California Comprehensive Major Medical (PPO) for Small Business Certificate of Insurance

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

Group Name: KPIC SMALL NCR SAMPLE GROUP AGREEMENT
Group Policy # 999999805
Contract ID: 1.21
Contract Option ID: 793210573
CERTIFICATE OF INSURANCE

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

This Certificate is not an insurance policy. The complete terms of the coverage are set forth in the Group Policy. Benefit Payment is governed by all the terms, conditions and limitations of the Group Policy. If the Group Policy and this Certificate differ, the Group Policy will govern. Any amendment to the Group Policy will not affect a claim initiated before the amendment takes effect. The Group Policy is available for inspection at the Policyholder’s office.

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

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

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

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

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under Your policy and that You or Your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before You become a Policyholder or select a network provider. Call Your prospective doctor or clinic, or call the Kaiser Permanente Insurance Company at 1-800-788-0710 (TTY users call 711) for assistance to ensure that You can obtain the health care services that You need.
Please refer to the General Limitations and Exclusions section of this Certificate for a description of the plan’s general limitations and exclusions. Likewise, the Schedule of Coverage contains specific limitations for specific benefits.

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

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

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

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

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

To verify the current participation status of a provider, please call the toll-free number listed in the Participating Provider directory. A current copy of KPIC’s Participating Provider directory is available at no cost from Your employer, or 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. If a Covered Person receives care from a Non-participating Provider, benefits under the Group Policy will be payable at the Non-participating Provider level.

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

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

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

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

Who Can Answer Your Questions?

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

For coverage: 1-800-788-0710 (TTY users call 711)
Eligibility, name or address change: 1-800-554-3099
Or You may write to the Administrator:

Dell Healthcare Services
PO Box 261155
Plano, TX 75026

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

**PPO plans only** - If You have any questions regarding services, facilities, or care You receive from a Participating Provider, please call the toll free number listed in the Participating Provider directory.

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

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

**Kaiser Permanente Insurance Company (KPIC)**
Attn: KPIC Operations
Grievance and Appeals Coordinator
1800 Harrison Street, 20th Floor
Oakland, CA 94612
1-877-847-7572

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

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

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

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

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

**www.insurance.ca.gov**
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The following terms have special meaning throughout this Certificate. Other parts of this Certificate contain definitions specific to those provisions. Terms that are used only within one section of the Certificate are defined in those sections.

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

Administrator means Dell Healthcare Services, PO Box 261155, Plano, TX 75026 and Delta Dental of California, PO Box 997330, Sacramento, CA 94105. Dell Healthcare Services is the Administrator of your medical coverage while Delta Dental is the Administrator of the Pediatric Dental coverage. KPIC reserves the right to change the Administrator at any time during the term of the Group Policy without prior notice. Neither KPIC nor its Administrator is the administrator of the Policyholder’s employee benefit plan as that term is defined under Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA) as then constituted or later amended.

Alcohol or Chemical Dependency means the addictive relationship with any drug or alcohol characterized by either a physical or psychological relationship, or both, that interferes with the person’s social, psychological, or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to, or dependency on, tobacco, tobacco products or foods.

Allowance means a specified credit amount that can be used toward the purchase price of a covered item. If the price of the item(s) selected exceeds the Allowance, amounts in excess of the Allowance are paid by the Covered Person and that payment does not apply toward the satisfaction of the annual Out of Pocket Maximum.

Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism, and that meet all of the following criteria:
1. The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
2. The treatment is provided under a Treatment Plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
   a) A Qualified Autism Service Provider.
   b) A Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider.
   c) A Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider.
3. The Treatment Plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The Treatment Plan shall be reviewed no less than once every six months by the qualified autism service provider and modified whenever appropriate, and shall be consistent with Section
4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service provider does all of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Covered Charge or Covered Charges means the Maximum Allowable Charge(s) for a Covered Service.

Covered Person means a person covered under the terms of the Group Policy and who is, duly enrolled as an Insured Employee or Insured Dependent under the Plan.

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

Creditable Coverage means
1. Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans. The term includes continuation coverage but does not include accident only, credit, disability income, Champus supplement, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical
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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 Medicaid program pursuant to Title XIX of the Social Security Act.
3. Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
5. A medical care program of the Indian Health Service or of a tribal organization.
7. A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (FEHBP).
8. 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.
9. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. 2504)).

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

Benefits will not be payable for Covered Charges applied to the Deductible. Covered Charges applied to satisfy the Deductible will be applied toward satisfaction of the Out-of-Pocket Maximum. Charges in excess of the Maximum Allowable Charge and additional expenses a Covered Person must pay because Pre-certification was not obtained will not be applied toward satisfying the Deductible or the Out-of-Pocket Maximum.

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

**Dependent** means only: a) Your spouse or Domestic Partner; and b) Your child who is of an age within the Age Limits for Dependent Children shown in the ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE section, or is a disabled child of any age. The word “child” includes: Your step-child; adopted child; child of Your Domestic Partner; or recognized natural child; and any other child for whom You have assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by You, as certified at the time of enrollment of the child, and annually thereafter.

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

**Durable Medical Equipment** means equipment that is:
1. designed for repeated use;
2. mainly and customarily used for medical purposes;
3. not generally of use to a person in the absence of a Sickness or Injury; and
4. approved for coverage under Medicare, except for apnea monitors; or
5. is otherwise required by law.
SUPPLIES necessary for the effective use of Durable Medical Equipment are also considered Durable Medical Equipment, such as oxygen or drugs dispensed by Durable Medical Equipment vendors for use in Durable Medical Equipment items. However, drugs obtained at pharmacies are considered under the Outpatient Prescription Drug benefit even when obtained for use in a Durable Medical Equipment item.

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

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

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

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

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

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

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

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

External Prosthetics and Orthotics means:

1. An External Prosthetic device is a device that is located outside of the body which replaces all or a portion of a body part or that replaces all or portion of the function of a permanently inoperative or malfunctioning body part. Examples of external prosthetics includes artificial limbs, parental and enteral nutrition, urinary collection and retention systems, colostomy bags and other items and supplies directly related to ostomy care and eyeware after cataract surgery or eyeware to correct aphakia. Other examples are prosthetic devices incident to a mastectomy, including custom-made prostheses when medically necessary; adhesive skin support attachment for use with external breast prosthesis; and brassieres for breast prostheses and Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired.
as a result of disease, injury, or congenital defect. Supplies necessary for the effective use of prosthetic device are also considered prosthetics.

2. Orthotics that are rigid or semi rigid external devices. They must: a) support or correct a defective form or function of an inoperative or malfunctioning body part; or b) restrict motion in a diseased or injured part of the body. Orthotics do not include casts.

**Free-Standing Surgical Facility** means a legally operated institution which is accredited by the Joint Commission on the Accreditation of Health Organizations (JCAHO) or other similar organization approved by KPIC that:
1. has permanent operating rooms;
2. has at least one recovery room;
3. has all necessary equipment for use before, during and after surgery;
4. is supervised by an organized medical staff, including Registered Nurses available for care in an operating or recovery room;
5. has a contract with at least one nearby Hospital for immediate acceptance of patients requiring Hospital care following care in the Free-Standing Surgical Facility;
6. is other than: a) a private office or clinic of one or more Physicians; or b) part of a Hospital; and
7. requires that admission and discharge take place within the same working day.

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

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

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

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

**Home Health Care** means services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists when:
1. You are substantially confined to Your home (or a friend’s or relative’s home).
2. Your condition requires the services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide services are not covered unless you are also getting covered...
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home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide).

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

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

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

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

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

**Injury** means bodily damage or harm of a Covered Person.

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

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

**Intensive Care Unit** means a section, ward or wing within the Hospital which:
1. is separated from other Hospital facilities;
2. is operated exclusively for the purpose of providing professional care and treatment for critically-ill patients;
3. has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use;
4. provides Room and Board; and
5. provides constant observation and care by Registered Nurses or other specially trained Hospital personnel.
Licensed Vocational Nurse (LVN) means an individual who has 1) specialized nursing training; 2) vocational nursing experience; and 3) is duly licensed to perform nursing service by the state in which he or she performs such service.

Maximum Allowable Charge means the lesser of:
1. The Usual, Customary and Reasonable Charge (UCR):
The UCR is the charge generally made by a Physician or other provider of Covered Services. The charge cannot exceed the general level of charge made by other providers within an area in which the charge is incurred for Injury or Sickness comparable in severity and nature to the Injury or Sickness being treated. The general level of charges is determined in accord with schedules on file with the authorized Claims Administrator. For charges not listed in the schedules, KPIC will establish the UCR. KPIC reserves the right to periodically adjust the charges listed in the schedules.

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

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

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

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

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

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

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

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

3. The amount that Medicare (Part A or B) would pay for the service.
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Under any of the above, KPIC may deduct, any Participating Provider Copayments and/or Coinsurance amount that would have been paid had the Emergency Service been rendered at a Participating Provider and/or any Non-Participating Provider deductible amount.

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

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

Medically Necessary means services that are:
1. Essential for the diagnosis or treatment of a Covered Person’s Injury or Sickness;
2. In accord with generally accepted medical practice and professionally recognized standards in the community;
3. Appropriate with regard to standards of medical care;
4. Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
5. Not provided solely for the convenience of the Covered Person or the convenience of the health care provider or facility; and
6. Not primarily custodial care; and
7. Provided at the most appropriate supply, level and facility. When applied to Confinement in a Hospital or other facility, this test means that the Covered Person needs to be confined as an inpatient due to the nature of the services rendered or due to the Covered Person’s condition and that the Covered Person cannot receive safe and adequate care through outpatient treatment.

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

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

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

Month means a period of time: 1) beginning with the date stated in the Group Policy; and 2) terminating on the same date of the succeeding calendar month. If the succeeding calendar month has no such date, the last day of the month will be used.
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**Necessary Services and Supplies** means Medically Necessary Covered Services and supplies administered during any covered confinement or administered during other covered treatment, such as during a Physician office visit. Only drugs and materials that require supervision or administration by medical personnel during a covered confinement or other covered treatment are covered as Necessary Services and Supplies. Necessary Services and Supplies include, but are not limited to, surgically implanted prosthetic devices, oxygen, blood, blood products, and biological sera. The term does not include charges for: 1) Room and Board; 2) an Intensive Care Unit; or 3) the services of a private duty nurse, Physician, or other practitioner. This does not include drugs and materials obtained from a pharmacy under the Outpatient Prescription Drug benefit.

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

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

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

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

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

**Out-of-Pocket Maximum** means the maximum amount of Cost Share a Covered Person will be responsible for in a given period of time (the Accumulation Period). The Accumulation Period is set forth in the Schedule of Coverage. Cost sharing for Emergency Care Services, including emergency hospital care and emergency medical transportation, obtained from a Non-Participating Provider will apply toward satisfaction of the Out-of-Pocket Maximum at the Participating Provider level.

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

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

**Participating Provider Organization (PPO)** means a KPIC indemnity plan type, in which Covered Persons have access to a network of contracted providers and facilities referred to as preferred providers. In most instances, a higher level of benefits applies to Covered Services received from preferred providers and facilities. The Schedule of Coverage shows the plan type under which the Covered Person is insured.

**Patient Protection and Affordable Care Act (PPACA) –** means Title XXVII of the Public Health Service Act (PHS), as then constituted or later amended.
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**Percentage Payable** means that percentage of Covered Charges to be paid by KPIC as shown in the Schedule of Coverage. The Percentage Payable is applied against the Maximum Allowable Charge for Covered Services.

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

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

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

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

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

**PPO Service Area** means the entire state of California.

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

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

**Preventive Care** means measures taken to prevent diseases rather than curing them or treating their symptoms. Preventive care: 1) protects against disease such as in the use of immunizations, 2) promotes health, such as counseling on tobacco use, and 3) detects disease in its earliest stages before noticeable symptoms develop such as screening for breast cancer.

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

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

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

**Qualified Autism Service Paraprofessional** means an unlicensed and uncertified individual who meets all of the following criteria:
1. Is employed and supervised by a Qualified Autism Service Provider.
2. Provides treatment and implements services pursuant to a Treatment Plan developed and approved by the Qualified Autism service Provider.
3. Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.
4. Has adequate education, training, and experience, as certified by a qualified autism service provider.

**Qualified Autism Service Professional** means an individual who meets all of the following criteria:
1. Provides Behavioral Health Treatment.
2. Is employed and supervised by a Qualified Autism Service Provider.
3. Provides treatment pursuant to a Treatment Plan developed and approved by the Qualified Autism Service Provider.
4. Is a behavioral service provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations.
5. Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

**Qualified Autism Service Provider** means either of the following:
1. A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive developmental disorder or Autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified; or
2. A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for Pervasive developmental disorder or Autism, provided the services are within the experience and competence of the licensee.

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

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

**Rehabilitation Services** means services provided to restore previously existing physical function.
**Residential Treatment** means Medically Necessary services provided in a licensed residential treatment facility that provides 24-hour individualized chemical dependency or mental health treatment. Services must be above the level of custodial care and include:
1. Room and board;
2. Individual and group chemical dependency therapy and counseling;
3. Individual and group mental health therapy and counseling;
4. Physician services;
5. Medication monitoring;
6. Social services; and
7. Drugs prescribed by a physician and administered during confinement in the residential facility.

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

**Routine Patient Care Costs** means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:
8. Health care services typically provided absent a clinical trial.
9. Health care services required solely for the provision of the investigational drug, item, device, or service.
10. Health care services required for the clinically appropriate monitoring of the investigational item or service.
11. Health care services provided for the prevention of complications arising from the provision of the investigational drug item, device, or service.
12. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

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

**Serious Emotional Disturbances of a Child** means mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of minors under the age of 18, other than a primary substance use disorder or developmental disorder, which result in behavior inappropriate to the child’s age according to expected developmental norms, and who meets one or more of the following criteria:
1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
   a) The child is at risk of removal from home or has already been removed from the home.
b) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

2. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

3. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

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

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

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

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

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

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

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

**Treatment Plan** means a written document developed and approved by a Qualified Autism Service Provider for the specific patient being treated for Pervasive Developmental Disorder or Autism. The Treatment Plan must have measurable goals over a specific timeline and shall be reviewed at least once every six months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the Qualified Autism Service Provider does all of the following:
1. Describes the patient’s behavioral health impairments to be treated.
2. Designs an intervention plan that includes:
   a) the service type,
   b) number of hours, and
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c) parent participation needed to achieve the plan’s goal and objectives, and
d) the frequency at which the patient’s progress is evaluated and reported.
3. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
4. Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

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

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

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

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

You/ Your refers to the Insured Employee who is enrolled for benefits under This Plan.
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

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

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

NOTE: The term "Eligible Employee" does not include a person who is eligible for Medicare Part A or Medicare Part B, except that this does not apply to those entitled to Medicare benefits who under federal law elect, or are required, to have the Policyholder’s health coverage as their primary health care coverage.

