitations and Exclusions sections of this Rider, we cover drugs as described in this Section, in accordance with our Preferred Drug List guidelines, when prescribed by a–Physician or by a dentist. Each prescription refill is subject to the same conditions as the original prescription. Plan Providers prescribe drugs in accordance with Health Plan's Preferred Drug List. If the price of the drug is less than the Rx Copayment, the Member will pay the lesser amount. You must obtain these drugs from a Plan Pharmacy. It may be possible for you to receive refills using our Mail Service Delivery Program. You can ask for details at a Plan Pharmacy.

We cover the following:

- FDA-approved drugs for which a prescription is required by law, when the drug is listed in our Preferred Drug List.
- Compounded preparations that contain at least one ingredient requiring a prescription and are listed in our Preferred Drug List, if (1) there is no medically appropriate alternative in our Preferred Drug List; and (2) the compound is prescribed for an appropriate FDA-approved indication.
- Insulin.
- Drugs that are FDA-approved for use as contraceptives, including over-the-counter contraceptives for women when prescribed by a Plan Provider, and diaphragms. For coverage of other types of contraception, including contraceptive injections, implants and devices, refer to "Family Planning Services" in Section 3 – Benefits of your EOC.
- Tobacco Cessation Drugs (both prescription and over-the-counter) approved by the FDA for treatment of tobacco dependence.
- Off label use of drugs when a drug is recognized in Standard Reference Compendia or certain Medical Literature as appropriate in the treatment of the diagnosed condition.
- Growth hormone therapy (GHT) for treatment of children under age 18 with a growth hormone deficiency.
- Non-prescription drugs when they are prescribed by a Plan Provider and are listed on the Preferred Drug List.

The Pharmacy and Therapeutics Committee sets dispensing limits in accordance with therapeutic guidelines based on the Medical Literature and research. The Committee also meets periodically to consider adding and removing prescribed drugs and accessories on the Preferred Drug List. If you would like information about whether a particular drug or accessory is included in our Preferred Drug List, please visit us on line at www.kp.org, or call the Member Services Call Center at:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 879-6380

Outside the Washington, D.C. Metropolitan Area
1-800-777-7902

Where to Purchase Covered Drugs

We cover prescribed drugs only when purchased at a Plan Pharmacy or through Health Plan's Mail Service Delivery Program. Most non-refrigerated prescription medications drugs ordered through the Health Plan's Mail Service Delivery Program can be delivered anywhere in the United States.

Members may obtain prescribed drugs and accessories from either a Participating Network Pharmacy or a Non-Participating Pharmacy that has previously notified Health Plan, by facsimile or otherwise, of its agreement to accept as payment in full reimbursement for its services at rates applicable to Participating Network Pharmacies, including any Rx Copayment and Rx Coinsurance consistently imposed by the Plan, as payment in full.

Generic and Preferred Drug Requirements

Generic vs. Brand Name Drugs

Plan Pharmacies will substitute a generic equivalent for a Brand Name Drug unless the prescribing provider indicated "dispense as written" (DAW) on the prescription.

Brand Name Drugs will be covered only when: (1) prescribed by a Plan physician or by a dentist or a referral physician; and (2) (a) there is no equivalent Generic Drug, or (b) an equivalent Generic Drug (i) has not been effective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. The applicable Cost Share for the Brand Name Drug will apply.

If a Member requests a Brand Name Drug, for which the prescribing provider has not indicated "dispense as written" (DAW), the Member will be responsible for the full Allowable Charge for that drug.

Preferred vs. Non-Preferred Drugs

Plan Pharmacies will dispense Preferred drugs unless the prescribing provider indicated "dispense as written" (DAW) on the prescription.

Non-Preferred Drugs will be covered only when: (1) prescribed by a Plan physician or by a dentist or a referral physician; and (2) (a) there is no equivalent drug in our Preferred Drug List, or (b) an equivalent Preferred drug (i) has not been effective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. The applicable Non-Preferred Drug Cost Share will apply.

If a Member requests a Non-Preferred Drug, for which the provider has not indicated "dispense as written" (DAW), the Member will be responsible for the full cost of that drug.

Dispensing Limitations

Except for Maintenance Medications as described below, Members may obtain up to a 30 day supply and will be charged the applicable Rx Copayment or Rx Coinsurance based on: (a) the place of purchase, (b) the prescribed dosage, (c) Standard Manufacturers Package Size, and (d) specified dispensing limits.

Drugs that have a short shelf life may require dispensing in smaller quantities to assure the quality is maintained. These drugs will be limited to a 30-day supply. If a drug is dispensed in several smaller quantities (for example three 10-day supplies), the Member will be charged only one Cost Share at the initial dispensing for each 30-day supply.

Except for Maintenance Medications as described below, injectable drugs that are self-administered and dispensed from the pharmacy are limited to a 30-day supply.

Maintenance Medication Dispensing Limitations

Members may obtain up to a 90-day supply of Maintenance Medications in a single prescription, when authorized by the prescribing Plan Provider or by a dentist or a referral physician. This does not apply to the first prescription or change in a prescription. The day supply is based on (a) the prescribed dosage, (b) Standard Manufacturer's Package Size, and (c) specified dispensing limits.

C. Prescriptions Covered Outside the Service Area; To Get Reimbursement

The Health Plan covers drugs prescribed by non-Plan Providers and purchased at non-Plan Pharmacies when the drug was prescribed during the course of an emergency care visit or an urgent care visit (see "Emergency Services" and "Urgent Care Services" sections of the Group Evidence of Coverage), or associated with a covered, authorized referral outside Health Plan's Service Area. To get reimbursed, you must submit a copy of the itemized receipts for the prescriptions to the Health Plan. We may require proof that urgent or emergency care Services were provided. We will reimburse you at the Allowable Charge less the applicable Rx Copayment or Rx Coinsurance.

Claims should be submitted to:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Claims Department
P. O. Box 6233
Rockville, Maryland 20849-6233

D. Limitations:

Benefits are subject to the following limitations:

1. For drugs prescribed by a dentist, coverage is limited to antibiotics and pain relief drugs that are included on our Preferred Drug List and purchased at a Plan Pharmacy.

2. In the event of a civil emergency or the shortage of one or more prescription drugs, we may limit availability in consultation with the Health Plan's emergency management department and/or our Pharmacy and Therapeutics Committee. If limited, the applicable Cost Share per prescription will apply.

E. Exclusions:

The following are not covered under the Outpatient Prescription Drug Rider. Certain Services excluded below may be covered under other benefits of your Group EOC. Please refer to the applicable benefit to determine if drugs are covered:

1. Drugs for which a prescription is not required by law, except when the drug is listed in our Preferred Drug List.

2. Compounded preparations that do not contain at least one ingredient requiring a prescription and are not listed in our Preferred Drug List; or for which: (1) there is a medically appropriate alternative in our Preferred Drug List; or (2) the compound was not prescribed for an appropriate FDA-approved indication.

3. Drugs obtained from a non-Plan or non-Network Pharmacy, except when the drug is prescribed during an emergency or urgent care visit in which covered Services are rendered, or associated with a covered authorized referral outside the Service Area.

4. Take home drugs received from a hospital, Skilled Nursing Facility, or other similar facility. Refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in Section 3 – Benefits of your EOC.

5. Drugs that are not listed in our Preferred Drug List, except as described in this Rider.

6. Drugs that are considered to be experimental or investigational. Refer to "Clinical Trials" in Section 3 – Benefits of your EOC.

7. Except as covered under this Outpatient Prescription Drug Rider, a drug (a) which can be obtained without a prescription, or (b) for which there is a non-prescription drug that is the identical chemical equivalent to a prescription drug (i.e., same active ingredient and dosage).

8. Drugs for which the Member is not legally obligated to pay, or for which no charge is made.

9. Blood or blood products. Refer to "Blood, Blood Products and their Administration" in Section 3 – Benefits of your EOC.

10. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes, including but not limited to drugs used to slow or reverse the effects of skin aging or to treat nail fungus or hair loss.

11. Medical foods. Refer to "Medical Foods" in Section 3 – Benefits of your EOC.

12. Drugs for the palliation and management of terminal illness if they are provided by a licensed hospice agency to a Member participating in our hospice care program. Refer to "Hospice Care Services" in Section 3 – Benefits of your EOC.

13. Replacement prescriptions as a result of damage, theft or loss.

14. Prescribed drugs and accessories that are needed for Services that are excluded under the EOC.

15. Special packaging (e.g., blister pack, unit dose, unit-of-use packaging) that is different from the Health Plan's standard packaging for prescription drugs.

16. Alternative formulations or delivery methods that are (1) different from the Health Plan's standard formulation or delivery method for prescription drugs and (2) deemed not Medically Necessary.

17. Durable medical equipment, prosthetic or orthotic devices and their supplies, including: peak flow meters, nebulizers, and spacers; and ostomy and urological supplies. Refer to "Durable Medical Equipment" and "Prosthetic Devices" in Section 3 – Benefits of your EOC.

18. Drugs and devices provided during a covered stay in a hospital or Skilled Nursing Facility; or that require administration or observation by medical personnel and are provided to you in a medical office or during home visits. This includes equipment and supplies associated with the administration of a drug. Refer to "Drugs, Supplies, and Supplements" and "Home Health Services" in Section 3 – Benefits of your EOC.

19. Bandages or dressings. Refer to "Drugs, Supplies, and Supplements" and "Home Health Services" in Section 3 – Benefits of your EOC.

20. Diabetic equipment and supplies. Refer to "Diabetic Equipment, Supplies, and Self-Management" in Section 3 – Benefits of your EOC.

21. Growth hormone therapy (GHT) for treatment of adults age 18 or older.

22. Immunizations and vaccinations solely for the purpose of travel. Refer to "Outpatient Care" in Section 3 – Benefits of your EOC.

23. Any prescription drug product that is therapeutically equal to an over-the-counter drug, upon a review and determination by the Pharmacy and Therapeutics Committee.

24. Drugs for the treatment of sexual dysfunction disorders.

F. Copayments/Coinsurance:

Covered drugs are provided upon payment of the Rx Copayment or Rx Coinsurance per prescription or refill set forth below:

30 Day Supply	**Mail Delivery**	**Plan Pharmacy**
Generic Drugs	$10	$10
Preferred Brand Drugs	$20	$20
Non-Preferred Brand Drugs	$35	$35

90-day Supply of Maintenance Medication	**Mail Delivery**	**Plan Pharmacy**
Generic Drugs	2 Rx Copayment(s) shown above	2 Rx Copayment(s) shown above
Preferred Brand Drugs	2 Rx Copayment(s) shown above	2 Rx Copayment(s) shown above
Non-Preferred Brand Drugs	2 Rx Copayment(s) shown above	2 Rx Copayment(s) shown above

Weight management drugs for 50% of the Allowable Charge.

Drugs for the treatment of infertility for 50% of the Allowable Charge.

Oral Anticancer Medication for no charge.

Drugs required to be covered by the Affordable Care Act (ACA) without Cost Sharing, including over-the-counter medications when prescribed by a Plan Provider, and obtained at a Plan or Participating Network Pharmacy for no charge.You can find a list of these drugs at:

https://healthy.kaiserpermanente.org/static/health/en-us/pdfs/nat/nat_preventive_services_under_health_reform.pdf
http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

If the cost share for the prescription drug is greater than the Allowable Charge for the prescription drug, the Member will only be responsible for the Allowable Charge for the prescription drug.

G. Deductible:

Benefits set forth in this Rider are not subject to the Deductible set forth in the Summary of Services and Cost Shares in the EOC to which this Rider is attached

H. Out-of-Pocket Maximum:

Cost Shares set forth in this Rider do not apply toward the Out-of-Pocket Maximum set forth in the Summary of Services and Cost Shares in your EOC to which this Rider is attached. The Rx Copayment and Rx Coinsurance set forth above will continue to apply even after the Out-of-Pocket Maximum in your EOC has been met.

This Outpatient Prescription Drug Rider is subject to all the terms and conditions of the Group Agreement and Group EOC to which this Rider is attached. This Rider does not change any of those terms and conditions, unless specifically stated in this Rider.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

By: 

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

KAISER FOUNDATION HEALTH PLAN
OF THE MID-ATLANTIC STATES, INC.
2101 East Jefferson Street, Rockville, Maryland 20849

EXTENEDED INFERTILITY SERVICES RIDER

GROUP EVIDENCE OF COVERAGE

This Extended Infertility Services Rider (herein called "Rider") is effective as of the date of your Group Agreement and Group Evidence of Coverage and shall terminate as of the date your Group Agreement and Group Evidence of Coverage terminates.

The following benefits, limitations, and exclusions for extended infertility Services are hereby added to the Benefits Section of the Group Evidence of Coverage (herein referred to as the Group EOC) in consideration of the application and payment of the additional Dues for such Services.