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

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

Plan Service Area Enrollment Requirement
PPO Plan - To ensure access to a Participating Provider, a Covered Person must live within the PPO Service Area as defined under the General Definitions section of this Certificate.

Eligibility Date
Your eligibility date is the date Your employer becomes a Policyholder if You are an eligible employee on that date, or the Policyholder’s Application for coverage indicates that the eligibility waiting period does not apply to initial employees. Otherwise, Your eligibility date is the first day of the calendar month coinciding with or next following the date You complete the eligibility waiting period elected by the Policyholder.

Effective Date of Your Insurance
Your effective date of insurance is described in the subsection Enrollment Rules for Eligible Employee or Dependent provision set forth below under this section.

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

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

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

The term "Dependent" means only: a) Your spouse or Domestic Partner; and b) Your child who is of an age within the Age Limits for Dependent Children shown below, or is a disabled child of any age. The word "child" includes: a) Your step-child; b) adopted child; c) child of Your Domestic Partner; d) recognized natural child; and e) any other child whom You have assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by YOU, as certified at the time of enrollment of the child, and annually thereafter.

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

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

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

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

Age Limits for Disabled Dependent Children
A Disabled Dependent child means Your child of any age who is both: 1) incapable of self-sustaining employment by reason of a physically or mentally disabling sickness, injury or condition; and 2) chiefly dependent upon You for support and maintenance.
Initial enrollment of a Disabled Dependent child age 26 or over

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

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

Continued Enrollment for Disabled Dependents age 26 and over

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

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

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

Eligibility Date
A Dependent’s eligibility date is the later of: a) Your eligibility date; or b) the date the person qualifies as Your Dependent. A child named in a Qualified Medical Child Support Order qualifies as Your Dependent on the date specified in the court order. An adopted child qualifies as Your Dependent on the earlier of: the date of adoption or the date of placement for adoption.

Effective Date of Dependent Coverage
A Dependent’s effective date of insurance is subject to the Enrollment Rules that follow.

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

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

   Effective date. Initial enrollment for newly eligible Employees and Dependents is effective following completion of any waiting period or probationary period, (not to exceed 60 days), if required by the Policyholder is completed. In the absence of a waiting period or probationary period, the enrollment becomes effective according to the eligibility rules established by the Policyholder, either on the date of hire or on the first day of the calendar month following the month in which the employee was hired.
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

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

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

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

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

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

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

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

1) Loss of health care (minimum essential) coverage, resulting from any of the following:
   a. loss of employer sponsored coverage because You or Your Dependent no longer meet the eligibility requirements,
   b. Your or Your Dependent’s employer no longer offers coverage or stops contributing premium payments;
   c. loss of eligibility for COBRA coverage (for a reason other than termination for cause or nonpayment of premium);
   d. Your and/or Your Dependent’s individual, Medi-Cal, Medicare, or other governmental coverage ends;
   e. for any reason other than failure to pay premiums on a timely basis or situations allowing for a rescission under section 10384.17 of the California Insurance Code (fraud or intentional misrepresentation of material fact); or
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

f. loss of health care coverage including, but not limited to, loss of that coverage due to the circumstances described in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the Code of Federal Regulations and the circumstances described in Section 1163 of Title 29 of the United States Code.

2) Gaining or becoming a dependent due to marriage, domestic partnership, birth, adoption, placement for adoption or assumption of a parent-child relationship;

3) A valid state or federal court orders that you or your dependent be covered;

4) Permanent relocation, such as moving to a new location and having a different choice of health plans;

5) Being released from incarceration;

6) The prior health coverage issuer substantially violated a material provision of the health coverage contract;

7) A network provider’s participation in Your and/or Your Dependent’s health plan ended when You were under active care for one of the following conditions
   a. an acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration;
   b. a serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration;
   c. pregnancy;
   d. terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less;
   e. care of a newborn child between birth and age 36 months; or
   f. performance of a surgery or other procedure that has been recommended and documented by the provider to occur within 180 days of the contract’s termination date or within 180 days of the effective date of coverage for a newly covered insured.

8) A member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service under Title 32 of the United States Code.

9) An individual demonstrates to the Department of Insurance, with respect to health benefit plans offered outside the Exchange that the individual did not enroll in a health benefit plan during the immediately preceding enrollment period available because the individual was misinformed that he or she was covered under minimum essential coverage.

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

Court or Administrative Ordered Coverage for a Dependent Child
If a Covered Person is required by an Order to provide health coverage for an eligible child and the Covered Person is eligible for coverage under a family plan, the Covered Person, employee, employer or group administrator may enroll the eligible child under family coverage by sending KPIC a written application and paying KPIC any additional amounts due as a result of the change in coverage. Enrollment period restrictions will not apply in these circumstances. However, the child should be enrolled within 60 days of the court or administrative order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

If the Covered Person, employee, administrator or employer fails to apply for coverage for the Dependent child pursuant to the Order, the custodial parent, district attorney, child’s legal custodian or the State Department of Health Services may submit the application for insurance for the eligible child. Enrollment period restrictions will not apply in these circumstances. However, the child must be enrolled within 60 days of the Order to avoid any delays in the processing of any claim that may be submitted on behalf of the child.

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

Effective Date for Future Dependents
The effective date of insurance for a Dependent will be the date You acquire the Dependent in the case of birth, adoption, or placement for adoption. In the case of marriage or becoming a registered domestic partner, enrollment is effective on the first day of the month following the date we receive the request for special enrollment. The Dependent must be enrolled within 60 days of their eligibility date or they will be considered a Late Enrollee.

Exception for Newborns
A newborn Dependent child is insured from the moment of birth for the first 31 days (including the date of birth. You must enroll the newborn Dependent within 60 days of that Dependent’s birth in order for insurance to extend beyond the 60-day period. If coverage terminates at the expiration of the 60-day period, the child will be considered a Late Enrollee and You must wait until the next annual Open Enrollment period to enroll the child for coverage.

Exception for Adopted Children
An adopted child is insured from the earlier of the date of adoption or the date of placement for adoption. You must enroll the adopted child within 60 days of his eligibility date in order for insurance to extend beyond the 60-day period. If coverage terminates at the expiration of the 60-day period, the child will be considered a Late Enrollee and You must wait until the next annual Open Enrollment period to enroll the child for coverage.

Termination of an Insured Employee’s Insurance
Your insurance will automatically terminate on the earlier of:
1. the date You cease to be covered by KPIC;
2. the date the Group Policy is terminated;
3. the date You, or Your representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
4. the end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion. (The grace period that the Policyholder has in which to pay the premium then due is the later of 31 days from each premium due date (except the first) or 31 days from the date KPIC provides notice of non-renewal due to non-payment of premium to the Policyholder.);
5. the last day of the month You cease to qualify as an Eligible Employee; or
6. the date You relocate to a place outside of the geographic service area of a provider network, if applicable. (See the eligibility section for information about the Plan Service Areas.) If You cease to qualify as an Eligible Employee because You no longer live in an area specified for the Plan in which You are enrolled, Your insurance will end on the last day of the Policy Year in which You change residence.

In no event will Your insurance continue beyond the earlier of the date Your employer is no longer a Policyholder and the date the Group Policy terminates.
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

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

Termination of Insured Dependent Coverage
An Insured Dependent’s coverage will end on the earlier of:
1. the date You cease to be covered by KPIC;
2. the last day of the of the calendar month in which the person ceases to qualify as a Dependent;
3. the date Your insurance ends, unless continuation of coverage is available to the Dependent under the provisions of the Group Policy;
4. the end of the grace period after the Policyholder fails to pay any required premium to KPIC when due or KPIC does not receive the premium payment in a timely fashion. (The period that the Policyholder has in which to pay the premium then due is the later of 31 days from each premium due date (except the first) or 31 days from the date KPIC provides notice of non-renewal due to non-payment of premium to the Policyholder.);
5. the date the Group Policy is terminated;
6. the date the Dependent, or the Dependent’s representative, commits an act of fraud or makes an intentional misrepresentation of a material fact;
7. the date the Dependent relocates to a place outside of the geographic service area of a provider network, if applicable, unless specifically provided otherwise in the Group Policy.

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

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

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

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

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

If KPIC rescinds the Group Policy, we will send a notice to the Insured via regular certified mail at least 30 days prior to the effective date of the rescission explaining the reasons for the intended
ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION DATE

rescission and notifying the Insured of his or her right to appeal that decision to the California Insurance Commissioner.

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

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

Benefit levels for Participating Providers or Non-Participating Providers
Your coverage provided under the Group Policy may include coverage for Covered Services that are received from either Participating Providers or Non-Participating Provider. See Your Schedule of Coverage to determine if Your coverage includes Participating Providers. Normally, benefits payable under the Group Policy are greater for Covered Services received from Participating Providers than those benefits payable for Non-Participating Providers. In order for benefits to be payable at the Participating Provider level, the Covered Person must receive care from a Participating Provider.

A current listing of KPIC’s Participating Providers is available from Your employer in a paper copy at no cost to You, or 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.

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

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

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

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

When You’re Not Sure What Kind of Care You Need
Sometimes it’s difficult to know what kind of care You need, so we have licensed health care professionals available to assist You by phone 24 hours a day, seven days a week. Here are some of the ways they can help You:

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

You can reach one of these licensed health care professionals by calling 1-888-251-7052. When You call, a trained support person may ask You questions to help determine how to direct Your call.
If you have a complaint regarding your ability to access needed health care in a timely manner, you may contact KPIC at:

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

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

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

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

The covered person may write to the California Department of Insurance at:

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

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

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

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

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

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

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

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

1. Hospital Confinements*.
2. Inpatient Mental Health admissions and services*.
3. Inpatient Chemical Dependency admissions and services*.
4. Inpatient care at a Skilled Nursing Facility or any other licensed medical facility.
5. Home Health Care Services, including Home Infusion and Home Therapy.
6. Inpatient Rehabilitation Therapy admissions, services and programs.
7. Inpatient Residential Treatment
8. Outpatient surgery at a Hospital, Free-Standing Surgical Facility or other licensed medical facility.
9. The following specific treatments and procedures:
   a) Bariatric Surgery
   b) Blepharoplasty, Pitosis Repair
   c) Breast Augmentation/Implants
   d) Breast Reduction
   e) Clinical Trials
   f) Cosmetic Procedures
   g) Craniofacial Reconstruction
h) Dental and Endoscopic Anesthesia
i) Durable Medical Equipment (DME):
   i. Airway Clearance Vest
   ii. Bone stimulator
   iii. Cardiopulmonary resuscitation (CPR) Vest
   iv. Cough Stimulator Device
   v. Communicators
   vi. CPAP/BIPAP
   vii. External Vacuum Erection Devices
   viii. Hospital-grade electric breast pump
   ix. Insulin pump
   x. Neuromuscular Stimulators
   xi. Oxygen
   xii. Patient Lifts
   xiii. Specialty beds
   xiv. TENS Units
   xv. Wheelchair Cushions/Seating Systems
   xvi. Woundvac
j) Enteral Solutions
k) Genetic Testing
l) Habilitative Services (outpatient physical therapy, occupational therapy, and speech therapy and pulmonary therapy)
m) Injectable medications
n) Imaging Services: MRI, MRA, CT, CTA, PET, EBCT
o) Implantable prosthetics (includes breast, bone conduction, cochlear)
p) Medical Food Products for treatment of Phenylketonuria (PKU)
q) Non-Emergency Air or Ground Ambulance Transport
r) Orthognathic Surgery (non dental jaw surgery)
s) Orthotics/Prosthetics
t) The following Outpatient Procedures
   i. Outpatient sleep studies (lab or home)
   ii. Outpatient vein procedures (office or outpatient); includes sclerosing, ablations, stripping
   iii. Cosmetic procedures (office or outpatient)
   iv. Dermatology procedures (office or outpatient); includes injection of fillers, photopheresis, laser, tattooing, phototherapy
   v. Outpatient hyperbaric treatment
   vi. Pill or wireless endoscopy (office or outpatient)
   vii. Oral procedures (office or outpatient); includes palate, tongue, floor of mouth, prosthesis
   viii. External counterpulsation
   ix. Complex wound care (office or outpatient); includes wound vacuum, cultured or biomechanical skin graft
u) Pain Management.
   x. Epidural Injections
   xi. Use of Neurolytic agent
   xii. Decompression Procedure
   xiii. Epidural or Intrathecal Implant procedures
   xiv. Epidural or Intrathecal Pump use.
   xv. Injection of anesthetic agent
   xvi. Insertion or removal of Neurostimulator
   xvii. Paravertebral or Transforminal injections
xviii. Sacroiliac Injection.
v) Pediatric low vision aids
w) Pediatric Medically Necessary contact lenses
x) Radiation Therapy Services
y) Reconstruction Surgery (including all procedures by plastic surgeon)
z) Rehabilitative Services (outpatient physical therapy, occupational therapy, speech therapy and pulmonary rehabilitation)
aa) Spinal surgery
bb) Temporomandibular Joint Surgery
cc) Transgender Surgery
dd) Transplants

* Precertification is not required for emergency admissions. You or Your attending Physician should notify the Medical Review Program of the admission as soon as reasonably possible and not later than 24 hours following an emergency admission.

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

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

Pregnancy Precertification: When a Covered Person is admitted to a Hospital for the delivery of a child, the Covered Person is entitled to stay in the hospital without any Precertification for a minimum of:
Forty-eight (48) hours for a normal vaginal delivery; and Ninety-six (96) hours for a Cesarean section delivery.

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

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

**Review Process**

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

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

**Failure to Comply with the Precertification Procedures**

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

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

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

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

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

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

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

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

Out-of-Pocket Maximums
Any part of a charge that does not qualify as a Covered Charge, will not be applied toward satisfaction of the Out-of-Pocket Maximum. Covered Charges applied to satisfy any Deductibles under this Group Policy count toward satisfaction of the Out-of-Pocket Maximum. Cost Sharing incurred for all Covered Services apply to the Out-of-Pocket Maximum. Cost sharing for Emergency Care Services, including emergency hospital care and emergency medical transportation, obtained from a Non-Participating Provider will apply toward satisfaction of the...
DEDUCTIBLES AND MAXIMUMS

Out-of-Pocket Maximum at the Participating Provider level and the Non-Participating Provider level.