Extended Infertility Services

A. ***Benefits***

We cover in vitro fertilization, if:

- the Member's oocytes are fertilized with the Member's spouse's sperm; and
- the Member and the Member's spouse have a history of infertility of at least 2 years duration; or the infertility is associated with any of the following:
  - endometriosis;
  - exposure in utero to diethylstilbestrol, commonly known as DES;
  - blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy);
    or
  - abnormal male factors, including oligospermia, contributing to the infertility; and
- the Member has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under this Group EOC; and,
- the in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or the American Fertility Society minimal standards for programs of in vitro fertilization.

Note: Diagnostic procedures and drugs administered by or under the direct supervision of a Plan Provider are covered under this Rider. Refer to the Prescription Drug Rider, if applicable, for coverage of outpatient infertility drugs.

B. ***Limitations***

Coverage for in-vitro fertilization is limited to three (3) attempts per lifetime, not to exceed a maximum lifetime benefit of $100,000.

C. ***Exclusions***

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member's eggs and/or male Member's sperm for future attempts.
- Assisted reproductive procedures and any related testing or service that includes the use of donor sperm, donor eggs or donor embryos.
- Any charges associated with donor eggs, donor sperm or donor embryos.
- Infertility Services when the member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive Endocrinology.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies and procedures other than those described above, including but not limited to: gamete intrafallopian transfers (GIFT); zygote interafallopian transfers (ZIFT); intracytoplasmic sperm

injection (ICSI); assisted hatching; preimplantation genetic diagnosis (PGD); and prescription drugs related to such procedures.

D. ***Your Cost Share***

Refer to the Summary of Benefits and Cost Shares in the Group EOC for cost share information. The cost shares for "Infertility Services" in the Summary of Benefits and Cost Shares in the Group EOC also apply to the Services covered under this Rider.

This Extended Infertility Services Rider is subject to all the terms and conditions of the Group Evidence of Coverage to which this Rider is attached. This Rider does not change any of those terms and conditions, unless specifically stated in this Rider.

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

By: _____

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.
AMENDMENT RIDER TO GROUP AGREEMENT AND EVIDENCE OF COVERAGE

(Grandfathered Group Plan with Preventive Care)

The Group Agreement and Evidence of Coverage (hereinafter severally and collectively referred to as the "Agreement") to which this amendment rider is attached is amended as described below.

Definitions

Capitalized terms shall have the meaning ascribed to them in the Agreement unless defined in this amendment rider. The following definition is added to the Agreement:

"Essential Health Benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and as further defined by the Secretary of the United States Department of Health and Human Services and includes: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services· and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Notice of Grandfathered Coverage

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. believes that your Plan is "a grandfathered health plan" under the PPACA. As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when PPACA was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the PPACA that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the PPACA.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause your Plan to change from grandfathered health plan status can be directed to your plan administrator. If your Plan is governed by ERISA, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov./ebsa/healthreform. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Children's Coverage to Age 26

The provisions of your Agreement that define a "child" or that describe the eligibility requirements or causes of termination of a child's coverage are revised as follows to comply with 45 CFR Parts 144, 146, and 147.

Eligibility

Any provision of the Agreement that indicates that a child's eligibility for coverage is based on any factor other than the relationship between the child and an individual covered under the Agreement is deleted. Any requirement that: the child be financially dependent on an individual covered under the Agreement; that a child share a residence with the individual covered under the Agreement; that the child meet certain student status requirements; that the child be unmarried; or that the child not be employed, is deleted.

For contract years beginning before January 1, 2014, any requirement that the adult child not be eligible for other coverage is amended to apply only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent.

Termination

Any provision of the Agreement that indicates that a child's coverage will terminate when: the child marries; ceases to be financial dependent on an individual covered under the Agreement; ceases to share a residence with an individual covered under the Agreement; ceases to be a full-time or part-time student; becomes employed full-time or part-time; or reaches any limiting age which is less than 26, is deleted.

For contract years beginning before January 1, 2014, any provision of the Agreement that indicates that coverage of the adult child will cease due to eligibility of the adult child for other coverage is revised to provide that termination of coverage will occur only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent. For contract years beginning on or after January 1, 2014, any provision of the Agreement that indicates that coverage of the adult child will cease due to eligibility of the adult child for other coverage is deleted.

The Agreement is revised to provide that a child shall remain eligible for coverage through the last day of the month in which the child turns 26 years of age. The limiting age will not apply to a child, who at the time of reaching the limiting age, is incapable of self-support because of mental or physical incapacity that started before the child attained the limiting age, provided the incapacitated child is unmarried and dependent on an individual covered under the Agreement. Coverage of the incapacitated child will continue for as long as the child remains: incapable of self-support because of a mental or physical incapacity; unmarried; and dependent on an individual covered under the Agreement.

Definition of Child

Any provision of the Agreement that defines or describes which children can be covered under the Agreement is revised to include a child who has not attained the child's 26th birthday irrespective of the child's:

(1) Financial dependency on an individual covered under the Agreement;
(2) Marital status;
(3) Residency with an individual covered under the Agreement;
(4) Student status;
(5) Employment; or,
(6) Satisfaction of any combination of the above factors.

If the provision of the Agreement prohibits the adult child from being covered if the child is eligible for other coverage, the eligibility requirement prohibiting coverage for children eligible for other coverage is amended to apply only for contract years beginning before January 1, 2014; and only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan of a parent.

Transition for Children Previously Denied Enrollment or Who Terminated Coverage Due to Attaining Limiting Age

The Agreement is amended to provide coverage from the first day of the first contract year occurring on or after September 23, 2010, if the child meets both of the following:

(1) The child was terminated from coverage previously due to failure to satisfy the child definition of the Agreement; or the child was prohibited from enrolling under the Agreement due to failure to meet the child definition in the Agreement; and
(2) The child enrolls during the first 30 days of the first contract year occurring on or after September 23, 2010.

Annual Dollar Limits

Any annual dollar limit on any Essential Health Benefits in the Agreement is amended to be the greater of: (1) the annual dollar limit permitted under 45 CFR 147.126; and (2) the annual dollar limit described in the Agreement.

Rescissions

Any provision of the Agreement that describes the right of Health Plan to rescind or void the Agreement, or to rescind the coverage of a Member, is amended to permit Health Plan to rescind or void the entire Agreement or the coverage of a Member only if: (1) the Member (or a person seeking coverage on behalf of the Member) performs an act, practice, or omission that constitutes fraud; or (2) the Member (or a person seeking coverage on behalf of the Member) makes an intentional misrepresentation of material fact.

Any provision of the Agreement that describes notice of rescission of coverage and that provides less than 30-days advance written notice of rescission is amended to provide 30-days advance written notice of any rescission of coverage.

Prohibition on Pre-Existing Conditions for Children

The following provisions of the Agreement shall not apply to any child who is under the age of 19:

(1) Any provision that describes a pre-existing condition exclusion or limitation;
(2) Any provision that indicates that a pre-existing condition exclusion or limitation is applicable;
(3) Any provision that indicates that benefits are contingent on an injury occurring or a sickness first manifesting itself while the child is covered under the Agreement; and
(4) Any provision of the Agreement that describes possible denial or rejection of coverage due to underwriting.

Preventive Services

In addition to any other preventive benefits described in the group contract or certificate, Health Plan shall cover the following preventive services and shall not impose any cost-sharing requirements, such as: Deductibles; Copayment amounts; or Coinsurance amounts, to any Member receiving any of the following benefits for services from Plan Providers:

(1) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

(2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(4) With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Health Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

This amendment rider shall be effective the first day of the first contract year on or after September 23, 2010.

Mark Ruszczyk
Vice President, Marketing, Sales & Business Development

KAISER PERMANENTE INSURANCE COMPANY

Mid-Atlantic

Flexible Choice

KAISER PERMANENTE INSURANCE COMPANY

One Kaiser Plaza
Oakland, California 94612

CERTIFICATE OF INSURANCE

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

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

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

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

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

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

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

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

TABLE OF CONTENTS

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

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

INTRODUCTION

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

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

Introduction to Your Plan

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

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

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

For the Participating Providers (Option 2) and Out-of-Network Providers (Option 3) options, KPIC is responsible for paying for the medical and hospital services described in this Certificate/Group Policy. Your coverage under the Group Policy includes coverage for certain Covered Services received from Participating Providers. To verify the current participating status of a provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Providers is available from your employer , or call the phone number listed on Your ID card, or you may visit the network's web site at: www.multiplan/kpmas. If You receive Covered Services from a Non-Participating Provider, benefits under the Group Policy will be payable by KPIC at the Non-Participating Provider level at the Out-of-Network Providers (Option 3) option level. Your financial responsibility is different for Covered Services rendered by Participating and Non-Participating Providers and you should consult the Schedule of Coverage to determine the amount which KPIC will pay for a Covered Service.

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

Neither Health Plan nor KPIC is responsible for any Covered Person's/Member's decision to receive treatment, services or supplies at any option level. Neither Health Plan or KPIC is liable for the qualifications of providers or treatment, services or supplies rendered under the other

payor's coverage. This Certificate and the Group Policy set forth the terms of the coverage underwritten by KPIC.

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

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

Who Can Answer Your Questions?

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

For coverage:	1-800-392-8649
Eligibility, name or address change:	1-800-392-8649

Or You may write to the Administrator:

Dell
2300 West Plano Parkway
Plano, Texas 75075

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

If You have any questions regarding services, facilities, or care You receive from a Participating Provider, please call the toll free number listed in the Participating Provider directory.

For Pre-certification of Covered Services or Utilization Review please call the number listed on Your ID card or 1-888-567-6847.

GENERAL DEFINITIONS

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

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

Administrator means Dell, 2300 West Plano Parkway, Plano, Texas 75075 and refers to the administrator of the Group Policy only. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior notice. Neither KPIC nor Health Plan is the administrator of Your employee benefit plan as that term is defined under Title I of the federal Employee Retirement Income Security Act of 1974 (ERISA), as then constituted or later amended.

Advanced Practice Registered Nurse means a person licensed as a RN and certified as an advanced practice RN by the District of Columbia or by the state or territory where the person practices as an advance practice registered nurse.

Alcohol Abuse means any pattern of pathological use of alcohol that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

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

Birth Center means an outpatient facility which:

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

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

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

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

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

Clinically Significant means sufficient to impair substantially a person's judgment, behavior, capacity to recognize, or ability to cope with the ordinary demands of life.

Clinical Trials means clinical research studies, clinical investigations, and treatment studies on a life-threatening condition; or prevention, early detection, and treatment studies on cancer. Coverage for treatment studies shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial. To be eligible, a Clinical Trial must be approved by one or more of the following:

1. The National Cancer Institute;
2. An NCI cooperative group or an NCI center;
3. The FDA in the form of an investigational new drug application;
4. The federal Department of Veterans Affairs; or
5. The National Institutes of Health;
6. The Centers for Disease Control and Prevention;
7. The Agency for Health Care Research and Quality;
8. The Centers for Medicare and Medicaid Services;
9. A bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS;
10. The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant; or
11. An investigation or study approved by an Institution Review Board registered with the Department of Health and Human Services (DHHS) that is associated with an institution which has a multiple project assurance contract or federal-wide assurance contract approved by the DHHS.

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

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

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

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

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

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

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

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

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

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

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

Creditable Coverage means

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

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

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

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

Domestic Partner means an unmarried same or opposite sex adult who resides with the Covered Person and has registered in a state or local domestic partner registry with a Covered Person; or "your company's requirements."

Drug Abuse means any pattern of pathological use of a drug that causes impairment in social or occupational functioning, or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

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

Durable Medical Equipment means medical equipment which:

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

Durable Medical Equipment will not include:

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

Emergency Medical Condition means 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) means 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, and rendered therein, 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.

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. Unless otherwise prohibited by applicable law, day or visit limits may be imposed on Essential and non Essential Health Benefits.

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

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

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

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

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

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

Habilitative Services means health care services, including occupational therapy, physical therapy, and speech therapy, that help a person keep, learn, or improve skills and functioning for daily living, including, but not limited to, applied behavioral analysis for the treatment of autism spectrum disorder

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

Home Health Care Agency means an agency or other provider licensed under state law, if required, to provide Home Health Care.

Home Health Aide means a person, other than a RN or nurse, who provides maintenance or personal care services to persons eligible for Home Health Care Services.