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

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

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

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

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

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

Insuring Clause

Upon receipt of a satisfactory notice of claim and proof of loss, KPIC will pay the Percentage Payable for Expenses Incurred up to the Maximum Allowable Charge (shown in the Schedule of Coverage) for a Covered Service, provided:

1. the expense is incurred while the Covered Person is insured for this benefit;
2. the expense is for a Covered Service that is Medically Necessary;
3. the expense is for a Covered Service prescribed or ordered by the attending Physician or those prescribed or ordered by Non-Participating Provider who are duly licensed by the state to provide medical services without the referral of a Physician;
4. the Covered Person has satisfied the applicable Deductibles, co-payments, and other amounts payable; and
5. the Covered Person has not exceeded any benefit maximum shown in the Schedule of Coverage.

Payments under this Group Policy:

1. Will be subject to the limitations shown in the Schedule of Coverage;
2. Will be subject to the General Limitations and Exclusions; and
3. May be subject to Precertification.

Covered Services:

1. Room and Board in a Hospital, including private room accommodation or semi-private room accommodation, upon determination by the attending Physician that such is Medically Necessary.
2. Room and Board in a Hospital Intensive Care Unit.
3. Skilled Nursing Care Services provided in a Skilled Nursing Facility or other licensed medical facility include:
   a) Physician and nursing services;
   b) Room and board;
   c) Drugs prescribed by a physician as part of the plan of care in the plan skilled nursing facility in accord with the plan’s drug formulary guidelines if they are administered in the skilled nursing facility by medical personnel;
   d) Durable medical equipment in accord with the plan’s durable medical equipment formulary if skilled nursing facilities ordinarily furnish the equipment;
   e) Imaging and laboratory services that skilled nursing facilities ordinarily provide;
   f) Medical social services; Blood, blood products, and their administration;
   g) Medical supplies;
   h) Physical, occupational, and speech therapy;
   i) Behavioral health treatment for pervasive developmental disorder or autism;
   j) Respiratory therapy.

Care in a Skilled Nursing Facility is limited to: a) the maximum number of covered days shown in the Schedule of Coverage; b) care in a licensed Skilled Nursing Facility or other
GENERAL BENEFITS

licensed medical facility; c) care under the active medical supervision of a Physician; and d) services consistent with medical needs.

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

5. Treatment in an Emergency Department of a Hospital or an Urgent Care Center. Please refer to the subsection, “Benefits for Emergency Services” in this General Benefits section for further information.

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

7. Transportation of a Covered Person to or from Covered Services, by licensed ambulance or licensed psychiatric transport van service, when a Physician determines that the use of other means of transportation may endanger the Covered Person’s health.

8. Emergency medical transportation without Precertification provided through the 911 emergency response system in the following situations:
   a) the request was made for an emergency medical condition and ambulance transport services were required;
   b) the Covered Person reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

9. Nursing care by an RN, or, an LVN, as certified by the attending Physician if an RN is not available. Outpatient private duty nursing will only be covered for the period for which KPIC validates a Physician’s certification that: a) the services are Medically Necessary and b) that, in the absence of such nursing care, the Covered Person would be receiving Covered Services as an inpatient in a Hospital or Skilled Nursing Facility in the absence of these nursing services.

10. Services by a Certified Nurse Practitioner; Certified Clinical Nurse Specialist; Licensed Midwife; or Certified Nurse-Midwife. This care must be within the individual’s area of professional competence.

11. Radiation treatment limited to: a) radiation therapy when used in lieu of generally accepted surgical procedures or for the treatment of malignancy; or b) the use of isotopes, radium or radon for diagnosis or treatment.

12. X-ray, other imaging including diagnostic mammogram and lab tests.

13. Ultraviolet light treatment

14. Anesthesia and its administration when provided by a licensed anesthesiologist or licensed nurse anesthetist.

15. Genetic testing, limited to genetic testing used to diagnose, treat, or determine predisposition to breast cancer and prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures.

16. Home Health Care Services except:
   a) meals;
   b) personal comfort items; and
   c) housekeeping services.

Covered Home Health Care Services are limited to part-time or intermittent home health care consisting of up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide. Up to three visits per day (counting all home health visits from nurses, medical social workers, and home health aides; the visit limit does not apply to physical, occupational, and speech therapists visits) are covered. Up to 100 visits per Accumulation Period (counting all home health visits from nurses, medical social workers, and home health aides; the visit limit does not apply to physical, occupational, and speech therapists visits) are covered. They must be provided in the Covered Person’s home and according to a prescribed treatment plan.
If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to Your home for three hours and then leaves, that counts as two visits. Also, each person providing services counts toward these visit limits. For example, if a home health aide and a nurse are both at Your home during the same two hours, that counts as two visits.

17. Outpatient surgery in a Free-Standing Surgical Facility or other licensed medical facility.
18. Hospital charges for use of a surgical room on an outpatient basis.
19. Hospice Care limited to:
   a) Interdisciplinary team care with development and maintenance of an appropriate plan of care.
   b) Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse.
   c) Bereavement Services.
   d) Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.
   e) Medical direction with the medical director being also responsible for meeting the general medical needs of the enrollees to the extent that these needs are not met by the attending physician.
   f) Volunteer services.
   g) Short-term inpatient care arrangements.
   h) The following shall be provided to the extent reasonable and necessary for the palliation and management of terminal illness and related conditions: pharmaceuticals, medical equipment and supplies.
   i) Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
   j) Ostomy and urological supplies including incontinence supplies.
   k) The following care during periods of crisis when You need continuous care to achieve palliation or management of acute medical symptoms:
      i. nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain You at home.
      ii. respite care (short-term inpatient care) required at a level that cannot be provided at home.

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

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

Durable Medical Equipment includes but is not limited to
a. the following Base Durable Medical Equipment items:
  i. Diabetic Shoes and Inserts: off-the-shelf depth-inlay shoes; custom-molded
     shoes; custom-molded multiple density inserts; fitting, modification, and follow-
     up care for podiatric devices; repair or replacement of podiatric devices.
  ii. Glucose Monitors, Infusion Pumps, and Related Supplies: external single or
       multiple channel electric or battery-operated ambulatory infusion pumps; home
       blood glucose monitors; blood glucose test or reagent strips for home blood
       glucose monitors; interstitial glucose monitors; programmable and non-
       programmable implantable infusion pumps; infusion pump used for uninterrupted
       parenteral administration of medication; infusion sets for external insulin pumps;
       infusion supplies for external drug infusion pumps; lancets; calibrator
       solution/chips; single or multi-channel stationary parenteral infusion pumps;
       replacement batteries for home blood glucose monitors and infusion pumps;
       spring-powered device for lancet; syringe with needle for insulin pump.
  iii. Respiratory Drug Delivery Devices: large and small volume nebulizers; disposable
       and non-disposable administration sets; aerosol compressors; aerosol mask;
       disposable and non-disposable corrugated tubing for nebulizers; disposable and
       non-disposable filters for aerosol compressors; peak expiratory flow rate meter;
       distilled water for nebulizer; water collection device for nebulizer, spacer for use
       with metered dose inhaler.
  iv. Tracheostomy Equipment: artificial larynx; replacement battery for artificial
      larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including:
      adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder,
      cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and
      tracheostomy care kits.
  v. Canes and Crutches: adjustable and fixed canes, including standard curved
     handle and quad canes; adjustable and fixed crutches, including underarm and
     forearm crutches; replacement supplies for canes and crutches, including
     handgrips, tips, and underarm pads.
  vi. Dry pressure pad for a mattress.
  vii. Cervical traction equipment (over door).
  viii. Osteogenesis Stimulation Devices: non-invasive electrical osteogenesis
       stimulators, for spinal and non-spinal applications; non-invasive low density
       ultrasound osteogenesis stimulator.
  ix. IV pole.
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x. Phototherapy (bilirubin) light with photometer.
xi. Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage.

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

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

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

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

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

This benefit includes coverage for diabetic day-care self-management program, training, education and medical nutrition therapy services. For the purposes of this provision, “diabetic day-care self-management program” means an educational program of instruction which will enable diabetic patients and their families to gain an understanding of the diabetic process, and the daily management of diabetic therapy in order to avoid frequent hospitalizations and complications.

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

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

27. Rehabilitative Services. The following Services are covered
   a) Physical therapy rendered by a certified physical therapist or other provider practicing within the scope of their license or registration. Therapy must be attended as prescribed by the attending Physician.
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b) Speech therapy rendered by a certified speech therapist or certified speech pathologist.

c) Occupational therapy rendered by a certified occupational therapist. Therapy must be attended as prescribed by the attending Physician.

d) Pulmonary therapy.

e) Multidisciplinary rehabilitation services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program. The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

28. Respiratory therapy rendered by a certified respiratory therapist.

29. Mental Health Services for diagnosis and treatment of a Mental Disorder, including Severe Mental Illness and Serious Emotional Disturbances of a Child, limited to:

   a) Outpatient mental health services, including the following: (1) individual and group mental health evaluation and treatment; (2) psychological testing when necessary to evaluate a Mental Disorder; and (3) outpatient Services for the purpose of monitoring drug therapy.

   b) Intensive psychiatric treatment programs, including the following: (1) short-term hospital-based intensive outpatient care; (2) short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program; (3) short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis; (4) treatment in a residential care facility; and (5) psychiatric observation for an acute psychiatric crisis.

   c) Inpatient psychiatric hospitalization, including coverage for room and board, prescription drugs, and services of physicians and providers who are licensed health care professionals acting within the scope of their license.

30. Chemical dependency services are limited to:

   a) Inpatient detoxification: hospitalization only for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling.

   b) Outpatient chemical dependency care: day-treatment programs, intensive outpatient programs, individual and group chemical dependency counseling, medical treatment for withdrawal symptoms.

   c) Methadone maintenance treatment at no charge at a licensed treatment center approved by the insurer.

   d) Treatment in a residential care facility, including transitional residential recovery services for chemical dependency treatment in a nonmedical transitional residential recovery setting. These settings provide counseling and support services in a structured environment.

31. Transplant services in connection with an organ or tissue transplant procedure, harvesting the organ, tissue, or bone marrow and treatment of complications, including charges incurred by a donor or prospective donor who is not insured under the plan will be paid as though they were incurred by the insured provided that the services are directly related to the transplant. Coverage for transplant services shall not be denied based upon the Covered Person being infected with the human immunodeficiency virus (HIV).

32. Treatment for breast cancer. Some services may be considered preventive benefits and are covered at no Cost Share. Please refer to Preventive Care Exams and Services in this General Benefits section for coverage of preventive benefits to screen for or diagnose breast cancer.

33. Allergy testing and treatment, services, material and serums.
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34. Treatment for infertility, except in vitro fertilization. Treatment of infertility is limited to treatment by artificial means for the purpose of causing pregnancy, such as: a) drugs; b) medicines; c) artificial insemination; d) gamete intrafallopian transfer; e) ovum transplants; f) donor eggs; or g) donor sperm. Treatment must be consistent with prevailing standards for efficacy. Benefits payable for diagnosis of infertility will be covered on the same basis as a Sickness.

35. Treatment of covered conditions directly affecting the upper or lower jawbone, or associated bone joints, including craniomandibular and temporomandibular joint disorders limited to Medically Necessary non-dental surgical treatment only.

36. Reconstructive Surgery. Coverage is limited to a surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following: 1) to improve function; or 2) to create a normal appearance to the extent possible. Reconstructive Surgery includes, but is not limited to, non-dental jaw surgery, incidental surgery to a covered mastectomy and Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Reconstructive breast surgery following a mastectomy including reconstruction of the healthy breast to produce a symmetrical appearance; prostheses; and treatment of complications at all stages of the mastectomy, including lymphedemas. Please refer to “Prosthetic and Orthotic Devices that are Medically Necessary” in this GENERAL BENEFITS section for coverage of breast prostheses needed after a covered mastectomy.

37. General anesthesia and associated facility charges for dental procedures rendered in a Hospital or surgery center setting, when the clinical status or underlying medical condition of the Covered Person requires that the dental procedure be performed while the Covered Person is under general anesthesia in a Hospital or surgery center setting. Coverage shall not be provided unless the Covered Person is: a) under seven years of age; or b) developmentally disabled; or c) one whose health is compromised and for whom general anesthesia is medically necessary.

This provision does not apply to treatment rendered for temporal mandibular joint disorders nor does it provide coverage for any dental procedure or the professional fees or services of the dentist.

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

39. Screening and treatment of Phenylketonuria (PKU), including coverage for medical food products, such as formula that are Medically Necessary for the treatment of PKU. Such coverage for formula and special food products is limited to the extent that the cost of such formulas or special food products exceed the cost of a normal diet.

40. Coverage for a second medical opinion, limited to charges for Physician consultation, and charges for any additional x-rays, laboratory tests and other diagnostic studies. Benefits will not be payable for x-ray, laboratory tests, or diagnostic studies that are repetitive of those obtained as part of the original medical opinion and/or those for which KPIC paid benefits. For benefits to be payable, the second medical opinion must be rendered by a Physician who agrees not to treat the Covered Person’s diagnosed condition. The Physician offering the second medical opinion may not be affiliated with the Physician offering the original medical opinion.

41. Behavioral Health Treatment for Pervasive Developmental Disorder or Autism. The treatment must be prescribed by a physician or surgeon; or is developed by a psychologist and provided under the Treatment Plan prescribed by a Qualified Autism Service Provider and administered by one of the following:
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a) A Qualified Autism Service Provider.
b) A Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider.
c) A Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider.

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

43. Covered Services in connection with the diagnosis of Obesity. These include Covered Services to diagnose the causes of obesity, for treatment of diseases causing obesity, or resulting from obesity including screening, diagnostic testing and lab services.

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

45. Telehealth when used as a mode of delivering otherwise Covered Services via interactive and non-interactive communications methods, including, email or the transmission of data via online technology, telephone and fax. Coverage is limited to services obtained from a Participating Provider.

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

47. Habilitative Services. The following services are covered:
   a) Physical therapy rendered by a certified physical therapist or other provider practicing within the scope of their license or registration.
   b) Occupational therapy performed by a licensed occupational therapist.
   c) Speech therapy rendered by a certified speech therapist or certified speech pathologist.
   d) Pulmonary therapy.
   e) Multidisciplinary habilitation services while confined in a Hospital or any other licensed medical facility or through a comprehensive outpatient rehabilitation facility (CORF) or program. Rehabilitation services are limited to those provided in an organized, multidisciplinary rehabilitation program.