Home Health Care Services means services and supplies that can be safely and effectively provided in the Covered Person's home by health care by a Home Health Care Agency when the Covered Person is bedridden or functionally limited due to an Sickness or Injury that restricts his or her ability to leave his or her residence. Home Health Care Services are limited to:

1. part-time or intermittent skilled nursing care provide by or under the supervision of a Registered Nurse;
2. Part-time or intermittent care by a Home Health Aide, provide in conjunction with skilled nursing care; or
3. Therapeutic care services provided by or under the supervision of a speech, occupational, physical or respiratory therapist licensed under state law (if required).
4. Assistance with activities of daily living;
5. Respite care services; and
6. Homemaker services.

Services by a private duty nurse are excluded under this benefit.

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

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

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

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

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

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

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

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

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

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

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

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

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

Maximum Allowable Charge means:

1. For Participating Providers, the Negotiated Rate.

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

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

2. For Non-Participating Providers, the lesser of the following:

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

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

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

   b. The charges actually billed by the provider for Covered Services.

In some instances, KPIC or its Administrator may negotiate rates and/or discounts with Non-Participating Providers for Covered Services. In such instances, the Maximum Allowable Charge will be limited to the Negotiated Rate.

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

Hospital Routine Care Daily Limit:	the Hospital's average semi-private room rate
Intensive Care Daily Limit:	the Hospital's average Intensive Care Unit room rate
Other licensed medical facility Daily Limit:	the facility's average semi-private room rate

Exception For Emergency Services rendered by 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 Contracted Provider 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.

Medically Necessary means services that, in the judgment of KPIC, are:

1. Essential for the diagnosis or treatment of a Covered Person's Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the Covered Person or the convenience of the health care provider or facility; and
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility. When applied to Confinement in a Hospital or other facility, this test means that the Covered Person needs to be confined as an inpatient due to the nature of the services rendered or due to the Covered Person's condition and that the Covered Person can not receive safe and adequate care through outpatient treatment.

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

Medically or Psychologically Necessary means essential treatment of Drug Abuse, Alcohol Abuse, or Mental Illness, as determined by a Physician, Psychologist or Social Worker. The fact that a Physician, Psychological may prescribe, authorize, or direct a service does not of itself make it Medically Necessary or covered by the Group Policy.

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

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

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

Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnostic and Statistical Manual.

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

Morbid Obesity means:
1. A weight that is at least 100 pounds over or twice the ideal weight for a patients frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
2. A body mass index (BMI) that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, a cardiopulmonary conditions, sleep apnea, or diabetes; or
3. A BMI of 40 kilograms per meter squared without such comorbidity.

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

Necessary Services and Supplies means Medically Necessary Services and Supplies actually administered during any covered Hospital Confinement or other covered treatment. Only drugs and materials that require administration by medical personnel during self-administration are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to surgically implanted prosthetic devices, oxygen, blood, blood products, biological sera, internally implanted medications, contraceptive devices and implantable contraceptives. The term does not include charges for: 1) Room and Board; 2) an Intensive Care Unit; or (3) the services of a private duty nurse, Physician or other practitioner. The term does not include charges for: 1) Room and Board; 2) an Intensive Care Unit; or 3) the services of a private duty nurse, Physician, or other practitioner.

Negotiated Rate means the rates and/or discounts negotiated by KPIC or its Administrator with providers or suppliers of Covered Services. Any such rate is referred to as the Negotiated Rate. If a Negotiated Rate applies to a Covered Service, benefit payments and calculation of Your financial responsibility for payment of deductibles, copayments and Coinsurance amounts will be based on the Negotiated Rate.

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

Non-hospital Residential Facility means a facility certified by the District of Columbia or by any state or territory of the United States as a qualified non-hospital provider of treatment for Drug Abuse, Alcohol Abuse, and Mental Illness, or any combination of these, in a residential setting. The term "non-hospital rehabilitation facility" includes any facility operated by the District of Columbia or by any state or territory or the United States, to provide these services in a residential setting.

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

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

Non-preferred Brand Name Drug means a prescription drug that has been patented and is only produced by one manufacturer under that name or trademark and is not listed by Us as a drug preferred or favored to be dispensed.

Occupational Therapy means those services necessary to achieve and maintain improved self-care and other customary activities of daily living.

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

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

Orthotics means rigid and semi-rigid external Orthotic devices used to support a weak or deformed body member, or for restricting or eliminating motion in a diseased or injured part of the body.

Orthotic devices will not include:
1. Dental devices and appliances;
2. Comfort, convenience, or luxury equipment or features;
3. Shoes or arch supports, even if custom-made, except for severe diabetic foot disease in accord with Medicare guidelines.
4. More than one orthotic device for the same part of the body, except for replacements other than those necessitated because of misuse or loss.
5. Replacement of lost orthotic devices;
6. Repair, adjustments or replacements necessitated by misuse; and
7. Spare or alternate use appliances or apparatus.

Out-of-Plan means those benefits underwritten by KPIC and set forth in the Group Policy. Unless specifically stated otherwise in the Group Policy, KPIC will not pay for services arranged, provided or reimbursed under Health Plan's In-Plan coverage.

Out-of-Pocket Costs means a Covered Person's share of Covered Charges. For purposes of the Out of Pocket Maximum, a Covered Person's Out-of-Pocket costs means the difference between the amount payable by KPIC for Covered Charges and the Maximum Allowable Charge. Out-of-Pocket does not include co-payments/coinsurance for prescription drugs under your prescription drug card benefit or any amount in excess of the Maximum Allowable Charge.

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

Outpatient Rehabilitative Services means occupational therapy, speech therapy, and physical therapy, provided to the Covered Person while receiving Home Health Care, Hospice Care and Skilled Nursing Care. The attending Physician must determine that the condition is subject to measurable improvement in function within a two-month period.

Outpatient Treatment Facility means a clinic, counseling center, or other similar location that is certified by the District of Columbia or by any state or territory of the United States as a qualified provide of outpatient services for the treatment of Alcohol Abuse, Drug Abuse of Mental Illness. The term "outpatient treatment facility" includes any facility operated by the District of Columbia, any state or territory or the United States to provide these services on an outpatient basis.

Partial Hospitalization means short term treatment of not more than 24 hours and not less than 4 hours for mental illness, emotional disorders, drug or alcohol abuse in a licensed or certified facility or program.

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

Participating Provider means a Hospital, Physician or other duly licensed health care provider or facility that is operating under an agreement with KPIC, its Administrator, or KPIC's designated preferred provider organization to provide Covered Services at Negotiated Rates.

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

Preferred Provider Organization (PPO) means an organization of Hospitals, Physicians and other duly licensed health care providers or facilities designated by KPIC to provide Covered Services at Negotiated Rates. In most instances, Your Out-of-Pocket costs are lower when you receive Covered Services from Participating Providers. Please refer to Your Schedule of Coverage to determine if a PPO is applicable to Your plan.

Percentage Payable means that percentage of Covered Charges payable by KPIC. The Percentage Payable and the Covered Service to which it applies is set forth in the Schedule of Coverage. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services to calculate the benefit payable under the Group Policy.

Physical Therapy means those services limited to the restoration of an existing physical function, except as provided in the "Early Intervention Services" of the **General Benefits** section of this Certificate.

Physician means a health practitioner who is duly licensed as such in the state in which the treatment is rendered. He or she must be practicing within the scope of that license. The term

does not include a practitioner who is defined elsewhere in this **GENERAL DEFINITIONS** section.

Policyholder means the employer(s) or trust or other entity named in the Group Policy as the Policyholder and whom conforms to the administrative and other provisions established under the Group Policy.

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

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

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

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

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

Prosthetics means internally implanted devices and/or external prosthetic devices that are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person in the absence of a Sickness or Injury. Internally implanted devices include, but are not limited to, devices implanted during surgery, such as pacemakers, ocular lens implants, artificial hips and joints, breast implants and cochlear implants that are approved by the Federal Food and Drug Administration. External devices are limited to ostomy and urological supplies as well as breast prosthesis, including a mastectomy bra needed following a mastectomy and custom-made prosthetics.

Prosthetic devices will not include:

1. Internally implanted breast prosthetics for cosmetic purposes;
2. Dental prosthetics, devices, implants and appliances. This exclusion does not include treatment of children with congenital and genetic birth defects to enhance the child’s ability to function, such as cleft lip, cleft palate, or both;
3. Hearing aids;
4. Corrective lenses and eyeglasses, except as provided under the “Vision Care” benefit;
5. Repair or replacement of prosthetics due to misuse or loss;
6. More than one prosthetic device for the same part of the body, except for replacements, spare devices or alternative use device;
7. Non-rigid supplies, such as elastic stockings, and wigs;
8. Electronic voice producing machines;
9. Hair prosthesis;
10. Replacement of lost prosthetic devices;
11. Repair, adjustments or replacements necessitated by misuse;
12. Spare or alternate use equipment; and
13. Prosthetics for the treatment of sexual dysfunction disorders.

Psychologist means a person licensed to practice psychology by the District of Columbia or by the state or territory of the United States where the person practices psychology.

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

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

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

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

Routine Prenatal Care means an office visit that includes one or more of the following:
1. The initial and subsequent histories;
2. Physical examinations;
3. Recording of weight, blood pressures;
4. Fetal heart tones; and
5. Routine chemical urinalysis.

Sickness means illness or a disease of a Covered Person. Sickness includes congenital defects or birth abnormalities and pregnancy.

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

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

Social Worker means a person licensed as an independent clinical social worker by the District of Columbia or who is licensed to practice social work with authority to engage in the independent practice of psychotherapy by the state of territory where the person practices social work.

Specialty Care Visits means consultations with Physicians other than Primary Care Physicians in departments other that those listed under the definition of Primary Care Physicians.

Speech Therapy means those services limited to the treatment for speech impairments due to a sickness or injury.

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

Stabilize means 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).

Telehealth means the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment; provided, that services delivered through audio-only telephones, electronic mail messages, or facsimile transmissions are not included.

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

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

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

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

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

Eligibility for Insurance

The following persons will be eligible for insurance:

Insured Employees and their dependents who meet the eligibility requirements set forth in the Health Plan's Evidence of Coverage and who are enrolled in Health Plan as Point-of-Service Members in a timely manner. Eligibility for benefits under the Group Policy will terminate when coverage under the Health Plan's Evidence of Coverage terminates. Health Plan, on behalf of KPIC, will make all decisions regarding eligibility and termination.

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 as a Point-of-Service Member.

Termination of a Covered Person's Insurance

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

1. The date the Covered Person ceases to be covered by Health Plan as a Point-of-Service Member;
2. The date the Group Policy terminates;
3. The date a Covered Person, or the Covered Person's representative, commits a fraudulent act or knowingly makes a misrepresentation of a material fact;
4. The end of the grace period after the employer group fails to pay any required premium to KPIC, Health Plan, or its Administrator when due or KPIC does not receive the premium payment in a timely fashion;
5. The date the Insured employee and/or his/her Dependents cease to be eligible for under Health Plan's Evidence of Coverage;
6. The date You no longer live or work in Health Plan's Service Area (as that term is defined in the Evidence of Coverage and is hereby incorporated by reference); or
7. The date the Group Agreement between Your group and Health Plan terminates.

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

The Health Plan Point-of-Service Evidence of Coverage more fully explains eligibility, effective date and termination.

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 will be effective, on:

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

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

PRE-CERTIFICATION

Pre-certification through the Medical Review Program

This section describes:
1. The Medical Review Program and Pre-certification procedures;
2. How failure to obtain pre-certification affects coverage;
3. Pre-certification administrative procedures;
4. Which clinical procedures require Pre-certification;

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

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

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

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

The following treatment or services must be pre-certified by the Medical Review Program:
1. Inpatient admissions and services
2. Inpatient Rehabilitation Therapy admissions, services and programs
3. Inpatient Skilled Nursing Facility, long term care, and sub acute admissions and services
4. Bariatric Surgery/Gastric Bypass, Stapling or Banding
5. Dental Anesthesia
6. Spinal Surgery
7. Upper Airway Procedures
8. Orthotics/Prosthetics
9. Endoscopy (pill/capsule only)
10. Pain Management
11. Varicose Vein Treatment/Sclerotherapy
12. Experimental/Investigational Procedures and Drugs
13. Hyperbaric Oxygen Treatment
14. Non-Emergent Air or Ground Ambulance Transport
15. Enhanced External Counterpulsation (EECP)
16. Genetic Testing
17. Plasma Pheresis for Multiple Sclerosis
18. Anodyne Therapy
19. Vagal Nerve Stimulation for Epilepsy
20. Imaging Service: Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography Angiography(CTA), Positron Emission Tomography (PET), Electronic Beam Computed Tomography (EBCT)
21. Home Health & Home Infusion
22. Outpatient & Home Therapy: Physical, Speech, Occupational , Respiratory beyond 10 visits in calendar year
23. Cardiac Rehabilitation
24. Infertility
25. Outpatient Injectable Drugs

26. Durable Medical Equipment (DME)
27. Habilitative Services (physical therapy, occupational therapy, and speech therapy)
28. Rehabilitative Services (physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation)
29. Transgender Surgery
30. The following surgical procedures regardless of cost:
    (a) Blephasoplasty
    (b) Carpal tunnel release
    (c) Hammertoes repair
    (d) Orthognathic surgery
    (e)Reconstructive surgery
    (f) Repair of nasal septum
    (g) Septoplasty
    (h)Temporomandibular joint dysfunction surgery

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

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

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

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

A shorter length of stay may be Pre-certified if the Physician, in consultation with the mother, determines that the newborn and the mother meet the criteria for medical stability in accordance with the Guidelines for Prenatal Care or the Standards for Obstetric-Gynecologic Services. In all such cases of early discharge, We will provide coverage for post-delivery care within the above-stated minimum time periods. The postpartum care may be delivered in the patient's home or the provider's office, as determined by the Physician in consultation with the mother.