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

49. Foreign travel immunizations.

50. Covered Services associated with cancer clinical trials if all of the following requirements are met:
   a) You are diagnosed with cancer;
   b) You are accepted into a phase I, II, III, or IV clinical trial for cancer;
   c) Your treating Physician, for treatment of cancer, recommends participation in the clinical trial after determining that it has a meaningful potential to benefit You;
   d) The services would be covered under this Policy if they were not provided in connection with a clinical trial;
   e) The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity; and
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f) The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs.

For Covered Services related to a clinical trial, You will pay the Cost Sharing You would pay if the Covered Services were not related to a clinical trial.

51. Diagnosis, treatment and management of osteoporosis, including but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

52. Transgender Surgery Services. Medically Necessary surgery to treat gender dysphoria including genital surgery, mastectomy, tracheal shave and facial hair removal. Benefits for Covered Services which are associated with transgender surgery are provided in the same manner as any other medical or surgical coverage, as set forth under this Certificate. Non-Medically Necessary surgical procedures, including services that are intended primarily to change or maintain one’s appearance, are excluded, as set forth under the GENERAL LIMITATIONS & EXCLUSIONS section of this Certificate. Please refer to the PRECERTIFICATION section for information about Precertification through the Medical Review Program.

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

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

Eyeware
The following eyeware is covered:

1. Lenses
   a. Single vision
   b. Conventional (Lined) Multifocal
   c. Lenticular
   d. Other optional lenses and treatments
      i. Ultraviolet Protective Coating
      ii. Polycarbonate Lenses
      iii. Gradient tinting
      iv. Blended Segment Lenses
      v. Intermediate Vision Lenses
      vi. Standard Progressives
      vii. Premium Progressives
      viii. Photochromic Glass Lenses
      ix. Plastic Photosensitive Lenses (Transitions®)
      x. Glass-grey #3 prescription sunglass lenses
      xi. Polarized Lenses
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xii. Standard Anti-Reflective (AR) Coating
xiii. Premium AR Coating
xiv. Ultra AR Coating
xv. Hi-Index Lenses
xvi. Oversized

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

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

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

Other Vision Services
Low Vision services are services provided to children with a significant loss of vision but not total blindness. The goal of services is to maximize the remaining usable vision for children with low vision who have visual impairments not fully treatable by medical, surgical interventions or conventional eyewear or contact lenses. Coverage is limited to the following:
1. Comprehensive low vision evaluation
2. Low vision aids such as high-power spectacles, magnifiers, and telescopes
3. Follow up care

The following vision services are not covered:
All pediatric vision services not listed above including but not limited to:

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

Preventive Care
Unless otherwise stated, the requirement that Medically Necessary Covered Services be incurred as a result of Injury or Sickness will not apply to the following Covered Services. Please refer to Your Schedule of Coverage regarding each benefit in this section:
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Preventive Care Exams and Services
As shown in the Schedule of Coverage, the following preventive services are not subject to Deductibles, Copayments or Coinsurance when received from a Participating Provider. Consult with Your physician to determine what preventive services are appropriate for You.

Exams
1) Well-Baby, Child, Adolescent Exam according to the Health Resources and Services Administration (HRSA) guidelines.
2) Well woman exam visits, including routine prenatal care office visits, according to the Health Resources and Services Administration (HRSA) guidelines.

Screenings
1) Abdominal aortic aneurysm screening
2) Asymptomatic bacteriuria screening
3) Breast cancer mammography screening
4) Cervical cancer and dysplasia screening including Human Papilloma Virus (HPV) screening and Pap test,
5) Colorectal cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy. This includes anesthesia required for colonoscopies, pathology for biopsies resulting from a screening colonoscopy, and a specialist consultation visit prior to the procedure.
6) Depression screening
7) Gestational diabetes screening
8) Hepatitis B virus infection screening
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
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

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
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4) Tobacco use and tobacco-caused disease counseling and interventions. All FDA-approved tobacco cessation prescription over-the-counter smoking cessation medication when prescribed by a licensed health care professional authorized to prescribe drugs for women who are not pregnant and men. Coverage of FDA-approved tobacco cessation prescription or over-the-counter medications for pregnant women is described below under the “Other Preventive Care” subsection of this General Benefits section.

5) Referral for testing for breast and ovarian cancer susceptibility, genetic counseling 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

8) When prescribed by a licensed health care professional authorized to prescribe drugs:
   a) aspirin in the prevention of cardiovascular disease and preeclampsia in pregnant women.
   b) iron supplementation for children from 6 months to 12 months of age.
   c) oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
   d) topical fluoride varnish treatments applied in a primary care setting by primary care providers, within the scope of their licensure, for the prevention of dental caries in children.
   e) folic acid supplementation for women planning or capable of pregnancy.
   f) 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 counseling by a provider acting within the scope of his or her license or certified under applicable state law during pregnancy and/or in the post partum period, and the purchase of a breast pump. In lieu of purchase of a breast pump, rental of a hospital-grade electric breast pump (including a hospital-grade double breast pump kit), including any equipment that is required for pump functionality, when prescribed by a physician. KPIC may decide to purchase the hospital-grade electric breast pump if purchase would be less expensive than rental or rental equipment is not available.

10) Screening and counseling for interpersonal and domestic violence.

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

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

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
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2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration, including:
   a. The American Academy of Pediatrics Bright Futures Recommendations for Pediatric Preventive Health Care, and
   b. The Uniform Screening Panel recommended by the U.S. Department of Health and Human Services Secretary’s Discretionary Advisory Committee on Heritable Disorders in Newborns and Children.

4. For women, to the extent not described in paragraph (a), evidence-informed preventive care and screenings provided for in the Health Resources and Services Administration Women’s Preventive Services Guidelines.

These 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: 1-800-464-4000. You may also visit:

- U.S. Centers for Medicare & Medicaid Services Preventive Care Benefits.
- U.S. Preventive Services Task Force Grade A & B recommendations.
  www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
- The Advisory Committee on Immunization Practices (ACIP) that have been adopted by the Center for Disease Control and Prevention.
  www.cdc.gov/vaccines/acip/index.html
- Guidelines for women’s preventive health care as supported by the Health Resources and Services Administration (HRSA).
  www.hrsa.gov/womensguidelines/
- Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care.
  www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf

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

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

Other Preventive Care
These other preventive care covered under this Policy that are listed below may be subject to Deductibles, Copayments or Coinsurance as described in the Schedule of Coverage. Please
Please refer to your Schedule of Coverage regarding each benefit in this section.

1. Routine nursery care and Physician charges for a newborn while the mother is confined.

2. Adult preventive screening. Services must meet the prevailing standards. The care will include:
   a) Screening and diagnosis of prostate cancer, including but not limited to prostate-specific antigen testing and digital rectal examination when Medically Necessary and consistent with good professional practice. This coverage does not cover the surgical and other procedures known as radical prostatectomy, external beam radiation therapy, radiation seed implants, or combined hormonal therapy; and
   b) All other cancer screening tests not covered under PPACA, including any cervical cancer screening test approved by the Federal Food and Drug Administration.

3. Adult routine physical examinations. Services must meet prevailing standards. The care shall include: a) examination; b) history; and c) x-ray and laboratory tests limited to: EKG, chest x-rays, CBC, comprehensive metabolic panel, urinalysis (when performed in conjunction with a routine adult physical examination).

4. Other hearing screenings and hearing exams limited to services to determine the need for a hearing correction

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

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

7. Family planning limited to:
   a) The charge of a Physician for consultation concerning the family planning alternatives available to You and Your spouse or Domestic Partner (except those considered preventive benefits under PPACA), including any related diagnostic tests; and
   b) Charges for the following procedures:
      i) vasectomy;
      ii) elective abortion; and
      iii) fertility testing and counseling.

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

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

8. AIDS vaccine limited to those approved for marketing by the federal Food and Drug Administration and that is recommended by the United States Public Health Service.

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

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

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

12. Iron deficiency anemia screening for pregnant women.
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Length of Stay for 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. Your Physician may order a follow-up visit for You and Your newborn to take place within 48 hours after discharge.

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

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

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

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

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

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

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

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

Pediatric Dental Benefits

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

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0120</td>
<td>Periodic oral examination - established patient</td>
</tr>
<tr>
<td>D0140</td>
<td>Limited oral examination - problem focused</td>
</tr>
<tr>
<td>D0145</td>
<td>Oral examination for a patient under three years of age and counseling with primary caregiver</td>
</tr>
<tr>
<td>D0150</td>
<td>Comprehensive oral examination - new or established patient</td>
</tr>
<tr>
<td>D0160</td>
<td>Detailed and extensive oral examination - problem focused, by report</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-examination - limited, problem focused (established patient; not post-operative visit)</td>
</tr>
<tr>
<td>D0171</td>
<td>Re-evaluation – post-operative office visit</td>
</tr>
<tr>
<td>D0171</td>
<td>Comprehensive periodontal examination - new or established patient</td>
</tr>
</tbody>
</table>

Radiographs/diagnostic imaging (including interpretation)

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>D0210</td>
<td>Intraoral - complete series of radiographic images</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first radiographic image</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional radiographic image</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal radiographic image</td>
</tr>
<tr>
<td>D0250</td>
<td>Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector</td>
</tr>
<tr>
<td>D0260</td>
<td>Extra-oral - each additional radiographic image</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - single radiographic image</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two radiographic images</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - three radiographic images</td>
</tr>
</tbody>
</table>
GENERAL BENEFITS

D0274  Bitewings - four radiographic images
D0277  Vertical bitewings - 7 to 8 radiographic images
D0290  Posterior-anterior or lateral skull and facial bone survey radiographic image
D0310  Sialography
D0320  Temporomandibular joint arthrogram, including injection
D0322  Tomographic survey
D0330  Panoramic radiographic image
D0340  2D cephalometric radiographic image – acquisition, measurement and analysis
D0350  2D oral/facial photographic image obtained intra-orally or extra-orally
D0460  Pulp vitality tests
D0470  Diagnostic casts

Oral pathology laboratory
D0502  Other oral pathology procedures, by report
D0601  Caries risk assessment and documentation, with a finding of low risk
D0602  Caries risk assessment and documentation, with a finding of moderate risk
D0603  Caries risk assessment and documentation, with a finding of high risk
D0999  Unspecified diagnostic procedure, by report

PREVENTIVE
Preventive services are the necessary procedures and techniques to prevent the occurrence of dental abnormalities or diseases. Preventive services include:

Dental prophylaxis
D1110  Prophylaxis - adult
D1120  Prophylaxis - child

Topical fluoride treatment
D1206  Topical application of fluoride varnish
D1208  Topical application of fluoride – excluding varnish

Other preventive services
D1310  Nutritional counseling for control of dental disease
D1320  Tobacco counseling for the control and prevention of oral disease
D1330  Oral hygiene instructions
D1351  Sealant - per tooth
D1352  Preventive resin restoration in a moderate to high caries risk patient – permanent tooth
D1353  Sealant repair – per tooth
D1999  Unspecified preventive procedure, by report

Space maintenance (passive appliances)
D1510  Space maintainer - fixed - unilateral
D1515  Space maintainer - fixed - bilateral
D1520  Space maintainer - removable - unilateral
D1525  Space maintainer - removable - bilateral
D1550  Re-cement or re-bond space maintainer
D1555  Removal of fixed space maintainer

BASIC SERVICES

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

Amalgam restorations (including Polishing)
D2140  Amalgam - one surface, primary or permanent
GENERAL BENEFITS

D2150 Amalgam - two surfaces, primary or permanent
D2160 Amalgam - three surfaces, primary or permanent
D2161 Amalgam - four or more surfaces, primary or permanent

Resin – based composite restorations - direct
D2330 Resin-based composite - one surface, anterior
D2331 Resin-based composite - two surfaces, anterior
D2332 Resin-based composite - three surfaces, anterior
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2390 Resin-based composite crown, anterior
D2391 Resin-based composite - one surface, posterior
D2392 Resin-based composite - two surfaces, posterior
D2393 Resin-based composite - three surfaces, posterior
D2394 Resin-based composite - four or more surfaces, posterior

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

Inlay/onlay restorations
D2510 Inlay - metallic - one surface
D2520 Inlay - metallic - two surfaces
D2530 Inlay - metallic - three or more surfaces
D2610 Inlay - porcelain/ceramic - one surface
D2620 Inlay - porcelain/ceramic - two surfaces
D2630 Inlay - porcelain/ceramic - three or more surfaces
D2650 Inlay - resin-based composite - one surface
D2651 Inlay - resin-based composite - two surfaces
D2652 Inlay - resin-based composite - three or more surfaces

Crowns – single restoration only
D2710 Crown - resin-based composite (indirect)
D2712 Crown - 3/4 resin-based composite (indirect)
D2720 Crown - resin with high noble metal
D2721 Crown - resin with predominantly base metal
D2722 Crown - resin with noble metal
D2740 Crown - porcelain/ceramic substrate
D2750 Crown - porcelain fused to high noble metal
D2751 Crown - porcelain fused to predominantly base metal
D2752 Crown - porcelain fused to noble metal
D2780 Crown - 3/4 cast high noble metal
D2781 Crown - 3/4 cast predominantly base metal
D2782 Crown - 3/4 cast noble metal
D2783 Crown - 3/4 porcelain/ceramic
D2790 Crown - full cast high noble metal
D2791 Crown - full cast predominantly base metal
D2792 Crown - full cast noble metal
D2799 Provisional crown– further treatment or completion of diagnosis necessary prior to final impression

Other restorative services
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core
D2920 Re-cement or re-bond crown
D2929 Prefabricated porcelain/ceramic crown – primary tooth
GENERAL BENEFITS

D2930  Prefabricated stainless steel crown - primary tooth
D2931  Prefabricated stainless steel crown - permanent tooth
D2932  Prefabricated resin crown
D2933  Prefabricated stainless steel crown with resin window
D2940  Protective restoration
D2949  Restorative foundation for an indirect restoration
D2950  Core buildup, including any pins when required
D2951  Pin retention - per tooth, in addition to restoration
D2952  Post and core in addition to crown, indirectly fabricated
D2953  Each additional indirectly fabricated post - same tooth
D2954  Prefabricated post and core in addition to crown
D2955  Post removal
D2957  Each additional prefabricated post - same tooth
D2970  Temporary crown (fractured tooth)
D2971  Additional procedures to construct new crown under existing partial denture framework
D2980  Crown repair necessitated by restorative material failure
D2999  Unspecified restorative procedure, by report

OTHER BASIC SERVICES

Unclassified treatment
D9110  Palliative (emergency) treatment of dental pain – minor procedure
D9120  Fixed partial denture sectioning