The at-home post-delivery care shall be provided by a Physician, RN, Certified Nurse Practitioner, Certified Nurse-Midwife or Licensed Midwife or Physician assistant. Postpartum care includes

1. Parental education
2. Assistance and training in breast or bottle feeding; and
3. Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

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

Pre-certification Procedures

The Covered Person, or provider acting on behalf of the Covered Person, must notify the Medical Review Program as follows:

1. Planned Hospital Confinement - as soon as reasonably possible after the Covered Person learns of a Hospital Confinement, but at least three days prior to admission for such Hospital Confinement.
2. Extension of a Hospital Confinement - as soon as reasonably possible prior to extending the number of days of Hospital Confinement beyond the number of days originally Pre-certified.

3. Other treatments or procedures requiring pre-certification - As soon as reasonably possible after the Covered Person learns of the need for any other treatment or service requiring pre-certification but at least three days prior to performance of any other treatment or service requiring pre-certification.
4. During the first trimester of pregnancy if the Covered Person intends to have Maternity Services covered under this plan.

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

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

DEDUCTIBLES AND MAXIMUMS

Individual Deductible

The Deductible for an individual, as shown in the Schedule of Coverage, applies to all Covered Services incurred by a Covered Person during a Policy Year, unless otherwise indicated in the Schedule of Coverage. The Deductible may not apply to some Covered Services, as shown in the Schedule of Coverage. When Covered Charges equal to the Deductible are incurred during the Policy Year and are submitted to Us, the Deductible will have been met for that Covered Person for that Policy Year. Benefits will not be payable for Covered Charges applied to the Deductible.

In addition, some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles do not contribute toward the satisfaction of the Individual Deductible and Family Deductible.

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

Family Deductible Maximum

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

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

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

Benefit-Specific Deductibles

Some Covered Services are subject to additional or separate deductible amounts as shown in the Schedule of Coverage. These additional or separate deductibles contribute toward the satisfaction of the Individual Deductible and the Family Deductible**.**

Common Accident

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

Percentage Payable

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

DEDUCTIBLES AND MAXIMUMS

Out-of-Pocket Maximums

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

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

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

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

Effect of Prior Coverage on Deductible and Out-of-Pocket Maximum Take-over

Any Expenses Incurred by a Covered Person while covered under the Prior Coverage will be credited toward satisfaction of Deductibles and Out-of-Pocket Maximums, as applicable, under the Group Policy if:

1. the expenses were incurred during the same Policy Year ninety (90) days before the Effective Date this Group Policy becomes effective;
2. the expenses were applied toward satisfaction of the deductibles or Out-of-Pocket maximum under the Prior Coverage during the same Policy Year ninety (90) days before the Effective Date this Group Policy becomes effective; and
3. the expenses would be considered Covered Charges under the Group Policy.

As used in this provision, "Prior Coverage" means the Policyholder's group medical plan that the Group Policy replaced. KPIC will insure any eligible person under the Group Policy on its Effective Date, subject to the above provisions, which apply only to Covered Persons who on the day before the Group Policy's Effective Date were covered under the Prior Coverage.

Maximum Allowable Charge

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

Maximum Benefit While Insured

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

Essential Health Benefits, as defined under the Policy are not subject to the Maximum Benefit While Insured or any dollar Benefit Maximum specified under the Policy. Unless otherwise

prohibited by applicable law, day or visit limits may be imposed on Essential and non-Essential Health Benefits.

Other Maximums

In addition to the Maximum Benefit While Insured, certain treatments, services and supplies are subject to benefit-specific limits or maximums. These additional limits or maximums items are shown in the Schedule of Coverage**.**

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

Benefit levels for Participating Providers or Non-Participating Providers (For PPO Plans only)

Your coverage provided under the Group Policy may include coverage for Covered Services that are received from either Participating Providers or Non-Participating Provider. See Your Schedule of Coverage to determine if Your coverage includes Participating Providers. Generally, benefits payable are greater for Covered Services received from Participating Providers than those benefits payable for Non-Participating Providers. In order for benefits to be payable at the Participating Provider level, the Covered Person must receive care from a Participating Provider. A current copy of KPIC's Participating Provider Directory is available from Your employer, or You may call the phone number listed on Your ID card or You may visit KPIC's contracted provider network web site at: www.Multiplan.com/Kaiser. To verify the current participation status of any provider, please call the toll-free number listed in the provider directory. If the Covered Person receives care from a Non-Participating Provider, benefits under the Group Policy are payable at the Non-Participating Provider level.

Reinstatement of Your Maximum Benefit While Insured

After Covered Charges have been paid for a Covered Person in an amount equal to the Maximum Benefit while Insured shown in the Schedule of Coverage, KPIC will automatically reinstate benefits for such Covered Person each year in an amount equal to the lesser of:

1. $5,000; or
2. the amount paid for all Covered Charges incurred in the prior Policy Year.

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

GENERAL BENEFITS

This section describes the general benefits under the Group Policy. The limitations and exclusions are listed in the General Limitations and Exclusions section. Optional benefits are set forth under, the Optional Benefits, Limitations, and Exclusions section. Please refer to Your Schedule of Coverage to determine which, if any, optional benefits Your employer elected.

Insuring Clause

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

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

Payments under the Group Policy:
1. Will be subject to the limitations shown in the Schedule of Coverage;
2. Will be subject to the General Limitations and Exclusions and all terms of the Group Policy;
3. May be subject to Pre-certification; and
4. Does not duplicate any other benefits paid or payable by KPIC.

Covered Services:

1. Room and Board in a Hospital.
2. Room and Board in a Hospital Intensive Care Unit.
3. Room and Board and other Skilled Nursing services in a Skilled Nursing Facility or other licensed medical facility. Care in a Skilled Nursing Facility must be in lieu of Hospital Confinement, and is limited to: a) the maximum number of covered days shown in the Schedule of Coverage; b) care in a licensed Skilled Nursing Facility; c) care under the active medical supervision of a Physician; and d) services consistent with medical needs. Covered Services will include Durable Medical Equipment furnished during a Confinement in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish such Durable Medical Equipment. A Benefit Period specific to care in a Skilled Nursing Facility begins when a Physician admits a Covered Person to a Hospital or Skilled Nursing Facility and ends when the Covered Person has not been a patient in either a Hospital or Skilled Nursing Facility for sixty (60) consecutive days.
4. Necessary Services and Supplies, including medication dispensed while confined in a Hospital.
5. Emergency Services for medical emergencies anywhere in the world. If a Covered Person is admitted to a Non-Participating Hospital, the Covered Person, or someone acting on behalf of the Covered Person, must notify Us within 48 hours, or as soon as reasonably possible. Upon such notification, a decision will be made as to whether the Covered Person can be safely transferred to a facility We so designate. Failure to provide such notification may result in the loss of coverage that would otherwise have been covered after transfer would have been possible.
6. Physicians' services, including office visits.
7. Ambulance service of a licensed ground or air ambulance only if, the judgment of a physician, your medical condition requires either the basic life support, advance life support, or critical care life support capabilities of an ambulance for interfacility or home transfer and the ambulance transportation has been ordered by a physician.
8. Nursing services by an RN, LVN, or LPN, as certified by the attending Physician if a RN is not available. Outpatient private duty nursing will only be covered for the period for which

KPIC validates a Physician's certification that: a) the services are Medically Necessary and b) that, in the absence of such nursing care, the Covered Person would be receiving Covered Services as an inpatient in a Hospital or Skilled Nursing Facility. Private duty nursing will not be covered unless otherwise indicated in the Schedule of Coverage.

9. Services by a Certified Nurse Practitioner; Clinical Nurse Specialist; Licensed Midwife; Physician's Assistant or Certified Nurse-Midwife. This care must be within the individual's area of professional competence.
10. 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.
11. Chemotherapy.
12. Outpatient X-ray, laboratory tests and other diagnostic services.
13. Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.
14. Home Health Care provided in a Covered Person's home when:
    a. The institutionalization of the Covered Person in a Hospital or related institution or Skilled Nursing Facility would otherwise have been required if home health care were not provided; and
    b. The plan of treatment covering the home health care service is established and approved in writing by the health care practitioner; and
    c. as an alternative to otherwise covered services in a hospital or related institution; or for Covered Persons who receive less than 48 hours of inpatient hospitalization following a mastectomy or removal of a testicle on an outpatient basis:
        i. one home visit scheduled to occur 24 hours after discharge from the hospital or outpatient health care facility, and
        ii. an additional home visit if prescribed by the covered person's attending physician.
15. Outpatient surgery in a Free-Standing Surgical Facility, other licensed medical facility or in a doctor's office.
16. Hospital charges for use of a surgical room on an outpatient basis.
17. Pre-admission testing, limited to diagnostic, x-ray, and laboratory exams made during a Hospital outpatient visit. The exams must be made prior to a Hospital Confinement for which a Room and Board charge is made.
18. Maternity Services including those performed in a Birth Center.
19. Rental of Durable Medical Equipment as prescribed by a Physician for use in Your home (or an institution used as Your home). We also cover Durable Medical Equipment used during a covered stay in a hospital or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment. Coverage is limited to the standard item of equipment that adequately meets Your medical needs.

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

    Purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental.

We decide whether to rent or purchase the equipment, and We select the vendor. We will repair the equipment without charge, unless the repair is due to loss or misuse. You must return the equipment to Us or pay Us the fair market price of the equipment when it is no longer prescribed.

20. Diabetes equipment, supplies, and other outpatient self-management training and education, when prescribed by a Physician, including: medical nutritional therapy for the treatment of insulin-dependent diabetes; insulin-using diabetes; gestational diabetes; non-insulin using diabetes; or elevated blood glucose levels induced by pregnancy, including gestational diabetes. if prescribed by a health care professional legally authorized to prescribe such item. Diabetic supplies are limited to the following:
    a. Insulin;
    b. Blood/urine testing agents, including glucose tests tablets, glucose test tape, and acetone test tablets.
    c. Disposable needles and syringes in quantities needed for injecting prescribed insulin.
21. Multidisciplinary Rehabilitative Services.
22. Physical therapy rendered by a certified physical therapist. To be eligible for coverage the therapy must be: 1) progressive therapy (not maintenance therapy); 2 Rendered according to the attending Physician's written treatment plan; 3) for a condition that the attending Physician determines is subject to significant improvement in the level of functioning within 60 days; and 4) completed by the Covered Person as prescribed. As used in this provision "maintenance therapy" means ongoing therapy after the Covered Person has 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
23. Speech therapy rendered by a certified speech therapist or certified speech pathologist. To be eligible for coverage the speech disorder must be a result of an Injury or Sickness of specific organic origin. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within 60 days.
24. Habilitative services for medically necessary speech therapy, occupational therapy, and physical therapy that help a person keep, learn or improve skills and functioning for daily living, including but not limited to, applied behavioral analysis for the treatment of autism spectrum disorder. Habilitative services delivered through early intervention or school services are not covered.
25. Occupational therapy rendered by a certified occupational therapist. Occupational therapy is limited to services to achieve and maintain improved self-care and other customary activities of daily living. To be eligible for coverage the therapy must be progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan for a condition that the attending Physician determines is subject to significant improvement within 60 days. As used in this provision "maintenance therapy" is defined as ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
26. Respiratory therapy rendered by a certified respiratory therapist. It must be rendered for a condition that the attending Physician determines is subject to significant improvement within 60 days and may not be maintenance therapy.
27. Rehabilitation services while confined in a Hospital or any other licensed medical facility. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program including those provided in a Comprehensive Rehabilitation Facility. To be eligible for coverage the therapy must be: 1) progressive therapy (not maintenance therapy); and 2) rendered according to a written treatment plan for a condition that the attending Physician determines is subject to significant improvement within 60 days. As used in this provision, "maintenance therapy" is defined as ongoing therapy after the Covered Person has: 1) reached maximum rehabilitation potential or functional level; or 2) shown no significant improvement.
28. Treatment, services, or supplies covered under the Group Policy if received as an inpatient or outpatient in a Hospital, other Non-hospital Residential Facility or an Outpatient Treatment Facility in connection with Clinically Significant Mental Illness. This includes treatment or services rendered according to a prescribed treatment plan by a state regulated, board-certified Social Worker, or certified marriage and family therapist. Inpatient services, outpatient services, or any combination thereof, must be certified as necessary by a

Physician, Psychologist, Advanced Practice Registered Nurse, or Social Worker. All Coverage for Mental Illness is subject to the limitations set forth in the Schedule of Coverage.

29. Treatment, services, or supplies covered under the Group Policy if received as an inpatient or outpatient in a Hospital, Non-hospital Residential Facility or Outpatient Treatment Facility, according to a prescribed treatment plan in connection with Clinically Significant substance abuse, the disorders of which are identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association. For purposes hereof, "substance abuse" means: a) Alcohol Abuse; and b) Drug Abuse. Inpatient services, outpatient services, or any combination thereof, must be certified as necessary by a Physician, Psychologist, Advanced Practice Registered Nurse, or Social Worker. Two days of partial hospitalization may be substituted for 1 inpatient day. Medical complications of alcoholism, which include, but are not limited to: a) cirrhosis of the liver; b) gastrointestinal bleeding; c) pneumonia; and d) delirium tremens are otherwise covered under the plan. All coverage for substance abuse is subject to the limitations set forth in the Schedule of Coverage.
30. Detoxification in a hospital or related institution, subject to the level of benefits set forth in the Schedule of Coverage.
31. Blood, blood products and its derivatives and components, the collection and storage of autologous blood for elective surgery, and as well as cord blood procurement and storage. In addition, benefits will be payable for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center. Covered services will not include directed blood donations.
32. Inpatient care following a mastectomy or lymph node dissection until the completion of the appropriate period of stay for such inpatient care as determined by the attending physician in consultation with the patient. If the period of stay if less than forty-eight (48) hours, then coverage will include:
    a. one home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility; and
    b. an additional home visit if prescribed by the patient's attending physician
33. Allergy testing and treatment, services, material and serums.
34. Reconstructive breast surgery, including coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive breast surgery is performed on the diseased breast. Coverage also includes prostheses and physical complications, including lymphedes.
35. Vision services, including routine exams from an optometrists or ophthalmologist, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses.
36. Prosthetics. Coverage will include fitting and adjustment of these devices, repair or replacement, and services and supplies to determine whether you need the prosthetic. Covered Services will be limited to the standard device that adequately meets your medical needs. Coverage will include internally implanted and external Breast Prosthetics following a mastectomy. Breast Prosthetics will also be provided for the non-diseased breast to achieve symmetry with the diseased breast.
37. Covered services rendered as part of an approved Clinical Trial.
38. Other services or treatment approved through the Medical Review Program.
39. Diagnostic and surgical treatment involving any bone or joint of the skeletal structure if the treatment is required because of a medical condition or injury which prevents normal function of the joint or bone and is deemed medically necessary to attain functional capacity of the affected part.
40. Hospice Care is limited to:
    a. Nursing care;
    b. Physical, speech or occupational therapy;
    c. Medical social services;
    d. Services of home health aides and homemakers;
    e. Medical supplies, drugs and appliances;
    f. Physician services;

g. Short-term inpatient care, including respite care and care for pain control and acute and chronic symptom management;
h. Palliative drugs in accord with our preferred drug formulary listing;
i. Counseling and bereavement services.

Hospice Care benefit is provided in lieu of continued hospitalization.

41. Diagnosis and treatment of Morbid Obesity, including gastric bypass surgery or other surgical methods that are recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity.
42. Medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry including a disease for which the State screens newborn babies. Coverage is provided if the medical foods and low protein food products are prescribed as medically necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Physician.
43. Medically Necessary early intervention services related to speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices for Dependents, from birth to age three, who were born with congenital birth defects, and who are eligible for Services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Early intervention services are Medically Necessary when such services are designed to help a Dependent attain or retain the capability to function age-appropriately within his or her environment, and shall include services that enhance functional ability without affecting a cure. Benefits payable are limited to $5,000 per Dependent per Policy Year. These Services are provided in addition to the Physical, Occupational, Speech Therapy and Multidisciplinary Rehabilitation Services described in this Certificate of Insurance.
44. Inpatient and outpatient services arising from orthodontics, oral surgery and otologic, audiological and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.
45. Anesthesia for dental services, limited to general anesthesia and Hospital or outpatient surgury facility charges for outpatient surgical procedures for dental care provided to a Covered Person who is determined by a licensed dentist, in consultation with the Covered Person's treating Physician, to require general anesthesia and admission to a Hospital or outpatient surgery facility to effectively and safely provide dental care. For the purpose of this Covered Service, a determination of medical necessity will include but not be limited to a consideration of whether the age, physical condition or mental condition of the Covered Person or mental condition of the Covered Person requires the utilization of general anesthesia and the admission to a Hospital or outpatient surgery facility to safely provide the underlying dental care. This provision does not provide coverage for any dental procedure or the professional fees or services of the dentist.
46. Accidental Dental Injuries are limited to restorative services necessary to promptly repair, but not replace, Sound Natural Teeth that have been injured as the result of an external force. For benefits to be payable all of the following conditions must be met:
    a. The injury occurred as the result of an external force hat is defined as violent contact with an external object, not force incurred while chewing;
    b. The injury was sustained to sound natural teeth;
    c. The Covered Services must begin within 60 days of the injury;
    d. The Covered Services are provided during the 12 consecutive month period commencing from the date that the injury occurred.

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

    For purposes of this benefit, Sound Natural Teeth are defined as tooth or teeth that:
    a. Have not been weakened by existing dental pathology such as decay or periodontal disease;
    b. Have not been previously restored by a crown, inlay, onlay, porcelain restoration, or treatment by endodontics.

Restorative Services will not include:
a. Services provided after 12 months from the date the injury occurred; and
b. Services for teeth that have been avulsed (knocked out) or that have been so severely damaged that in the opinion of the Participating Provider, restoration is impossible.

47. Artificial insemination
48. Physician services, including diagnosis, consultation, and treatment appropriately provided via Telehealth. Telehealth shall be subject to the same Deductible, Coinsurance and/or Copayments as are otherwise applicable to Physician office visits.
49. Transgender benefit includes sexual reassignment surgery and mastectomy/chest reconstruction services, in addition to behavioral health and hormone therapy services to treat a diagnosis of gender dysphoria. Medical necessity of sexual reassignment servics will be determined in accordance with the World Professional Association for Transgender Health Standards of Care ("WPATH Standards"). Covered services will include the following Medically Necessary services if the surgery is precertified and the member participates in case management: a) Pre-surgery consultations and post surgery follow-up exams; b) Outpatient surgery and other outpatient procedures; and c) Hospital inpatient care (including room and board, imaging, laboratory, special procedures, drugs, and Physician services).

Preventive Services

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

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

Exams

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

Screenings

1. Abdominal aortic aneurysm screening
2. Asymptomatic bacteriuria screening
3. Breast cancer mammography screening
4. Cervical cancer and dysplasia screening including Human Papillomavirus Screening (HPV),
5. Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy.
6. Depression screening
7. Gestational diabetes screening
8. Hepatitis B virus infection screening: for pregnant women
9. Hematocrit or Hemoglobin screening in children
10. High blood pressure screening
11. Iron deficiency anemia screening for pregnant women
12. Lead Screening
13. Lipid disorders screening
14. Lung cancer screening with low-dose computed tomography in adults who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years.
15. Newborn congenital hypothyroidism screening

16. Newborn hearing loss screening
17. Newborn metabolic/hemoglobin screening
18. Newborn sickle cell disease screening
19. Newborn Phenylketonuria screening
20. Obesity screening
21. Osteoporosis screening
22. Rh (D) incompatibility screening for pregnant women
23. Sexually transmitted infection screening such as chlamydia, gonorrhea, syphilis and HIV screening
24. Type 2 diabetes mellitus screening
25. Tuberculin (TB) Testing
26. Visual impairment in children screening
27. Emergency Department HIV screening test
28. High-risk human papillomavirus (HPV) DNA testing every three years for women age 30 years or older with normal cytology results.

Health Promotion

1. Alcohol and drug misuse assessment and behavioral counseling interventions in a primary care setting to reduce alcohol misuse
2. Healthy diet behavioral counseling
3. Offer Intensive counseling and behavioral interventions to promote sustained weight loss for obese adults and children
4. Tobacco use and tobacco-caused disease counseling
5. Referral for testing for breast and ovarian cancer susceptibility, referral for genetic risk assessment and BRCA mutation testing
6. Sexually transmitted infections counseling
7. Discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention and when prescribed by a physician for asymptomatic women, with an increased risk of breast cancer and no history of breast cancer, the risk reducing medication such as tamoxifen and raloxifene.
8. When prescribed by a licensed health care professional authorized to prescribe drugs:
   a) aspirin in the prevention of cardiovascular disease.
   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) folic acid supplementation for women planning or capable of pregnancy.
   e) Vitamin D to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls
9. Interventions to promote breastfeeding. The following additional services are covered: breastfeeding support and consulting by a trained provider during pregnancy and/or in the post partum period, purchase of a manual breast pump. A manual breast pump is one that does not require a power source to operate. In lieu of purchase of a manual breast pump, rental of a hospital-grade electric breast pump, including any equipment that is required for pump functionality, for 6 months 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.
10. All prescribed FDA-approved contraceptive drugs and prescribed FDA-approved cervical caps, vaginal rings, continuous extended oral contraceptives and patches. This includes contraceptives which require medical administration in Your doctor's office, implanted devices and professional services to implant them, female sterilization procedures, and patient education and counseling for all women with reproductive capacity. Over the counter FDA approved female contraceptive methods are covered only when prescribed by a licensed health care professional authorized to prescribe drugs.
11. Screening and counseling for interpersonal and domestic violence
12. Physical therapy to prevent falls in community-dwelling adults who are at increased risk for falls. Community dwelling adults means those adults not living in assisted living, nursing homes or other institutions

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.

Exclusions for Preventive Care

The following services are not covered as Preventive Care:

- Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases
- Replacement or upgrades of breast-feeding equipment

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

For a complete list of current preventive services required under the Patient Protection Affordable Care Act for which cost share does not apply, please call: 1-800-392-8649. You may also visit: www.healthcare.gov/center/regulations/prevention.html. Please note, however, for recommendations that have been in effect for less than one year, KPIC will have one year from the effective date to comply.

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

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

Other Preventive Care

Other Preventive Care covered under this Group Policy not required by the Patient Protection Affordable Care Act listed below may be subject to Deductibles, Copayments or coinsurance as described in the Schedule of Coverage:

1. Adult Physical Exam;
2. Double contrast barium enema as an alternative to colonoscopy;
3. Screening prostate specific antigen test (PSA);
4. Family planning limited to:
   a) The charge of a Physician for consultation concerning the family planning alternatives available to a male Covered Person, including any related diagnostic tests;
   b) Vasectomies;
   c) Services and supplies for diagnosis and treatment of involuntary infertility for females and males;
   d) Voluntary termination of pregnancy.

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

   Family planning charges do not include any charges for the following:
   a) The cost of donor semen and donor eggs including retrieval of eggs;
   b) Storage and freezing of eggs and/or sperm;
   c) Services to reverse voluntary, surgically induced infertility;

d) Services other than artificial insemination, related to conception by artificial means, including, but not limited to, in vitro fertilization, gamete intrafallopian tube transfer; ovum transplant; zygote intrafallopian transfer, and prescription drugs related to such services.
e) Other assistive reproductive technologies;
f) Diagnostic procedures;
g) Treatment or any infertility diagnosis services.

Extension of Benefits

Except with regard to any Optional Benefit that may be provided under the Group Policy, the benefits for the disabling condition of a Covered Person will be extended if:

1. The Covered Person becomes Totally Disabled while insured for that insurance under the plan; and
2. The Covered Person is still Totally Disabled on the date this Plan terminates.

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

1. The date on which the Total Disability ends;
2. The last day of the 12 month period that follows the date the Total Disability starts; or
3. The date on which the Covered Person becomes covered under any plan that: a) replaces this insurance; and b) covers the disabling condition so that benefits are not limited due to the Total Disability having started before that plan was in effect.
4. The Group Policy Terminates.

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

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

Benefits for Inpatient Maternity Care

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

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

For stays shorter than 48 hours following normal vaginal delivery and 96 hours following a Caesarean section, one home visit within 24 hours of hospital discharge will be scheduled, and an additional home visit if prescribed by the attending physician.