Anesthesia
D9210  Local anesthesia not in conjunction with operative or surgical procedures
D9211  Regional block anesthesia
D9212  Trigeminal division block anesthesia
D9215  Local anesthesia in conjunction with operative or surgical procedures
D9220  Deep sedation/general anesthesia – first 30 minutes
D9221  Deep sedation/general anesthesia – each 15 minute increment
D9230  Inhalation of nitrous oxide / anxiolysis, analgesia
D9241  Intravenous conscious sedation/analgesia – first 30 minutes
D9242  Intravenous moderate conscious sedation/analgesia – each 15 minute increment
D9248  Non-intravenous conscious sedation

Professional consultation
D9310  Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician
D9410  House/extended care facility call
D9420  Hospital or ambulatory surgical center call

Professional visits
D9430  Office visit for observation (during regularly scheduled hours) – no other services performed
D9440  Office visit – after regularly scheduled hours

Drugs
D9610  Therapeutic parenteral drug, single administration
D9612  Therapeutic parenteral drugs, two or more administrations, different medications
D9910  Application of desensitizing medicament

Miscellaneous
D9930  Treatment of complications (post-surgical) – unusual circumstances, by report
D9950  Occlusion analysis – mounted case
GENERAL BENEFITS

D9951 Occlusal adjustment – limited
D9952 Occlusal adjustment – complete
D9999 Unspecified adjunctive procedure, by report

MAJOR SERVICES

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

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

Endodontic therapy
D3310 Endodontic therapy, anterior tooth (excluding final restoration)
D3320 Endodontic therapy, bicuspid tooth (excluding final restoration)
D3330 Endodontic therapy, molar (excluding final restoration)
D3331 Treatment of root canal obstruction; non-surgical access
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth
D3333 Internal root repair or perforation defects

Endodontic retreatment
D3346 Retreatment of previous root canal therapy – anterior
D3347 Retreatment of previous root canal therapy – bicuspid
D3348 Retreatment of previous root canal therapy – molar

Apexification/recalcification procedures
D3351 Apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification – interim medication replacement
D3353 Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)

Apicoectomy/periradicular services
D3410 Apicoectomy – anterior
D3421 Apicoectomy – bicuspid (first root)
D3425 Apicoectomy – molar (first root)
D3426 Apicoectomy (each additional root)
D3427 Periradicular surgery without apicoectomy
D3430 Retrograde filling – per root

Other endodontic services
D3910 Surgical procedure for isolation of tooth with rubber dam
D3999 Unspecified endodontic procedure, by report

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

Surgical Services
D4210 Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth bounded spaces per quadrant
D4211 Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant
D4249 Clinical crown lengthening – hard tissue
D4260 Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant
D4261 Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant
D4265 Biologic materials to aid in soft and osseous tissue regeneration

Non-surgical periodontal services
D4341 Periodontal scaling and root
D4342 Periodontal scaling and root
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis
D4381 Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth

Other periodontal services
D4910 Periodontal maintenance
D4920 Unscheduled dressing change (by someone other than treating dentist or their staff)
D4999 Unspecified periodontal procedure, by report

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

Complete dentures
D5110 Complete denture – maxillary
D5120 Complete denture – mandibular
D5130 Immediate denture – maxillary
D5140 Immediate denture – mandibular

Partial dentures
D5211 Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)
D5212 Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)
D5213 Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214 Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

Adjustment to dentures
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture – mandibular

Repairs to complete dentures
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth – complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp – per tooth
GENERAL BENEFITS

D5640 Replace broken teeth – per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture – per tooth

Denture reline procedures
D5730 Reline complete maxillary denture (chairside)
D5731 Reline complete mandibular denture (chairside)
D5740 Reline maxillary partial denture (chairside)
D5741 Reline mandibular partial denture (chairside)
D5750 Reline complete maxillary denture (laboratory)
D5751 Reline complete mandibular denture (laboratory)
D5760 Reline maxillary partial denture (laboratory)
D5761 Reline mandibular partial denture (laboratory)

Other removable prosthetic services
D5850 Tissue conditioning, maxillary
D5851 Tissue conditioning, mandibular
D5860 Overdenture – complete, by report
D5862 Precision attachment, by report
D5863 Overdenture – complete maxillary
D5865 Overdenture – complete mandibular
D5899 Unspecified removable prosthodontic procedure, by report

Maxillofacial Prosthetics
D5911 Facial moulage (sectional)
D5912 Facial moulage (complete)
D5913 Nasal prosthesis
D5914 Auricular prosthesis
D5915 Orbital prosthesis
D5916 Ocular prosthesis
D5919 Facial prosthesis
D5922 Nasal septal prosthesis
D5923 Ocular prosthesis, interim
D5924 Cranial prosthesis
D5925 Facial augmentation implant prosthesis
D5926 Nasal prosthesis, replacement
D5927 Auricular prosthesis, replacement
D5928 Orbital prosthesis, replacement
D5929 Facial prosthesis, replacement
D5931 Obturator prosthesis, surgical
D5932 Obturator prosthesis, definitive
D5933 Obturator prosthesis, modification
D5934 Mandibular resection prosthesis with guide flange
D5935 Mandibular resection prosthesis without guide flange
D5936 Obturator prosthesis, interim
D5937 Trismus appliance (not for TMD treatment)
D5951 Feeding aid
D5952 Speech aid prosthesis, pediatric
D5953 Speech aid prosthesis, adult
D5954 Palatal augmentation prosthesis
D5955 Palatal lift prosthesis, definitive
D5958 Palatal lift prosthesis, interim
D5959 Palatal lift prosthesis, modification
D5960 Speech aid prosthesis, modification
**GENERAL BENEFITS**

D5982 Surgical stent  
D5983 Radiation carrier  
D5984 Radiation shield  
D5985 Radiation cone locator  
D5986 Fluoride gel carrier  
D5987 Commissure splint  
D5988 Surgical splint  
D5991 Vesiculobullous disease medicament carrier  
D5999 Unspecified maxillofacial prosthesis, by report

**PROSTHODONTICS, FIXED**

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

**Implant services**  
D6010 Surgical placement of implant body: endosteal implant  
D6040 Surgical placement: eposteal implant  
D6050 Surgical placement: transosteal implant  
D6053 Implant/Abutment supported removable denture for completely edentulous arch  
D6054 Implant/Abutment supported removable denture for partially edentulous arch  
D6055 Connecting bar – implant supported or abutment supported  
D6056 Prefabricated abutment – includes modification and placement  
D6057 Custom fabricated abutment – includes placement  
D6058 Abutment supported porcelain/ceramic crown  
D6059 Abutment supported porcelain fused to metal crown (high noble metal)  
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal)  
D6061 Abutment supported porcelain fused to metal crown (noble metal)  
D6062 Abutment supported cast metal crown (high noble metal)  
D6063 Abutment supported cast metal crown (predominantly base metal)  
D6064 Abutment supported cast metal crown (noble metal)  
D6065 Implant supported porcelain/ceramic crown  
D6066 Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)  
D6067 Implant supported metal crown (titanium, titanium alloy, high noble metal)  
D6068 Abutment supported retainer for porcelain/ceramic FPD  
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal)  
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)  
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal)  
D6072 Abutment supported retainer for cast metal FPD (high noble metal)  
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal)  
D6074 Abutment supported retainer for cast metal FPD (noble metal)  
D6075 Implant supported retainer for ceramic FPD  
D6076 Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)  
D6077 Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)  
D6078 Implant/Abutment supported fixed denture for completely edentulous arch  
D6079 Implant/Abutment supported fixed denture for partially edentulous arch  
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments  
D6090 Repair implant supported prosthesis, by report
GENERAL BENEFITS

D6091 Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment
D6092 Re-cement or re-bond implant/abutment supported crown
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture
D6094 Abutment supported crown – (titanium)
D6095 Repair implant abutment, by report
D6100 Implant removal, by report
D6110 Implant /abutment supported removable denture for edentulous arch – maxillary
D6111 Implant /abutment supported removable denture for edentulous arch – mandibular
D6112 Implant /abutment supported removable denture for partially edentulous arch – maxillary
D6113 Implant /abutment supported removable denture for partially edentulous arch – mandibular
D6114 Implant /abutment supported fixed denture for edentulous arch – maxillary
D6115 Implant /abutment supported fixed denture for edentulous arch – mandibular
D6116 Implant /abutment supported fixed denture for partially edentulous arch – maxillary
D6117 Implant /abutment supported fixed denture for partially edentulous arch – mandibular
D6190 Radiographic/surgical implant index, by report
D6194 Abutment supported retainer crown for FPD (titanium)
D6199 Unspecified implant procedure, by report

Fixed partial pontics
D6211 Pontic - cast predominantly base metal
D6241 Pontic - porcelain fused to predominantly base metal
D6245 Pontic - porcelain/ceramic
D6251 Pontic - resin with predominantly base metal

Fixed partial denture retainers - crowns
D6721 Retainer crown - resin with predominantly base metal
D6740 Retainer crown - porcelain/ceramic
D6751 Retainer crown - porcelain fused to predominantly base metal
D6781 Retainer crown - 3/4 cast predominantly base metal
D6783 Retainer crown - 3/4 porcelain/ceramic
D6791 Retainer crown - full cast predominantly base metal

Other fixed partial denture services
D6930 Re-cement or re-bond fixed partial denture
D6980 Fixed partial denture repair necessitated by restorative material failure
D6999 Unspecified fixed prosthodontic procedure, by report

ORAL AND MAXILLOFACIAL SURGERY

Extractions (including local anesthesia, suturing, if needed, and routine postoperative care)
D7111 Extraction, coronal remnants - deciduous tooth
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical extractions (including local anesthesia, suturing, if needed, and routine postoperative care)
D7210 Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated
D7220 Removal of impacted tooth – soft tissue
D7230 Removal of impacted tooth – partially bony
D7240 Removal of impacted tooth – completely bony
D7241 Removal of impacted tooth – completely bony, with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
GENERAL BENEFITS

Other surgical procedures
D7260 Oroantral fistula closure
D7261 Primary closure of a sinus perforation
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7283 Placement of device to facilitate eruption of impacted tooth
D7285 Incisional biopsy of oral tissue -hard (bone, tooth)
D7286 Incisional biopsy of oral tissue -soft
D7290 Surgical repositioning of teeth
D7291 Transseptal fiberotomy/ supra crestal fiberotomy, by report

Alveoloplasty – surgical preparation of ridge for dentures
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7311 Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
D7321 Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant

Vestibuloplasty
D7340 Vestibuloplasty - ridge extension (secondary epithelialization)
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

Surgical excision of lesions
D7410 Excision of benign lesion up to 1.25 cm
D7411 Excision of benign lesion greater than 1.25 cm
D7412 Excision of benign lesion, complicated
D7413 Excision of malignant lesion up to 1.25 cm
D7414 Excision of malignant lesion greater than 1.25 cm
D7415 Excision of malignant lesion, complicated
D7440 Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441 Excision of malignant tumor – lesion diameter greater than 1.25 cm
D7450 Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7451 Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7460 Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm
D7461 Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 cm
D7465 Destruction of lesion(s) by physical or chemical method, by report

Excision of bone tissue
D7471 Removal of lateral exostosis (maxilla or mandible)
D7472 Removal of torus palatinus
D7473 Removal of torus mandibularis
D7485 Surgical reduction of osseous tuberosity
D7490 Radical resection of maxilla or mandible

Surgical incision
D7510 Incision and drainage of abscess - intraoral soft tissue
D7511 Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7520 Incision and drainage of abscess - extraoral soft tissue
GENERAL BENEFITS

D7521 Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540 Removal of reaction producing foreign bodies, musculoskeletal system
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body

Treatment of fracture - simple
D7610 Maxilla - open reduction (teeth immobilized, if present)
D7620 Maxilla - closed reduction (teeth immobilized, if present)
D7630 Mandible - open reduction (teeth immobilized, if present)
D7640 Mandible - closed reduction (teeth immobilized, if present)
D7650 Malar and/or zygomatic arch - open reduction
D7660 Malar and/or zygomatic arch - closed reduction
D7670 Alveolus - closed reduction may include stabilization of teeth
D7671 Alveolus, open reduction may include stabilization of teeth
D7680 Facial bones - complicated reduction with fixation and multiple surgical approaches

Treatment of fracture - complicated
D7710 Maxilla open reduction
D7720 Maxilla – closed reduction
D7730 Mandible – open reduction
D7740 Mandible – closed reduction
D7750 Malar and/or zygomatic arch – open reduction
D7760 Malar and/or zygomatic arch – closed reduction
D7770 Alveolus – open reduction stabilization of teeth
D7771 Alveolus, closed reduction stabilization of teeth
D7780 Facial bones – complicated reduction with fixation and multiple surgical approaches

Reduction of dislocation and management of other temporomandibular joint dysfunctions
D7810 Open reduction of dislocation
D7820 Closed reduction of dislocation
D7830 Manipulation under anesthesia
D7840 Condylectomy
D7850 Surgical discectomy, with/without implant
D7852 Disc repair
D7854 Synovectomy
D7856 Myotomy
D7858 Joint reconstruction
D7860 Arthrotomy
D7865 Arthroplasty
D7870 Arthrocentesis
D7871 Non-arthroscopic lysis and lavage
D7872 Arthroscopy - diagnosis, with or without biopsy
D7873 Arthroscopy - surgical: lavage and lysis of adhesions
D7874 Arthroscopy - surgical: disc repositioning and stabilization
D7875 Arthroscopy - surgical: synovectomy
D7876 Arthroscopy - surgical: discectomy
D7877 Arthroscopy - surgical: debridement
D7880 Occlusal orthotic device, by report
D7899 Unspecified TMD therapy, by report

Repair of traumatic wounds
D7910 Suture of recent small wounds up to 5 cm
GENERAL BENEFITS

Complicated suturing
D7911 Complicated suture - up to 5 cm
D7912 Complicated suture - greater than 5 cm

Other repair procedures
D7920 Skin graft (identify defect covered, location and type of graft)
D7940 Osteoplasty - for orthognathic deformities
D7941 Osteotomy - mandibular rami
D7943 Osteotomy - mandibular rami with bone graft; includes obtaining the graft
D7944 Osteotomy - segmented or subapical
D7945 Osteotomy - body of mandible
D7946 Lefort I (maxilla - total)
D7947 Lefort I (maxilla - segmented)
D7948 Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft
D7949 Lefort II or lefort III - with bone graft
D7950 Osseous, osseoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach
D7952 Sinus augmentation via a vertical approach
D7955 Repair of maxillofacial soft and/or hard tissue defect
D7960 Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure
D7963 Frenuloplasty
D7970 Excision of hyperplastic tissue - per arch
D7971 Excision of pericoronal gingiva
D7972 Surgical reduction of fibrous tuberosity
D7980 Sialolithotomy
D7981 Excision of salivary gland, by report
D7982 Sialodochoplasty
D7983 Closure of salivary fistula
D7990 Emergency tracheotomy
D7991 Coronoidectomy
D7995 Synthetic graft - mandible or facial bones, by report
D7997 Appliance removal (not by dentist who placed appliance), includes removal of archbar
D7999 Unspecified oral surgery procedure, by report

ORTHODONTICS
Orthodontic treatment is a benefit of this dental plan only when medically necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8090 Comprehensive orthodontic treatment of the adult dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment examination to monitor growth and development
D8670 Periodic orthodontic treatment visit
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s))
D8691 Repair of orthodontic appliance
D8692 Replacement of lost or broken retainer
D8693 Re-cement or re-bond fixed retainer
D8694 Repair of fixed retainers, includes reattachment
GENERAL BENEFITS

D8999  Unspecified orthodontic procedure, by report

Limitations

• All Services

Services that are more expensive than the form of treatment customarily provided under generally accepted dental practice standards are called “Optional Services.” Optional Services also include the use of specialized techniques instead of standard procedures.

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

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

Services relates to re-evaluation of problem-focused oral exams are covered up to six (6) times in a three (3) month period but not to exceed 12 times in a 12 month period. This limit only applies to established patients and does not apply to post-operative visits. This limitation does not apply to multiple services performed on the same date with the same provider.

• Diagnostic and Preventive Services:

1. Roentgenology (x-rays) is limited as follows:
   a) Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months.
   b) Panoramic film x-rays are limited to once every twenty-four (24) consecutive months.
   c) Bitewing x-rays of two or more radiographic images, are limited to once every six (6) months. Bitewing x-rays of four radiographic images are limited to Covered Persons under the age of 10. Bitewings x-rays of any type are disallowed within 12 months of a full mouth series unless warranted by special circumstances. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
   d) Cephalometric x-rays and tomographic surveys are covered twice (2) in any 12 month period. Diagnostic casts are covered once per provider and only for the evaluation of Orthodontic Services when covered. If Orthodontic Services are covered, see Orthodontic Limitations as age limits may apply. However, 3D x-rays are not a covered benefit.

2. Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period.

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

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

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

6. Topical application of fluoride solutions is limited to twice in a Calendar Year.

7. Comprehensive oral examinations are covered once per patient per provider. Re-evaluation – limited, problem focused exams (established patient; not post-operative visits) are covered up to six (6) times in a three (3) month period and up to a maximum of 12 in a 12 month period.
GENERAL BENEFITS

month period. This procedure is not a benefit when provided on the same date of service with a detailed and extensive oral evaluation.

8. Space maintainer limitations:
   a) Space maintainers are limited to the initial appliance for a Covered Person under age 18 and covered once per quadrant in a lifetime, except bilateral fixed space maintainers which are covered once per arch in a lifetime.
   b) Recementation of space maintainer is limited to once per lifetime per applicable arch or quadrant.
   c) The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider’s office.

• Basic Services:
  1. Restorative Services are limited as follows:
     a) Treatment of caries for a tooth that can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations. Any other restoration such as a crown or jacket is considered an Optional Service.
     b) Composite resin or acrylic restorations in posterior teeth are Optional Services.
     c) Replacement of a restoration is covered only when it is defective (as evidenced by conditions such as recurrent caries or fracture) and replacement is dentally necessary.

• Major Services:
  1. Oral Surgery benefit is limited as follows:
     a) The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.
     b) Surgical repositioning of teeth and transseptal fiberotomy/ supra crestal fiberotomy, by report procedures are covered once per arch for permanent teeth for patients in active orthodontic treatment.
     c) Vestibuloplasty Limitations
        i) Ridge extension (secondary epithelialization) is covered once per arch in any 60 month period. Vestibuloplasty
        ii) Ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) is covered once per arch in a lifetime.
     d) Removal of lateral exostosis (maxilla or mandible) and of torus madibularis, as well as the surgical reduction of osseous tuberosity, are limited to once per quadrant per lifetime.
     e) Removal of torus palatinus is limited to once per lifetime.
     f) Incision and drainage of abscess – intraoral soft tissue is limited to one (1) per quadrant on the same date of service.
     g) Partial ostectomy/sequestrectomy for removal of non-vital bone is limited to one (1) per quadrant on the same date of service.
  2. Endodontics – Root canal therapy, including culture canal, is limited as follows:
     a) Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
     b) Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.
     c) We will not cover replacement of an amalgam, prefabricated crown or resin-based composite restorations (fillings) within 12 months of treatment for primary teeth or 36 months of treatment for permanent teeth. Replacement restorations performed within
GENERAL BENEFITS

12 months for primary teeth and within 36 months for permanent teeth are included in the fee for the original restoration.

d) Protective restorations (sedative fillings) are allowed once per tooth in a six (6) month period when definitive treatment is not performed on the same date of service. The fee for protective restorations are included in the fee for any definitive treatment performed on the same date.

e) Therapeutic pulpotomy is limited to once per tooth per lifetime for baby (deciduous) teeth only; an allowance for an emergency palliative treatment is made when performed on permanent teeth.

f) Pulpal therapy (resorbable filling) and pulpal debridement are limited to once per tooth per lifetime. Retreatment of root canal therapy by the same Provider/Provider office within 12 months is considered part of the original procedure.

g) Apexification is only benefited on permanent teeth with incomplete root canal development or for the repair of a perforation. Apexification visits have a lifetime limit per tooth with the fee for the final visit included in the fee for the final root canal.

h) Retreatment of apical surgery by the same Provider/Provider office within 24 months is considered part of the original procedure.

i) Pin retention is covered once per tooth per lifetime for permanent teeth. Fees for additional pins on the same tooth on the same date are considered a component of the initial pin placement.

j) Palliative treatment is covered per visit, not per tooth, and the fee for palliative treatment provided in conjunction with any procedures other than x-rays or select Diagnostic procedures is considered included in the fee for the definitive treatment. Note that periodontal cleanings, Procedure Codes that include periodontal cleanings, and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

3. Periodontics benefit is limited as follows:

   a) Benefits for periodontal scaling and root planing in the same quadrant are limited to once in every 24-month period for a Covered Person age 13 and older.

   b) Periodontal surgery in the same quadrant is limited to once in every 36-month period for a Covered Person age 13 and older and includes any surgical re-entry or scaling and root planing.

   c) Periodontal services, including covered graft procedures are only covered for the treatment of natural teeth and are not covered when submitted in conjunction with extractions, periapical surgery, ridge augmentation or implants.

   d) Periodontal surgery is subject to a 30 day wait following periodontal scaling and root planing in the same quadrant.

   e) Cleanings (regular and periodontal) and full mouth debridement are subject to a 30 day wait following periodontal scaling and root planing if performed by the same Provider office.

   Note that procedure codes that include periodontal cleanings, and full mouth debridement are covered as a Basic Benefit, and routine cleanings are covered as a Diagnostic and Preventive Benefit. Periodontal maintenance is only covered when performed following active periodontal therapy.

4. Crowns benefit is limited as follows:

   a) Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional. Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown.
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b) Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

c) Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

d) Crowns, excluding prefabricated crowns, are limited to a Covered Personage 13 and older and are covered not more often than once in any 60 month period except when we determine the existing Crown is not satisfactory and cannot be made satisfactory because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues. Services will only be allowed on teeth that are developmentally mature.

e) Post and core services are covered once in a lifetime on permanent teeth.

f) Crown repairs are covered not more than once in any 12 month period.

g) When allowed within six (6) months of a restoration, the Benefit for a Crown, Inlay/Onlay or fixed prosthodontic service will be reduced by the Benefit paid for the restoration.

h) Recementation of Crowns, Inlays/Onlays or bridges is included in the fee for the Crown, Inlay/Onlay or bridge when performed by the same Provider/Provider office within 12 months of the initial placement. After 12 months, payment will be limited to one (1) recementation in a 12 month period by the same Provider/Provider office.

5. Fixed Bridge benefit is limited as follows:

a) Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an Optional Service.

b) A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person thirteen (13) years of age or older and the patient’s oral health and general dental condition permits. For children under the age of thirteen (13), it is considered an Optional Service. If performed on an Enrollee under the age of thirteen (13), the applicant must pay the difference in cost between the fixed bridge and a space maintainer.

c) Fixed bridges used to replace missing posterior teeth are considered an Optional Service when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

d) Fixed bridges are an Optional Service when provided in connection with a partial denture on the same arch. However, when a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a Benefit.

e) Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

f) The Plan allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction. Full mouth reconstruction is considered an Optional Service.

6. Removable Prosthetic benefit is limited as follows:

a) Partial dentures will not be replaced within thirty-six (36) consecutive months, unless:
   iii) It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; or
   iv) The denture is unsatisfactory and cannot be made satisfactory

b) The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. Removable Denture Repairs are covered not more than twice per arch in any twelve (12) month period. Adding teeth to an existing partial denture is limited to a maximum of three (3) per date of service. However more elaborate or precision appliances, if chosen by the
GENERAL BENEFITS

patient and the Provider, and are not necessary to satisfactorily restore an arch are considered Optional Services. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered Optional Services.

c) Fixed partial dentures (bridgework) are not generally covered but shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. The Enrollee shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered. Approved fixed partial dentures are a benefit once in a 60 month period and only for a Covered Person age 13 and older.

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

i. the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,

ii. the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,

iii. patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

d) Tissue conditioning is limited to two (2) per denture.

e) Implants are considered an Optional Service. However, Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed by the Us for medical necessity for prior authorization. Diagnostic and treatment facilitating aids for implants are considered a part of, and included in, the fees for the definitive treatment. Exceptional medical conditions include, but are not limited to:

f) Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.

g) Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.

h) Skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).

i) Traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

j) Stayplates are a benefit only when used as anterior space maintainers for children.

k) Palital lift prosthesis modification and speech aid prosthesis modification are limited to twice in a 12 month period.

l) Prosthodontics that were provided under any program will be replaced only after 60 months have passed, except when We determine that there is such extensive loss of remaining teeth or change in supporting tissue that the existing fixed bridge or denture cannot be made satisfactory. Immediate dentures are a benefit once per patient per lifetime. Replacement of a prosthodontic appliance and/or implant supported prosthesis not provided under a program will be made if We determine it is unsatisfactory and cannot be made satisfactory. Services will only be allowed on teeth that are developmentally mature.

m) The initial installation of a prosthodontic appliance and/or implants is not a Benefit unless the prosthodontic appliance and/or implant, bridge or denture is made necessary by natural, permanent teeth extraction occurring during a time the Enrollee was under Our plan.

n) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.
GENERAL BENEFITS

o) Occlusion analysis – mounted case, and occlusal adjustments, limited and complete, are limited to one (1) in 12 months for diagnosed TMJ dysfunction only for a Covered Person age 13 and older.

p) Application of desensitizing medicament is limited to once in a 12 month period for permanent teeth only.

q) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.

r) Occlusion analysis – mounted case, and occlusal adjustments, limited and complete, are limited to one (1) in 12 months for diagnosed TMJ dysfunction only for a Covered Person age 13 and older.

s) Application of desensitizing medicament is limited to once in a 12 month period for permanent teeth only.

t) We limit payment for dentures to a standard partial or complete denture (Enrollee Coinsurances apply). A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post delivery care including any adjustments for the first six (6) months after placement and relines for the first 12 months after placement.

u) Dentures, removable partial dentures and relines include adjustments for six (6) months following installation. After the initial six (6) months of an adjustment, adjustments are limited to twice in a 12 month period and relining is limited to once in a 12 month period.

v) Tissue conditioning is limited to two (2) per prosthesis in a 36 month period. However, tissue conditioning is not allowed as a separate Benefit when performed on the same day as a denture reline service.

w) Recementation of fixed partial dentures is not a benefit within 12 months of a previous re-cementation by the same provider.

7. Orthodontic Services are limited as follows:

a) Services are limited to medically necessary orthodontics when provided by a Provider and when necessary and customary under generally accepted dental practice standards. Orthodontic treatment is a benefit of this dental plan only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained.

b) Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index or one of the automatic qualifying conditions below exist. The automatic qualifying conditions are:

   i. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

   ii. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,

   iii. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,

   iv. A crossbite of individual anterior teeth causing destruction of soft tissue,

   v. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,

   vi. Severe traumatic deviation.

c) The following documentation must be submitted with the request for prior authorization of services by the Provider:

   i. ADA 2006 or newer claim form with service code(s) requested;
ii. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
iii. Cephalometric radiographic image or panoramic radiographic image;
iv. HLD score sheet completed and signed by the Orthodontist; and
v. Treatment plan.
d) The allowances for comprehensive orthodontic treatment procedures (D8080, D8090) include all appliances, adjustments, insertion, removal and post treatment stabilization (retention). No additional charge to the Enrollee is permitted.
e) Comprehensive orthodontic treatment includes the replacement, repair and removal of brackets, bands and arch wires by the original Provider.
f) Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for a Covered Person under the age of 19 and shall be prior authorized.
g) Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the Enrollee is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
h) All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
i) Pre-orthodontic treatment visits are allowed once every three (3) months up to a maximum of six (6) per Enrollee.
j) Removable and fixed appliance therapy are allowed once per Enrollee age six (6) to 12.
k) When specialized orthodontic appliances or procedures chosen for aesthetic considerations are provided, We will make an allowance for the cost of a standard orthodontic treatment. The Enrollee is responsible for the difference between the allowance made towards the standard orthodontic treatment and the dentist’s charge for the specialized orthodontic appliance or procedure.
l) Repair of an orthodontic appliance inserted under this dental plan is covered once per appliance per lifetime. The replacement of an orthodontic appliance inserted under this dental plan is covered once per arch per lifetime.
m) Replacement of a lost or broken retainer is a benefit once per arch in a lifetime and only within 24 months following date of service of orthodontic retention.