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

GENERAL LIMITATIONS AND EXCLUSIONS

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

1. Charges for services approved by or reimbursed by Health Plan.
2. Charges in excess of the Maximum Allowable Charge.
3. Charges for non-Emergency Care in an Emergency Care setting to the extent that they exceed charges that would have been incurred for the same treatment in a non-Emergency Care setting. Final determination as to whether services were rendered in connection with an emergency will rest solely with KPIC.
4. Weekend admission charges for non-Emergency Care Hospital services. This exclusion applies only to such admission charges for Friday through Sunday, inclusive.
5. Confinement, treatment, services or supplies not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically set forth in this Certificate as a Covered Service.
6. Confinement, treatment, services or supplies received outside the United States, if such confinement, treatment, services or supplies are of the type and nature that are not available in the United States.
7. Injury or Sickness for which benefits are payable under any state or federal workers' compensation, employer's liability, occupational disease or similar law, or any motor vehicle no-fault law.
8. Injury or Sickness for which the law requires the Covered Person to maintain alternative insurance, bonding, or third party coverage.
9. Injury or Sickness arising out of or in the course of past or current work for pay, profit, or gain, unless workers' compensation or benefits under similar law are not required or available.
10. Services for military service related conditions regardless of service in any country or international organization.
11. Treatment, services, or supplies provided by the Covered Person; his or her spouse; a child, sibling, or parent of the Covered Person or of the Covered Person's spouse; or a person who resides in the Covered Person's home.
12. Confinement, treatment, services or supplies received where care is provided at government expense. This exclusion does not apply if: a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or b) payment is required by law
13. Dental care and treatment, dental x-rays; dental appliances; orthodontia; and dental surgery. This exclusion includes, but is not limited to: services to correct malocclusion; extraction of wisdom teeth (third molars); injury to teeth resulting from chewing; Dental appliances; dental implants; orthodontics; dental services associated with medical treatment.
14. Cosmetic services, plastic surgery or other services that: a) are indicated primarily to change the Covered Person's appearance; and b) will not result in significant improvement in physical function. This exclusion does not apply to services that: a) will correct significant disfigurement resulting from a non-congenital Injury or Medically Necessary surgery; or b) are incidental to a covered mastectomy; or c) are necessary for treatment of a form of congenital hemangioma known as port wine stains.
15. Non-prescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician.
16. Any treatment, procedure, drug or equipment, or device which KPIC determines to be experimental or investigational. This means that one of the following is applicable:
    a. The service is not recognized as efficacious as the term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technology that is current when care is rendered; or
    b. The service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

    Experimental or investigational procedures do not include Clinical Trials.
17. Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems. This applies whether or not the services are associated with manifest Mental Illness or other disturbances.

18. Confinement, treatment, services or supplies that are required: a) by a court of law; or b) for insurance, travel, employment, school, camp, government licensing, or similar purposes.
19. Personal comfort items such as telephone, radio, television, or grooming services.
20. Custodial care. Custodial care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
21. Care in an intermediate care facility. This is a level of care for which a Physician determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.
22. Routine foot care such as trimming of corns and calluses
23. Confinement or services that are not Medically Necessary or treatment that is not completed in accordance with the attending Physician's orders.
24. Services of a private duty nurse in a Hospital, Skilled Nursing Facility or other licensed medical facility, or in the Covered Person's home;
25. Medical social services except those services related to discharge planning in connection with: a) a covered Hospital Confinement; b) covered Home Health Care Services; or c) covered Hospice Care.
26. Living expenses or transportation, except as provided under Covered Services.
27. Reversal of sterilization.
28. Services provided in the home other than Covered Services provided through a Home Health Care Agency**.**
29. Maintenance therapy for rehabilitation.
30. The following Home Health Care Services:
    a. treatment of Mental Illness and substance abuse disorders,
    b. meals,
    c. personal comfort items,
    d. housekeeping services.
31. Biotechnology drugs and diagnostic agents. The following biotechnology drugs are excepted from this exclusion: Human insulin, vaccines, biotechnology drugs administered for the treatment or diagnosis of cancer, and Dornase for the treatment of cystic fibrosis, human growth hormones prescribed or administered for the treatment of documented human growth hormone deficiency such as Turner's Syndrome
32. Treatment, services or supplies to which a contributing cause was the commission of or attempt to commit a felony by the Covered Person, or to which a contributing cause was the Covered Person’s engagement in an illegal occupation.
33. Suicide, self-destruction, or self-inflicted injuries while sane or insane.
34. Covered Services received in connection with a surrogacy arrangement in which a woman agrees to become pregnant and to surrender the child to another person or persons who intend to raise the child.
35. Any drug, procedure or treatment for sexual dysfunction regardless of cause, including but not limited to Inhibited Sexual Desire, Female Sexual Arousal Disorder, Female Orgasmic Disorder, Vaginismus, Male Arousal Disorder, Erectile Dysfunction and Premature Ejaculation.
36. Biofeedback or hypnotherapy.
37. Health education, including but not limited to: a) stress reduction; b) smoking cessation; c) weight reduction; or d) the services of a dietitian. This exclusion will not apply to treatment of Morbid Obesity.
38. Hearing exams; hearing therapy; or hearing aids. This exclusion includes hearing exams to determine appropriate hearing aid, as well as hearing aids or tests to determine their efficacy. Internally implanted hearing aids are also excluded. This exclusion does not apply to newborn hearing screenings.
39. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye.
40. Services for which no charge is normally made in the absence of insurance.
41. Purchases of Durable Medical Equipment. Purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental.

42. Rehabilitation services while confined in a Hospital or any other licensed medical facility.
43. Transplants, including acquisition and/or donor costs.
44. Acupuncture.
45. Chiropractic Services, unless otherwise elected by the Policyholder as an optional benefit offered under the Group Policy and set forth on the Schedule of Coverage.
46. Treatment for in vitro fertilization such as: a) gamete intrafallopian tube transfer; b) ovum transplants; c) zygote intrafallopian transfer; d) cryogenic or other preservation techniques used in these or similar techniques.
47. Family planning services except as a limited benefit as set forth in the General Benefit section of this Certificate.
48. Treatment of craniomandibular, myofascial pain and temporomandibular joint disorders. Coverage is limited to medically necessary surgical treatment only.
49. Second medical opinion, except when required under the Medical Review Program.
50. Treatment of infertility limited to artificial insemination.
51. Orthotics.
52. Early Intervention Services shall not include services provided through federal, state or local early intervention programs, including school programs.
53. Outpatient Prescription Drugs, unless otherwise elected by the Policyholder as an optional benefit offered under the Group Policy and set forth on the Schedule of Coverage.
54. Cardiac Rehabilitation, except as a limited benefit as set forth in the Schedule of Coverage for Covered Persons with: a) history of acute myocardial infarction; b) surgery for coronary artery bypass; c) percutaneous therapeutic coronary artery intervention; d) heart or heart/lung transplant; or e) repair or replacement of a heart valve.

OPTIONAL OUTPATIENT PRESCRIPTION DRUG BENEFITS, LIMITATIONS, AND EXCLUSIONS

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

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

Outpatient Prescription Drugs Covered

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

1) Prescription drugs listed as Generic Drugs;
2) Prescription drugs listed as Preferred and Non-Preferred Brand Drugs;
3) internally implanted time-release medications;
4) insulin and the following diabetic supplies:
   a) syringes and needles
   b) blood glucose and ketone test strips or tablets and glucose ketone test strips or tablets
5) Compounded dermatological preparations which must be prepared by a pharmacist in accord with a Physician's prescription;
6) antacids;
7) Up to a 90-day supply of a Maintenance Drug in a single dispensing of the prescription.
8) Oral or nasal inhalers; The standard prescription amount for oral and nasal inhalers is the smallest standard package unit.
9) Compounded dermatological preparations which must be prepared by a pharmacist;
10) Spacer devices;
11) Migraine medications, including injectables. The standard prescription amount for migraine medications is the smallest package size available.
12) Opthalmic, otic and topical medications; The standard prescription amount for opthalmic, otic and topical medications is the smallest package available.
13) Any contraceptive drug or device that is approved by the United States Food and Drug Administration (FDA).
14) Hormone Replacement Therapy prescribed for treating symptoms and conditions of menopause.
15) Oral chemotherapy medication.

Outpatient Prescription Drugs Limitations and Exclusions

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

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

7) Drugs and injectables for the treatment of cosmetic services.
8) Drugs and injectables for the treatment of obesity, except as otherwise required to treat Morbid Obesity;
9) Replacement of lost or damaged drugs and accessories.
10) Experimental Drugs and Medicines. This exclusion will not apply if such experimental or investigational drug, device or procedure, as certified by the Physician is the only procedure, drug or device medically appropriate to the Covered Person's condition. In addition, this exclusion will not apply to routine patient care costs related to Clinical Trial if the Covered Person's treating Physician recommends participation in the Clinical Trial after determining that participation in such Controlled Clinical Trial has a meaningful potential to benefit the Covered Person.
11) All Biotechnology drugs and diagnostic agents, except as stated in the General Exclusions section, if any.
12) Drugs associated with non-covered services.
13) Infant formulas, except for amino acid-modified products used to treat congenital errors of amino acid metabolism. Such coverage for formula and special food products are limited to the extent that the cost of such formulas or special food products exceed the cost of a normal diet;
14) Human Growth Hormone (HGH), except for children with either Turner's syndrome or with classical growth hormone deficiency; and
15) Anorectic (any drug used for the purpose of weight loss unless prescribed in the treatment of morbid obesity.

Direct Member Reimbursement

If you purchased a covered medication without the use of your identification card or at a Non-Participating Pharmacy, and paid full price for your prescription, you may request a direct member reimbursement.

To submit a claim for direct member reimbursement you may access the direct member reimbursement form via www.MedImpact.com. For assistance you may call the MedImpact Customer Contact Center 24 hours a day 7 days a week at 1- 800-788-2949 or email via customerservice@medimpact.com.

OPTIONAL BENEFITS, LIMITATIONS, AND EXCLUSIONS

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

1. Routine adult physical examinations. Services must meet prevailing standards. The care shall include: a) examination; b) history; c) appropriate immunizations; and d) x-ray and laboratory tests. Examinations performed by Non-Participating Providers will be subject to the Policy Year Deductible and the standard Percentage Payable and Coinsurance percentage applicable under the Plan purchased by the Policyholder.
2. Vision services, including routine exams, eye refractions, orthoptics, glasses, contact lenses or the fitting of glasses or contact lenses
3. Hospice Care. Covered Services will include inpatient care; part-time nursing care by or supervised by a registered nurse; counseling, including dietary counseling; family counseling; bereavement counseling; respite care; medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the terminally ill Covered Person. Please see the definition of “Hospice Care”, as set forth in the General Definitions section, for a complete understanding of the terms used in this benefit.
4. Rental of Durable Medical Equipment. However, purchase of such equipment may be made if, in the judgment of KPIC: a) purchase of the equipment would be less expensive than rental; or b) such equipment is not available for rental.
5. Allergy testing and treatment, services, material and serums.
6. Chiropractic Services rendered by a Physician for chronic pain management or chronic illness management. Chiropractic Services shall be limited to musculoskeletal therapy involving manual manipulation of the spine to correct subluxation.
7. Prosthetic devices for all or part of an internal body organ (including contiguous tissue) or that replace all or part of the function of a permanently inoperative or malfunctioning external body part.
8. Orthotics limited to leg, arm, back, and neck braces. Coverage will include therapeutic shoes and inserts when prescribed by a Physician for individuals with severe diabetic foot diseases. Orthotics will not include:
   a. Orthopedic shoes or other supportive devices unless the shoe is an integral part of a leg brace;
   b. Non-rigid appliances and supplies; or
   c. Replacement due to misuse or loss.

FEDERAL CONTINUATION OF COVERAGE PROVISIONS

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

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

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

Qualifying Events

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

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

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

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

Continuation of Coverage Period

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

7. the date the employer ceases to provide any group health coverage for its employees;
8. the date any premium for continuation of coverage is not timely paid; or
9. the date that the privilege for conversion to an individual or family policy is exercised.

Requirements

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

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

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

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

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

Extension for Disabled Covered Persons

If Social Security, under its rules, determines that a Covered Person was disabled when a qualifying event set forth in "2" occurred, the 18 month maximum period of continued health coverage for such a qualifying event may be extended 11 months for a total period of 29 months. To obtain that extension, the Covered Person must notify the employer of Social Security's determination before the initial 18 month maximum period ends.