EXCLUSIONS
1. Services that are not Essential Health Benefits.
2. Treatment of injuries or illness covered by workers’ compensation or employers’ liability laws; services received without cost from any federal, state or local agency, unless this exclusion is prohibited by law.
3. Cosmetic surgery or procedures for purely cosmetic reasons.
4. Provisional and/or temporary restorations (except an interim removable partial denture to replace extracted anterior permanent teeth during the healing period for children 16 years of age or under). Provisional and/or temporary restorations are not separately payable procedures and are included in the fee for completed service.
5. Services for congenital (hereditary) or developmental (following birth) malformations, including but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth) and anodontia (congenitally missing teeth), except those services provided to children for medically diagnosed congenital defects or birth abnormalities.
6. Treatment to stabilize teeth, treatment to restore tooth structure lost from wear, erosion, or abrasion or treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion. Examples include but are not limited to: equilibration, periodontal splinting, or complete occlusal adjustments.
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7. Any Single Procedure provided prior to the date the Enrollee became eligible for services under this plan.
8. Pain killers or experimental/investigational procedures.
9. Charges for anesthesia, other than general anesthesia and IV sedation administered by a Provider in connection with covered oral surgery or selected endodontic and periodontal surgical procedures. Local anesthesia and regional/or trigeminal bloc anesthesia are not separately payable procedures.
10. Extraoral grafts (grafting of tissues from outside the mouth to oral tissues).
11. Laboratory processed crowns for a Covered Person under age 13.
12. Interim implants and endodontic endosseous implants.
13. Indirectly fabricated resin-based Inlays/Onlays.
14. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Provider for treatment in any such facility.
15. Treatment by someone other than a Provider or a person who by law may work under a Provider’s direct supervision.
16. Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments are not separately payable procedures.
17. Dental practice administrative services including, but not limited to, preparation of claims, any non-treatment phase of dentistry such as provision of an antiseptic environment, sterilization of equipment or infection control, or any ancillary materials used during the routine course of providing treatment such as cotton swabs, gauze, bibs, masks or relaxation techniques such as music.
18. Procedures having a questionable prognosis based on a dental consultant’s professional review of the submitted documentation.
19. Any tax imposed (or incurred) by a government, state or other entity, in connection with any fees charged for Benefits provided under the Contract, will be the responsibility of the Enrollee and not a covered Benefit.
20. Deductibles and/or any service not covered under the dental plan.
21. Services covered under the dental plan but exceed Benefit limitations or are not in accordance with processing policies in effect at the time the claim is processed.
22. The initial placement of any prosthodontic appliance or implant, unless such placement is needed to replace one or more natural, permanent teeth extracted while the Enrollee is covered under the Contract or was covered under any dental care plan with Us. The extraction of a third molar (wisdom tooth) will not qualify under the above. Any such denture or fixed bridge must include the replacement of the extracted tooth or teeth.
23. Services for Orthodontic treatment (treatment of malocclusion of teeth and/or jaws) except medically necessary Orthodontics provided a prior authorization is obtained.
24. Missed and/or cancelled appointments

Your Choice of Dental Providers

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

Free Choice of Provider

We recognize that many factors affect the choice of dentist and therefore support Your right to freedom of choice regarding Your Provider. This assures that You have full access to the dental treatment You need from the dental office of Your choice. You may see any Provider for Your covered treatment, whether the Provider is a PPO, Premier or a Non-Delta Dental Provider. In addition, You and Your family members can see different Providers.
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Participating or Premier Provider
When You choose a PPO or Premier Provider, Your out-of-pocket costs may be less. To take full advantage of Your benefits, we highly recommend You verify a dentist’s participation status within with Your dental office before each appointment. Review the section titled “Claims Provision” for an explanation of payment procedures to understand the method of payments applicable to Your dentist selection and how that may impact Your out-of-pocket costs.

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

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

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

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

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

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

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330
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Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination of Benefit is issued if the patient is eligible. Payment will depend on the patient’s eligibility and the remaining annual maximum when completed services are submitted to KPIC or to Delta Dental.

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

Definitions:

The following definitions apply to the Pediatric Dental coverage:

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

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

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

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

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

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

**Maximum Allowable Charge** means the lesser of:

1. **The Usual and Customary Charge (U&C):**
   
The usual and customary charge is the lesser of: (a) the charge generally made by a Dentist; or (b) the general level of charge made by Dentists within an area in which the charge is incurred comparable in severity and nature to the service or treatment being performed. The general level of charges is determined by KPIC in accord with schedules on file with the authorized Administrator. For charges not listed in the schedules, KPIC will establish the U&C. KPIC reserves the right to periodically adjust the charges listed in the schedules.
   
The term "area" as it would apply to any particular service means a city or such greater area as is necessary to obtain a representative cross section of level of charges.
   
   If the Maximum Allowable Charge is the U&C Charge, the Covered Person will be responsible for payment to the provider of any amounts in excess of the U&C Charge for a Covered Service when the U&C Charge is less than the actual billed charges for the Covered Service.
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2. **Premier or PPO Provider’s Contracted Fee**
   Delta Dental Premier Provider’s Contracted Fee (Premier Provider’s Contracted Fee) means the fee for each Single Procedure that a Premier Provider has contractually agreed to accept as payment in full for treating a Covered Person.

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

3. **Actual Billed Charges:**
   The actual charges billed by the Dentist for Covered Dental Services.

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

**Participating Dentist** means a licensed Delta Dental Premier Provider (Premier Provider) or Delta Dental PPO Provider (PPO Provider) who:
1. accepts the Premier Provider’s Contracted Fee or the PPO Provider’s Contracted Fee as payment in full for services provided under this dental insurance plan; or
2. complies with Delta Dental’s administrative guidelines.

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

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

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

**IMPORTANT:** If You receive dental services that are not covered services under this policy, a participating provider may charge You his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, You may call KPIC or its Administrator Delta Dental at 1(800)-765-6003. To fully understand your coverage, you may wish to carefully review this Certificate of Insurance.

**Outpatient Prescription Drug Benefits**

Prescribed drugs, medicines and supplies purchased from a licensed pharmacy on an outpatient basis are covered provided they: a) can be lawfully obtained only with the written prescription of a Physician or dentist; b) are purchased by Covered Persons on an outpatient basis; c) are covered
GENERAL BENEFITS

under the Group Plan; and 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.

Open drug formulary
This Outpatient Prescription Drug Benefit uses an open formulary. An open formulary is a list of
unrestricted drugs or devices that are covered under this Plan. The formulary consists of generic
and preferred and non-preferred brand drugs including specialty drugs. Unless specifically excluded
under the plan, all FDA-approved drugs are part of this Plan’s open formulary.

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

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

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

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

1. The Covered Person or the licensed prescribing provider can obtain a copy of the request form
   by calling 1-800-788-2949. Prior authorization requests not made on the prescribed request
   form shall not be accepted;
2. We will accept the request form through any reasonable means of transmission, including, but
   not limited to, paper, electronic, or any other mutually accessible method of transmission;
3. Upon receipt of a completed request form, We will notify the licensed prescribing provider
   within 72 hours for non-urgent requests and within 24 hours if exigent circumstances exist from
   receipt of a request form, that:
   a. The request is approved; or
   b. The request is disapproved due to:
      i. Not Medically Necessary; or
      ii. Missing material information necessary to determine Medical Necessity; or
      iii. The patient is no longer eligible for coverage; or
      iv. The request is not submitted on the prescribed Request Form and must be
         resubmitted using the prescribed request form.
4. If We fail to respond within 72 hours for non-urgent requests and within 24 hours if exigent
   circumstances exist from receipt of a request form from a licensed prescribing provider; the
   request shall; be deemed to have been approved.
5. In the event, the licensed prescribing provider’s prior authorization request is disapproved:
a. The notice of disapproval must contain an accurate and clear written explanation of the specific reasons for disapproving the request.
b. If the request is disapproved due to missing material information necessary to determine Medical Necessity, the notice of disapproval must contain an accurate and clear explanation that specifically identifies the missing material information.

6. The prescription drug prior authorization request shall be deemed approved in the event that:
   a. The notice of disapproval is not sent to the licensed prescribing provider within 72 hours of receipt of a non-urgent request and within 24 hours for exigent circumstances; or
   b. We accept any prescription drug prior authorization form other than the prescribed request form and We did not send timely disapproval.

7. Notices required to be sent to the Covered Person or to his/her designee or the licensed prescribing provider shall be delivered by Us in the same manner as the request form was submitted to Us, or any other mutually agreeable accessible method of notification.

8. Prescription drug prior authorization procedures conducted electronically through a web portal, or any other manner of transmission mutually agreeable, shall not require the licensed prescribing provider to provide more information than is required by the request form.

Step therapy process

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

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

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

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

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

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

Licensed prescribing provider shall include a provider authorized to write a prescription pursuant to subdivision (a) of the Business and Professional Code section 4040, to treat a medical condition of a Covered Person.

There are no precertification requirements for outpatient prescription drugs under the open formulary. As such, there are no prior authorization or exception request processes for outpatient prescription drugs under this coverage.
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Exception Requests
You or Your designated assignee or the licensed prescribing provider may request an exception to the Outpatient Prior Authorization Request and Step Therapy process described above if You are already being treated for a medical condition and currently under medication of a drug subject to prior authorization or step therapy, provided the drug is appropriately prescribed and is considered safe and effective for your condition.

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

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

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

Outpatient Prescription Drug Benefits
Covered Charges for outpatient prescription drugs are limited to charges from a licensed pharmacy for:

1. Legend Drugs. Legend Drugs means drugs that are approved by the U.S. Food and Drug Administration (FDA) and that are required by federal or state law to be dispensed to the public only by prescription from a licensed Physician or other licensed provider;

2. Experimental drugs and Medicines
   a) 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, or;
   b) if such Experimental drugs that are used to treat cancer if one or more of the following conditions is met:
      i) the drug is recognized for treatment of the Covered Person’s particular type of cancer in the United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations or the American Hospital Formulary Service Drug Information publication: or
      ii) the drug is recommended for treatment of the Covered Person’s particular type of cancer and has been found to be safe and effective in formal clinical studies, the result of which have been published in either the United States or Great Britain;

3. Off-label use of covered prescription drugs;
4. Insulin;
5. Prescriptive medications for the treatment of diabetes;
6. Glucagon;
7. Episodic drugs prescribed for the treatment of sexual dysfunction disorders;
8. Disposable devices that are Medically Necessary for the use of covered outpatient prescription drugs, including disposable needles and syringes needed for injecting covered drugs and supplements;
9. Drugs or devices that do not require a prescription by law (over the counter drugs). These drugs are limited to over the counter contraceptive and other oral over the counter drugs which are covered as preventive services under the Preventive Care and Services header in the General Benefits section;
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10. Weight loss drugs when Medically Necessary for the treatment of morbid obesity;
11. Continuity drugs. If this Plan is amended to exclude a drug that we had previously been covering and providing to You under this Plan we will continue to be provided if a Your Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.
12. All Medically Necessary outpatient prescription drugs pursuant to California Insurance Code section 10112.27 and California Code of Regulations Title 28 section 1300.67.24(a).

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

Limitations

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

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

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

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

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

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

e. If a Physician prescribes a Brand Name Prescription Drug and did not order such prescription as "DISPENSED AS WRITTEN", and a Generic Prescription Drug is available, but the Covered Person prefers a Brand Name Prescription Drug, the copayment due for such prescription is the applicable copayment for a Brand Name Prescription Drug, as shown in the Schedule of Coverage, plus the cost difference between the Brand Name Prescription Drug and the Generic Prescription Drug.

f. If a Physician prescribes a Brand Name Prescription Drug and did not order such prescription as "DISPENSED AS WRITTEN", and a Generic Prescription Drug is not available, the copayment due for such prescription is the applicable copayment for a Brand Name Prescription Drug, as shown in the Schedule of Coverage.

Exclusions

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

1. Experimental Drugs and Medicines not listed as covered.
2. Drugs or devices that do not require a prescription by law except when over the counter drug coverage is required by law.
3. Weight loss drugs not used for the treatment of morbid obesity.
4. Charges for the administration of any drug when the drug does not require administration by medical personnel.
5. Contraceptive drugs and devices, except that contraceptive supplies prescribed for reasons other than contraceptive purposes are covered, such as a) decreasing the risk of ovarian cancer; b) eliminating symptoms of menopause; or c) when it is necessary to preserve the life or health of an insured.
GENERAL LIMITATIONS AND EXCLUSIONS

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

1. Charges in excess of the Maximum Allowable Charge.
2. Confinement, treatment, services or supplies not Medically Necessary. This exclusion does not apply to preventive or other health care services specifically covered under the plan.
3. Services or supplies other than Emergency Services received outside the United States.
4. Treatment, services, or supplies provided by the Covered Person; his or her spouse; 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.
5. Confinement, treatment, services or supplies received where care is provided at government expense. This exclusion does not apply if: a) there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage; or b) payment is required by law.
6. Dental care including dental x-rays; dental appliances; orthodontia; and dental services resulting from medical treatment. This exclusion does not include: a) visits for repairs or treatment of accidental injury to a jaw or sound natural teeth when performed or rendered within 12 months following an accident, when the accident is sustained while covered under the Group Policy; b) service that is for an Insured Dependent child because of congenital disease or anomaly; c) the removal of impacted wisdom teeth when imbedded in bone; d) Medically Necessary dental or orthodontic services that are an integral part of Reconstructive Surgery for cleft palate procedures; e) dental services necessary to prepare your jaw for radiation therapy for cancer in Your head or neck; or f) dental care for children under the age of 19.
7. Services that are intended primarily to change or maintain one's appearance. This exclusion does not apply to covered Reconstructive services including services related to mastectomy or testicular implants, or prosthetics to replace all or part of an external facial body part or to covered transgender surgery services that are described under the General Benefits section.
8. Nonprescription drugs or medicines; vitamins, nutrients and food supplements, even if prescribed or administered by a Physician, except as listed under Preventive Care in the GENERAL BENEFITS section.
9. Any treatment, procedure, drug, or equipment, or device which is experimental or investigational. This means that one of the following is true:
   • the service is not recognized in accord with generally accepted medical standards as safe and effective for treating the condition in question, whether or not the service is authorized by law or use in testing or other studies on human patients; or
   • the service requires approval by any governmental authority prior to use and such approval has not been granted when the service is to be rendered.

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.
10. Clinical Trial services that are provided solely to satisfy data collection and analysis needs and are not used in Your clinical management, and services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial. In addition, this condition 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 clinical trial has a meaningful potential to benefit the Covered Person.
11. Special education and related counseling or therapy; or care for learning deficiencies or behavioral problems, except as otherwise provided for the treatment of Severe Mental Illness of a person of any age, Serious Emotional Disturbances of a Child, or Mental Disorders described in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

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

13. Recreational therapy.

14. Testing for ability, aptitude, intelligence or interest.

15. Items and services that are not health care items and services, including the following:
   a) Teaching manners and etiquette
   b) Teaching and support services to develop planning skills such as daily activity planning and project or task planning
   c) Items and services that increase academic knowledge or skills
   d) Teaching and support services to increase intelligence
   e) Academic coaching or tutoring for skills such as grammar, math, and time management
   f) Teaching You how to read, whether or not You have dyslexia
   g) Educational testing
   h) Teaching art, dance, horse riding, music, play or swimming, except that this exclusion for "teaching play" does not apply to Covered Services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the GENERAL BENEFITS section
   i) Teaching skills for employment or vocational purposes
   j) Vocational training or teaching vocational skills
   k) Professional growth courses
   l) Training for a specific job or employment counseling
   m) Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to covered physical therapy services that are part of a physical therapy treatment plan and covered under the GENERAL BENEFITS section.