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

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

Continued Health Coverage from a Prior Plan

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

STATE CONTINUATION OF COVERAGE PROVISIONS

Eligibility

A former employee who: a) worked for an employer for at least five years prior to the date of termination of employment; b) is 60 years of age or older on the date employment ends, c) and is entitled to and so elects to continue benefits under COBRA for himself or herself and for any spouse, may further continue benefits for himself or herself and for any spouse beyond the date coverage under COBRA ends. (See the "FEDERAL CONTINUATION OF HEALTH INSURANCE (COBRA)" section of Your Certificate.)

Electing this State Continuation

It is the responsibility of the former employer to notify the former employee or spouse of the availability of this continuation. To elect this continuation, the individual must notify KPIC in writing within 30 days prior to the date continuation coverage under COBRA is scheduled to end.

Individuals not eligible for continuation under COBRA, whichever is applicable, are not eligible for this continuation. Also, individuals who are eligible for COBRA but have not elected or exhausted the continuation coverage provided under COBRA are not entitled to coverage under this provision.

Termination of this State Continuation

This continuation coverage shall end automatically on the earlier of:

1. the date the individual reaches age 65;
2. the date the individual is covered under any group plan not maintained by the former employer, or any other insurer or health care service plan, regardless of whether that coverage is less valuable
3. the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act;
4. for a spouse, five years from the date the spouse's continuation of coverage under COBRA was scheduled to end; or
5. the date on which the former employer terminates its group contract with KPIC and ceases to provide coverage for any active employees through KPIC, in which case the former employee or spouse or both may apply for coverage under a conversion policy through KPIC. (See the "CONVERSION" section of this Certificate.)
6. the date required premiums are not submitted to KPIC under the terms of the Group Policy.

Benefits and Premium Under this State Continuation

The benefits under this continuation will not differ from those provided under the COBRA continuation.

If the rates charged to the former employer by KPIC are age-specific, the premium charged for the former employee will not exceed 102% of the premium charged by KPIC to the employer for an employee of the same age as the former employee electing this continuation for those individuals who were eligible for COBRA.

If the rates charged to the former employer by KPIC are not adjusted for age, the rate for this continuation of coverage shall not exceed 213% of the applicable current group rate. **"Applicable current group rate"** is the total premiums charged by KPIC for coverage of the group divided by the relevant number of covered persons, with no consideration of the claims experience of the former employee or any spouse.

COORDINATION OF BENEFITS

Application

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

The benefits of this Plan:

1. will not be reduced when this Plan is primary;
2. may be reduced when another Plan is primary and This Plan is secondary. The benefits of This Plan are reduced so that they and the benefits payable under all other Plans do not total more than 100 percent of the Allowable Expenses during any Policy Year; and
3. will not exceed the benefits payable in the absence of other coverage.

Order of Benefit Determination Rules

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

1. General: A Plan that does not coordinate with other Plans is always the primary Plan.
2. Non-dependent\Dependent: The benefits of the Plan which covers the person as a Covered Person, or subscriber (other than a Dependent) is the primary Plan; the Plan which covers the person as a Dependent is the secondary Plan.
3. Dependent Child--Parents Not Separated or Divorced: When This Plan and another Plan cover the same child as a Dependent of different parents, benefits for the child are determined as follows:
   a. the primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The secondary Plan is the Plan of the parent whose birthday falls later in the year.
   b. if both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the primary Plan; the Plan which covered the parent the shorter time is the secondary Plan.
   c. if the other Plan does not have the birthday rule, but has the male\female rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
4. Dependent Child: Separated or Divorced Parents: If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined as follows:
   a. first, the Plan of the parent with custody of the child;
   b. then, the Plan of the spouse 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 Policy Year during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the provider, if the custodial parent so requests.
5. Active/Inactive Service: The primary Plan is the Plan which covers the person as a Covered Person who is neither laid off or retired (or as that employee's Dependent). The secondary Plan is the Plan which covers that person as a laid off or retired Covered Person (or as that Covered Person’s Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.
6. Longer\Shorter Length Of Coverage: If none of the above rules determines the order of benefits. the primary Plan is the Plan which covered a Covered Person, or subscriber the longer time. The secondary Plan is the Plan which covered that person the shorter time.

COORDINATION OF BENEFITS

Effect of Medicare

This Plan will be primary to Medicare for an active employee and Dependent spouse of such active employee. This Plan will not be primary to Medicare if the Covered Person is eligible for Medicare as primary. Medicare is primary for an insured retiree or the Dependent spouse of a retiree age 65 or over; this applies whether or not the retiree or spouse is enrolled in Medicare.

Effect of No-fault Auto Coverage

No-fault auto coverage is considered the primary Plan.

Reduction in this Plan's Benefits

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

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

Right to Receive and Release Information

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

Facility of Payment

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

Right of Recovery

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

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

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

Definitions Related to Coordination of Benefits

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

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

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

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

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

Plan does not include any:

1. Individual or family policies or contracts, except no-fault auto coverage.
1. Public medical assistance programs.
2. Group or group-type Hospital indemnity benefits of $100 per day or less.
3. School accident-type coverages.

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

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

Closed Panel Plan

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

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

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

GENERAL PROVISIONS

All claims under This Plan will be administered by:

Dell Healthcare Services
2300 West Plano Parkway
Plano, Texas 75075

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

Participating Provider claims

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

For Non-Participating Provider claims

If you receive services from any other licensed provider, you may need to file the claim yourself and will be reimbursed in accordance with the terms set forth under the Schedule of Coverage.

Notice of Claims

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

Kaiser Permanente Insurance Company
P.O. Box 261130
Plano, Texas 75026

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 at the address shown on the preceding page or Our Administrator 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.

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

GENERAL PROVISIONS

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 request reconsideration. The request must be in writing and filed with KPIC's Administrator at the address specified above.

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

Legal Action

No legal action may be brought to recover on this policy before 60 days from the date written proof of loss has been given to Us as required under the Proof of Loss section. No such action may be brought more than three (3) years after the date written proof of loss is given to Us.

Rights of a Custodial Parent

If the parents of a covered Dependent child are:

1. divorced or legally separated; and
2. subject to the same Order,

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

1. a request from the custodial parent who is not a Covered Person under the policy; and
2. a copy of the Order.

If all of these conditions have been met, KPIC will:

1. provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Policy;
2. accept claim forms and requests for claim payment from the custodial parent; and
3. make claim payments directly to the custodial parent for claims submitted by the custodial parent, subject to all the provisions stated in the Policy. Payment of claims to the custodial parent, which are made in good faith under this provision, will fully discharge KPIC's obligations under the Policy to the extent of the payment.

KPIC will continue to comply with the terms of the Order until We determine that:

1. the Order is no longer valid;

2. the Dependent child has become covered under other health insurance or health coverage;
3. in the case of employer-provided coverage, the employer has stopped providing family coverage for all employees; or
4. the Dependent child is no longer a Covered Person under the Policy.

"Order" means a valid court or administrative order that:

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

Time Limitations

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

Overpayment

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

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

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

Assignment

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

a. Are not assignable and thereby not binding on KPIC, unless previously approved by KPIC in writing;

b. Shall be made by KPIC, in its sole discretion, directly to the provider or to the Insured Person on Insured Dependent or, in the case of the Insured Person's death, to his or her executor, administrator, provider, spouse or relative.

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 a Covered Person in applying for insurance under This Plan will be considered a representation and not a warranty. After This Plan has been in force for two years, its validity cannot be contested except for nonpayment of premiums or

fraudulent misstatement as determined by a court of competent jurisdiction. After a Covered Person's insurance has been in force for two 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 Covered Person can be used in a contest.

Legal Action

No legal action may be brought to recover on this policy before 60 days from the date written proof of loss has been given to Us as required under the Proof of Loss section. No such action may be brought more than three (3) years after the date written proof of loss is given to Us.

Misstatement of Age

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

Physical Examination and Autopsy

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

Money Payable

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

ERISA 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
  - First level of Appeal
  - Second Level of Appeal
  - Time Frame for Resolving Your Appeals
    - Post Service
    - Pre-service
      - Urgent Pre-service Claims
      - Non-Urgent Pre-service Claims
    - Concurrent-care Claims
      - Urgent Concurrent care Claims
      - Non-Urgent Concurrent care Claims
- Help With Your Appeal
- The External Appeals Process

A. Definitions Related to Claims and Appeals Procedures

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

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

1. deny Your Claim, in whole or in part, including but not limited to, reduction of benefits or a failure or refusal to cover an item or service resulting from a determination that an expense is:
   a) experimental or investigational;
   b) not Medically Necessary or appropriate.
2. terminate Your coverage retroactively except as the result of non-payment of premiums (also known as rescission), or
3. 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- 800-788-2949.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-788-2949.

CHINESE (中文): 如果需要中文的帮助,请拨打这个号码 1-800-788-2949.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-788-2949.

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.

ERISA 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:

Dell
KPIC Grievance and Appeals
P.O. Box 261155
Dallas, TX 75026
Telephone number 1-800-392-8694

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:

    Dell
    Kaiser Permanente Insurance Company (KPIC) – Claims Administrator
    P.O. Box 261155
    Plano, TX 75026

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

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

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

- If We deny Your Claim (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.

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.

Dell
KPIC Grievance and Appeals
P.O. Box 261155
Dallas, TX 75026

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
    5855 Copley Drive, Suite 250
    San Diego, CA 92111
    Telephone number: 1-888-567-6847
    Fax number: 1-866-338-0266

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

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

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

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

  - If We deny Your Claim (if We do not agree to cover or pay for all the Covered Services You requested), please refer to subsection **C. The Internal Appeals Process** provision under this section for a detailed provision regarding 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
    5855 Copley Drive, Suite 250
    San Diego, CA 92111
    Telephone number: 1-888-567-6847
    Fax number: 1-866-338-0266

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

  - We will review Your Claim, and if We have all the information We need We will make a decision within a reasonable period of time. If You submitted Your Claim 24 hours or more before Your care is ending, We will make Our decision before Your authorized care actually ends. If Your authorized care ended before You submitted Your Claim, We will make Our decision but no later than 15 days after We receive Your Claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond Our control delay Our decision, if We send You notice before the initial 15 day decision period ends. If We tell You We need more information, We will ask You for the

information before the initial decision period ends, and We will give You until Your care is ending or, if Your care has ended, 45 days to send Us the information. We will make Our decision as soon as possible, if Your care has not ended, or within 15 days after We first receive any information (including documents) We requested. We encourage You to send all the requested information at one time, so that We will be able to consider it all when We make Our decision. If We do not receive any of the requested information (including documents) within the stated timeframe after We send Our request, We will make a decision based on the information We have within the appropriate timeframe, not to exceed 15 days following the end of the timeframe We gave You for sending the additional information.

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

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

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

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 two mandatory levels of appeal for medical Claims and one level of appeal for claims arising from the optional prescription drug benefit.

First Level of Appeal

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

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

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

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

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

Second Level of Appeal (applicable to Medical Claims only

If Your first level appeal decision is not wholly in Your favor, You are entitled to a second level of review. We must receive Your second level appeal request within 180 days of Your receiving this notice of Our first level appeal decision. Please note that We will count the 180 days starting 5 business days from the date of the first level appeal notice to allow for delivery time unless You can prove that You received the notice after that 5 business day period. Contact Us at 877-847-7572 with any questions about Your appeal rights. You must either mail Your second level Appeal to Us, or fax Your second level Appeal to Us at:

Kaiser Permanente Insurance Company
Grievance and Appeals (level 2)
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

Providing Additional Information Regarding Your Claim

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

Kaiser Permanente Insurance Company
Grievance and Appeals (level 2)
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

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

Kaiser Permanente Insurance Company
Grievance and Appeals (level 2)
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

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: Dell
  KPIC Grievance and Appeals
  PO Box 261155
  Dallas, TX 75026

  For Optional Prescription Drug: Kaiser Permanente Insurance Company (KPIC)
  ATTN: KPIC Operations
  Grievance and Appeals Coordinator
  1800 Harrison Street, 20th Floor
  Oakland, CA 94612

- We will review your appeal as follows:

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

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

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

2) Non-Urgent Pre-Service Appeal

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

Dell
KPIC Grievance and Appeals
P.O. Box 261155
Dallas, TX 75026

- We will review your appeal as follows:

  - For Appeals involving medical claims - Because you have not yet received the services or equipment that You requested, we will review Your Appeal and send you a written decision of each level of your two level appeal process within a reasonable period of time appropriate to the circumstances, but in no event later than 15 days from the date that we receive your request for our review at that level unless we inform you otherwise in advance.
  - For appeals involving claims arising from the optional prescription drug benefit - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive your request for our review unless we inform you otherwise in advance.

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

3) Urgent Pre-Service Appeal

- Tell Us that You want to urgently Appeal Our Adverse Benefit Determination regarding Your pre-service Claim. Please include the following: (1) Your name and Medical Record Number, (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
5855 Copley Drive, Suite 250
San Diego, CA 92111
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

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

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

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

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

4) <u>Non-Urgent Concurrent Care Appeal</u>

- 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
5855 Copley Drive, Suite 250
San Diego, CA 92111
Telephone number: 1-888-567-6847
Fax number: 1-866-338-0266

- We will review your appeal as follows:

  - <u>For Appeals involving medical claims</u> - We will review Your Appeal and send you a written decision of each level of your two level appeal process within a reasonable period of time appropriate to the circumstances, but in no event later

than 15 days from the date that we receive your request for our review at that level unless we inform you otherwise in advance.

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

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

  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
  5855 Copley Drive, Suite 250
  San Diego, CA 92111
  Telephone number: 1-888-567-6847
  Fax number: 1-866-338-0266

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

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

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

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

6) <u>Appeals of retroactive coverage termination (rescission)</u>

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

-

Kaiser Permanente Insurance Company
Grievance and Appeals (level 2)
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax number 1-877-727-9664

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 either mail or fax Your Appeal to:

Kaiser Permanente Insurance Company
Grievance and Appeals
1800 Harrison Street, 20th Floor
Oakland, CA 94612
or fax (877) 727-9664

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

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

Help With Your Appeal

You may contact the state ombudsman:

Office of Health Care Ombudsman and Bill of Rights
Department of Health Care Finance
899 North Capitol Street, NE, 6th Floor
Washington, DC 20002
Office: (202) 724-7491
Fax: (202) 535-1216

D. External Review

After We have rendered Our final Adverse Benefit Determination at the level of the formal appeals process, as described above, You or Your designated representative have a right, under applicable law of the District of Columbia, to request an independent external review of Our final adverse determination through the Director of the District of Columbia Department of Insurance. You or Your representative must file a written request with the Director within four (4) months of the final Adverse Benefit Determination, together with a signed form allowing Us to release Your medical records that are pertinent to the external appeal.

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, you may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases, District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
441 4th Street, NW, 900 South – 9th Floor
Washington, D.C. 20001
1 (877) 685-6391
Fax: (202) 478-1397

If you are dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, you may contact the Commissioner at the following:

For Non -Medical Necessity cases:
Insurance Commissioner
Department of Insurance, Securities and Banking
810 First St. N.E., 7th Floor
Washington, D.C. 20002
202-727-8000
Fax: (202) 354-1085

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

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

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

You may have certain additional rights if you remain dissatisfied after you have exhausted all levels of review including external review. If you are enrolled through a plan that is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of the federal ERISA statute. To understand these rights, you should check with your

benefits office or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (3272). Alternatively, if your plan is not subject to ERISA (for example, most state or local government plans and church plans or all individual plans), you may have a right to request review in state court. The state ombudsman listed above should be able to help you understand any further review rights available to you.

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

Additional Information and Forms Applicable to Your Insurance Coverage

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

The following pages contain:
(1) information we are required to provide you and,
(2) forms for your use in submitting pharmacy claims.

DISTRICT OF COLUMBIA

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association").

The purpose of this Guaranty Association is to assure that policy or contract holders of certain types of insurance policies and contracts are covered up to the statutory levels of protection of contractual benefits in the unlikely event that a member insurer is unable to meet its financial obligations and found by a court of law to be insolvent. When a member company is found by a court to be insolvent, the Guaranty Association will assess its other member insurers to provide benefits on any outstanding covered claims of persons who reside in the District of Columbia. However, this additional protection provided through the Guaranty Association is subjected to certain statutory limits explained under "Coverage Limitations" section, below. In some cases, the Guaranty Association may facilitate the reassignment of policies or contracts to other licensed insurance companies to keep them in-force, with no change in contractual rights or benefits.

Coverage

The District of Columbia Life and Health Insurance Guaranty Association ("Guaranty Association"), established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 *et seq.*), provides insolvency protection for certain types of insurance policies and contracts. NOTE: Certain policies and contracts may not be covered or fully covered.

The insolvency protections provided by the Guaranty Association are generally conditioned on an individual being a resident of the District and are the insured or owner under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group policy insurance contract issued by a member insurer. Beneficiaries, payees, or assignees of District insureds are also covered under the Act, even if they live in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
- With respect to any one life, regardless of the number policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life; including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term insurance care benefits;
  - $300,000 for disability insurance
  - $500,000 for basic hospital, medical, and surgical insurance or major medical insurance;
  - $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 with respect to any one life ($500,000 in the event of basic hospital, medical, and surgical, and major medical claims).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner regardless of the number of policies owned.

DISTRICT OF COLUMBIA

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

Exclusions Examples

Policy or contract holders are not protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds that live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to The District of Columbia Department of Insurance, Securities and Banking (DISB) will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia
Department of Insurance, Securities and Banking
810 First Street, N.E., Suite 701
Washington, DC 20002
(202) 727-8000

District of Columbia
Life and Health Guaranty Association
1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and statutory coverage protections. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, the disclosure is not intended and should not be relied upon to alter any right established in any policy or contract, or under the Act.

KAISER PERMANENTE
Kaiser Permanente Insurance Company

PRIVACY NOTICE

Privacy Policy and Practices

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

Collection of Non-public Personal Information

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

- Information we receive from you as part of application forms, enrollment forms, claims forms, pre-certification/utilization reviews, etc, including, but not limited to, your name, address, sex, date of birth, Social Security number, martial status, dependents, and the identity of your employer.
- Information otherwise legally obtained by us, including information you authorize us to receive and/or resulting from your transactions with us, our affiliates, or non-affiliated third parties, including, but not limited to, medical information and claims history.

Disclosure of Non-public Personal Information

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

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

Non-public Personal Information Regarding Former Customers

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

Confidentiality and Security of Non-public Personal Information

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

- Employees are required to comply with our policies and procedures that exist to protect the confidentiality of customer information. Any employee who violates our privacy policy and practices is subject to a disciplinary process. Our policy requires medical records to be maintained in secure areas not accessible to the public.
- Employee access to information is provided on a business need-to-know basis such as: to facilitate administration, make benefit determinations, pay claims, managed care, underwrite coverage, or provide customer service.
- Mail and electronic security procedures to maintain confidentiality of the information we collect and to guard against its unauthorized access. Such methods include locked files, user authentication, encryption, and firewall technology.
- Contractual agreements with its non-affiliated third parties that require such third parties to maintain the confidentiality of non-public personal information.

Where to Write For More Information

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

Kaiser Permanente Insurance Company
Attention: President
One Kaiser Plaza, 25 B
Oakland, California 94612

HIPAA Notice of Privacy Practices

KAISER PERMANENTE INSURANCE COMPANY ("KPIC")

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

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

I. WHAT IS "PROTECTED HEALTH INFORMATION"?

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

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

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

II. ABOUT OUR RESPONSIBILITY TO PROTECT YOUR PHI

By law, we must

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

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

III. YOUR RIGHTS REGARDING YOUR PHI

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

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

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

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

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

Submit all written requests to us at:

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

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

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

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

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

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

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

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

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

Your right to request limits on uses and disclosures of your PHI
You may request that we limit our uses and disclosures of your PHI for treatment, payment and health care operations purposes. We will review and consider your request. You may write to us at:

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

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

IV. HOW WE MAY USE AND DISCLOSE YOUR PHI

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

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

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

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

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

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

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

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

- **Communications with family and others when you are not present**: There may be times when it is necessary to disclose your PHI to a family member or other person involved in your care because there is an emergency, you are not present, or you lack the decision-making capacity to agree or object. In those

instances, we will use our professional judgment to determine if it's in your best interest to disclose your PHI. If so, we will limit the disclosure to the PHI that is directly relevant to the person's involvement with your health care. For example, we may allow someone to pick up a prescription for you.

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

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

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

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

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

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

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

- **Military activity and national security**: We may sometimes use or disclose the PHI of armed forces personnel to the applicable military authorities when they believe it is necessary to properly carry out military missions. We may also disclose your PHI to authorized federal officials as necessary for national security and intelligence activities or for protection of the President and other government officials and dignitaries.

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

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

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

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

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

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

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

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

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

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

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

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

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

You also may notify the Secretary of the Department of Health and Human Services (HHS).

We will not take retaliatory action against you if you file a complaint about our privacy practices.

VII. CHANGES TO THIS NOTICE

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

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

VIII. EFFECTIVE DATE OF THIS NOTICE

This Notice is effective on September 23, 2013.

KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, CA 94612

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

IMPORTANT NOTICE REGARDING YOUR HEALTH INSURANCE COVERAGE

Women's Health and Cancer Rights Act of 1998

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

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

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

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

MedImpact
Delivering · Flexible · Choice
ATTN: CLAIMS DEPT
MedImpact Healthcare Systems, Inc. 10680 Treena Street 5th floor San Diego, CA 92131
Fax to: (858) 549-1569

PRESCRIPTION DRUG CLAIM FORM

In order to process your claim(s), you must provide all information requested below. Submit the completed form with the original pharmacy prescription label/receipt(s). Documents provided, other than original pharmacy receipts (i.e., prescription profiles) must be signed by the pharmacist and include the following information: NDC, quantity, day supply, Rx # and fill date, DEA#, NABP, and amount member paid).

Primary Member/Cardholder Information

Primary Member/Cardholder ID Number	Primary Member/Cardholder Name (First, Middle, Last)		
Name of Health Plan/Insurance	**Member Phone Number (Day)**	**Member Phone Number (Evening)**	
	( ) -	( ) -	
Address (Street)	**(City)**	**(State)**	**(Zip Code)**

Patient Information (if different than Primary Member's/Cardholder's)

Patient's Name (First, Middle, Last)	Patient's DOB (MM/DD/YYYY)	Relationship to Primary Member/Cardholder		
		Spouse ❑	Dependent ❑	Other ❑
Address (Street)	**(City)**	**(State)**	**(Zip Code)**	

Other Coverage Information

Covered under any other insurance? Coordination of Benefits (COB) ☐	Is Medicare the Primary Prescription Coverage?	Worker's Compensation? ❑
If COB, please indicate the name of primary insurance here:	Yes ☐ No ☐	If Worker's Compensation is selected, please **stop** and submit claim to your employer.

*Submit either **prescription receipts/labels** with the following information – and/or have your **pharmacist** sign and complete the Prescription Details.

Prescription Details
- Pharmacy Name/Address
- Prescription Number & Date Filled
- Physician's Name or DEA #
- Drug Name & Strength or NDC #
- Quantity and Day Supply Dispensed
- Member Paid Expense

1) Rx Number	Date Filled	Check One	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $

2) Rx Number	Date Filled	Check One	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $

3) Rx Number	Date Filled	Check One	Quantity	Day Supply	Directions	Total Price w/Tax
		New ☐ Refill ☐				$
Medication Name, Strength and Form (OR - NDC # below)			DAW (0-8)	Prescribing Physician's Name/DEA #		Compound Yes ☐ No ☐ If Yes, see pg.2
NDC # (11-digit)			**COB Claim?** Yes ☐ No ☐	COB Claims must be submitted with pharmacy receipts identifying copays paid and Explanation of Benefits from primary insurer		Copay Paid $

Pharmacy Information

Pharmacy Name			Pharmacy Telephone Number	
Street Address			NABP	
City	State	Zip	Pharmacy Signature	Date

I certify that the information on this claim form is true and correct to the best of my knowledge. I authorize the release of any medical information necessary to process this claim.

Claimant Signature **X**

Warning it is a crime to provide false information or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any persons knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

ATTN: CLAIMS DEPT
MedImpact Healthcare Systems, Inc. 10680 Treena Street 5th floor San Diego, CA 92131
Fax to: (858) 549-1569

COMPOUND PRESCRIPTIONS

*** Pharmacy or dispensing facility must complete the remaining portion and return this to member**

- Enter the NDC number of the most expensive ingredient of the legend drug used.
- Indicate the drug ingredient(s) and quantity.
- Indicate the metric quantity dispensed in number of tablets, grams or mls for liquids creams, ointments and injectables.
- Indicate the amount paid for the prescription by the patient.

COMPOUND PRESCRIPTIONS			
*For pharmacy use only			
NDC#	**Drug Ingredient**	**Quantity**	**Charge**
		Total Charge:	$

Note: If purchased in a foreign country, the currency must be converted into US dollars.

* The original paid pharmacy prescription label/receipt (including the required drug information) MUST accompany this claim form. Any documents provided other than the original pharmacy receipts (i.e. prescription profiles, etc.), must be signed by the pharmacist and include the following information: NDC, quantity, day supply, rx # and fill date, DEA#, NABP, and amount member paid. Pharmacy receipts will not be returned, you may wish to make copies for your records.

Notes

KAISER PERMANENTE

Kaiser Foundation Health Plan of
the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20849

151 **********SINGLE PIECE

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