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

18. Custodial care. Custodial Care is: a) assistance with activities of daily living which include, but are not limited to, activities such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking drugs; or b) care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse. This exclusion does not apply to custodial care that is provided as part of covered home health care or hospice care.

19. Care in an intermediate care facility. This is a level of care for which a Physician determines the facilities and services of a Hospital or a Skilled Nursing Facility are not Medically Necessary.

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

21. Confinement or services that are not Medically Necessary or treatment that is not completed in accordance with the attending Physician’s orders.

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

23. Medical social services except those services related to discharge planning in connection with: a) a covered Hospital Confinement; b) covered Home Health Care Services; or c) covered Hospice Care.

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

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

27. The following Home Health Care Services:
   a) meals,
   b) personal comfort items,
   c) housekeeping services.

28. 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.

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

30. Biofeedback or hypnotherapy.

31. Hearing aids.

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

33. Any vision service, treatment or materials not specifically listed as a covered service under the GENERAL BENEFITS section.

34. Services for which no charge is normally made in the absence of insurance.

35. Personal and convenience supplies associated with breast-feeding equipment such as pads, bottles, and carrier cases.
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. Adult Vision Care. This benefit covers the cost of a refraction vision exam, prescription lenses, and prescription contact lenses. This benefit does not cover plain sunglasses, plastic lenses that are not medically indicated, contact lenses for cosmetic purposes, replacement of lost or broken frames or lenses, or athletic or industrial frames or lenses.
CALIFORNIA CONTINUATION OF MEDICAL BENEFIT (CAL-COBRA)

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

Eligibility

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

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

Individuals Not Eligible for Cal-COBRA Continuation

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

1. Individuals who are entitled to Medicare benefits or become entitled to Medicare benefits pursuant to Title XVIII of the United States Social Security Act, as then constituted or later amended.
2. Individuals who have other hospital, medical, or surgical coverage or who are covered or become covered under another group benefit plan, that provides coverage to individuals and that does not impose any exclusion or limitation with respect to any preexisting condition, other than a preexisting condition limitation or exclusion that does not apply to or has been satisfied due to prior creditable coverage;
3. Individuals who are covered, become covered, or are eligible for federal COBRA coverage, except those individuals, who under applicable California law, are eligible for an extension of COBRA coverage.
4. Individuals who are covered, become covered, or are eligible for coverage pursuant to chapter 6A of the Public Health Service Act, 42 U.S.C. Section 300bb-1;
5. Individuals who do not meet the notice requirements of this State Continuation of Coverage provision or fail to make the election in a timely manner;
6. Individuals who do not submit the correct premium amount for the continuation coverage as required by the Group Policy or who fail to satisfy other terms and conditions of the Group Policy.

Qualifying Events

Individuals will qualify for Cal-COBRA as follows:

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

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

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

Termination of Cal-COBRA Continuation Coverage

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

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

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

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

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

Extension For Disabled Covered Persons

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

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

For those Covered Persons, the 18 month maximum period of continued health coverage for qualifying event (A) may be extended 11 months for a total continuation period of 29 months. To obtain the extension, the Covered Person must notify the employer or KPIC of Social Security's determination within 60 days of the date of the determination letter and prior to the end of the original 18-month continuation of coverage period.

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

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

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

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

Notice Requirements and Requests for Continuation Coverage

Notice of Event

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

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

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

Notice Required of Employer

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

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

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

**Notice to You and Your Dependent of Right of Continuation**

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

**Request for Continuation of Coverage and Payment of Premium**

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

A. The date the Covered Person’s coverage under the Group Policy terminated or will terminate by reason of a qualifying event; or
B. The date the Covered Person was sent notice of the right to continuation of coverage.

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

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

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

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

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

Qualifying Events

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

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

(C) If You retired from employment with the employer and Your health insurance coverage, or the health insurance coverage of Your Dependents, including Your surviving spouse:

1. is substantially eliminated as a result of the employer’s filing of a Title XI bankruptcy; or
2. was substantially eliminated during the calendar year preceding the employer’s filing of a Title XI bankruptcy,

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

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

Continuation of Coverage Period

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

1. 18 months following qualifying event (A) except if a qualifying event (B) occurs during this 18 months, the continuation of coverage period will be extended an additional 18 months for a total period of 36 months.
2. 36 months following qualifying event (B);
3. for a qualifying event (C):
   a) the date of Your death, at which time Your dependents (other than Your surviving spouse in (i) below) will be entitled to continue coverage on the same basis as if a qualifying event (B) had occurred.
   b) if You died before the occurrence of a qualifying event (C), Your surviving spouse is entitled to lifetime coverage.
4. the end of a 36 month period following an event described in qualifying event (D), without regard to whether that occurrence is a qualifying event, or for any subsequent qualifying event;
FEDERAL CONTINUATION OF HEALTH INSURANCE

5. the date You or Your dependents become covered under any other group coverage providing hospital, surgical or medical benefits, insured or self-insured, which does not contain any limitation with respect to any preexisting condition;
6. the date a Covered Person, other than those provided continuation of coverage under qualifying event (C) becomes entitled to Medicare benefits under Title XVIII of the Social Security Act;
7. the date the employer ceases to provide any group health coverage for its employees; or
8. the date any premium for continuation of coverage is not timely paid.

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

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

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

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

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

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

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

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

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

Extension of Coverage After Exhaustion of COBRA
If a Covered Person has exhausted continuation of coverage under COBRA and or Cal COBRA (if applicable) and the Covered Person was entitled to less than 36 months of COBRA and or Cal COBRA (if applicable) coverage, such continuation of coverage may be extended to a maximum of 36 months from the effective date of the COBRA coverage.

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

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

Insurance Continued from a Replaced Plan

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

Continued Insurance means the insurance of a Covered Person whose medical coverage under a Replaced Plan has ceased:
1. due to the Replaced Plan’s termination; or
2. due to a Policyholder’s termination of medical coverage under a Replaced Plan.

Continued Insurance

The effective date of a Covered Person’s continued insurance will not be deferred because:
1. an Insured Employee is not actively at work on that date; or
2. a Dependent is confined in a health care facility on that date;

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

Termination of Continued Insurance during Total Disability

The Continued Insurance of a Covered Person who became totally disabled while covered under a Replaced Plan will terminate on the earlier of these dates:
1. the date the Covered Person is no longer totally disabled; or
2. the last date of the 12-month period that follows the last day for which premiums were paid for the Covered Person’s medical coverage under the replaced plan;

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

Limitations and Reductions

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

Policy Termination during Total Disability - Extension of Benefits

The insurance of a Covered Person will be extended if:
1. the Covered Person becomes totally disabled while insured for that insurance under the plan; and
2. the Covered Person is still totally disabled on the date This Plan terminates or on the date the Covered Group ceases to be a Policyholder.

A Covered Person other than a Dependent minor is “totally disabled” only if in the judgment of a Physician, an illness or injury is:
1. expected to result in: death or has lasted or is expected to last for a continuous period of at least 12 months; and
2. makes the person unable, even with training, education and experience, to engage in any employment or occupation.
A Covered Person who is a Dependent minor is totally disabled only if, in the judgment of a Physician, an illness or injury:
1. is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months; and
2. makes the person unable to engage in most of the normal activities of persons in good health of like age.
COORDINATION OF BENEFITS

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

The benefits of this Plan:
1. will not be reduced when this Plan is primary;
2. may be reduced when another Plan is primary and This Plan is secondary. The benefits of This Plan are reduced so that they and the benefits payable under all other Plans do not total more than 100% of the Allowable Expenses during any Calendar Year; and
3. will not exceed the benefits payable in the absence of other coverage.

Order of Benefit Determination Rules
This Plan determines its order of benefits by using the first of the following that applies:
1. General: A Plan that does not coordinate with other Plans is always the primary Plan.
2. Non-dependent\Dependent: The benefits of the Plan which covers the person as a Covered Person, or subscriber (other than a Dependent) is the primary Plan; the Plan which covers the person as a Dependent is the secondary Plan.
3. Dependent Child--Parents Not Separated or Divorced: When This Plan and another Plan cover the same child as a Dependent of different parents, benefits for the child are determined as follows:
   a) the primary Plan is the Plan of the parent whose birthday (month and day) falls earlier in the year. The secondary Plan is the Plan of the parent whose birthday falls later in the year.
   b) if both parents have the same birthday, the benefits of the Plan which covered the parent the longer time is the primary Plan; the Plan which covered the parent the shorter time is the secondary Plan.
   c) if the other Plan does not have the birthday rule, but has the male\female rule and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
4. Dependent Child: Separated or Divorced Parents: If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined as follows:
   a) first, the Plan of the parent with custody of the child;
   b) then, the Plan of the spouse or Domestic Partner of the parent with custody of the child; and
   c) finally, the Plan of the parent without custody of the child.

However, if the specific terms of a court decree state that one parent is responsible for the health care expenses of the child and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, that Plan is the primary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits actually paid or provided before the entity has actual knowledge. Also, benefits for the child of a non-custodial parent who is responsible for the health care expenses of the child may be paid directly to the provider, if the custodial parent so requests.

5. Active/Inactive Service: The primary Plan is the Plan which covers the person as a Covered Person who is neither laid off or retired (or as that employee’s Dependent). The secondary Plan is the Plan which covers that person as a laid off or retired Covered Person (or as that
Covered Person’s Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule does not apply.

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

Effect of Medicare
This Plan will be primary to Medicare for an active employee and Dependent spouse or Domestic Partner of such active employee. This Plan will not be primary to Medicare if the Covered Person is eligible for Medicare as primary. Any such Covered Person may not continue enrollment under This Plan. Medicare is primary for an insured retiree or the Dependent spouse or Domestic Partner of a retiree age 65 or over; this applies whether or not the retiree or spouse is enrolled in Medicare.

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

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

Reduction in this Plan’s Benefits
When the benefits of This Plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable Benefit Maximum of This Plan.

Any benefit amount not paid under This Plan because of coordinating benefits becomes a benefit credit under This Plan. This amount can be used to pay any added Allowable Expenses the Covered Person may incur during the remainder of the Calendar Year, including any coinsurance payable under This Plan.

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

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

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

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

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

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

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

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

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

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

Plan does not include any:
1. individual or family policies or contracts
2. public medical assistance programs, including benefits under Medi-Cal or California Crippled Children Services program or any other coverage provided for or required by law when, by law, its benefits are excess to any private insurance or other non-governmental program.
3. group or group-type Hospital indemnity benefits of $100 per day or less.
4. school accident-type coverages.
5. traditional fault automobile or no-fault automobile policies.

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

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

This section contains the following:

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

A. Definitions Related to Claims and Appeals Procedures

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

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

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

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

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

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

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

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

Kaiser Permanente Insurance Company (KPIC)
Attn: KPIC Operations
Grievance and Appeals Coordinator
1800 Harrison Street, 20th Floor
Oakland, CA 94612
You must pay the cost of anyone You hire to represent or help You.

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

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 subsection C. The Internal Appeals Process provision under this section for a detailed explanation regarding the mandatory appeal process related to your specific type of claim. Likewise, Our Adverse Benefit Determination notice will tell You why We denied Your
CLAIM AND APPEALS PROCEDURES

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

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

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

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

Dell Health Services
P.O. Box 261130
Plano, TX 75026

All Claims related Your dental coverage will be administered by:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

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

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

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

    Dell Health Services
    P.O. Box 261130
    Plano, TX 75026

For claims related to Your dental benefits:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330
CLAIM AND APPEALS PROCEDURES

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

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

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

**Notice of Claims**

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

Dell Health Services  
P.O. Box 261130  
Plano, TX 75026

For claims related to Your dental benefits:

Delta Dental of California  
P.O. Box 997330  
Sacramento, CA 95899-7330

**Claim Forms**

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

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

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

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

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

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

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

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

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

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.

Dell Health Services
P.O. Box 261130
Plano, TX 75026

For claims related to your dental benefits:

Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

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

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

Any benefits for health expenses for covered medical transportation services are payable to the provider of these services. No benefits are payable to the Covered Person to the extent benefits for the same expenses are paid to the provider.
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 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**
  o Send Your request in writing to Us that You want to make a Claim for Us to Pre-certify a benefit or treatment You have not yet received. Your request and any related documents You give Us constitute Your Claim. You must either mail Your Claim to Us at the address below or, fax Your Claim to Us at 1-866-338-0266.

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

  o 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.

  o 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.
CLAIM AND APPEALS PROCEDURES

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

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

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

3. Concurrent Care Claims

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

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

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

Here are the procedures for filing a Concurrent Care Claim.

- Concurrent Care Claim

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

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

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

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

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

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

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

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 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.

For claims related to Your dental benefits:
Delta Dental of California
P.O. Box 997330
Sacramento, CA 95899-7330

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

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

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

Second Level of Appeal (applicable to Medical Claims only)
If Your first level appeal decision is not wholly in Your favor, You are entitled to a second level of review. We must receive Your second level appeal request within 180 days of Your receiving this notice of Our first level appeal decision. Please note that We will count the 180 days starting 5 business days from the date of the first level appeal notice to allow for delivery time unless You can prove that You received the notice after that 5 business day period. Contact Us at 877-847-7572 with any questions about Your appeal rights.

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

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

Providing Additional Information Regarding Your Claim
When You Appeal, You may send Us additional information including comments, documents, and additional medical records that You believe support Your Claim. If We asked for additional information and You did not provide it before We made Our initial decision about Your Claim, then You may still send Us the additional information so that We may include it as part of Our review of Your Appeal. Please send all additional information to Kaiser Permanente Insurance Company Grievance and Appeals Coordinator at the address above. You may also fax this information to (877) 727-9664.

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

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

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

Time frame for Resolving Your Appeal
There are several types of Claims, and each has a time frame in resolving Your Appeal.
- Post-service Claims
- Pre-service Claims (urgent and non-urgent)
- Concurrent care Claims (urgent and non-urgent)
CLAIM AND APPEALS PROCEDURES

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) all supporting documents. Your request and the supporting documents constitute Your Appeal. You must mail Your Appeal to:

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

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

   - We will review Your appeal as follows:
     - For Appeals involving medical claims - We will review Your Appeal and send You a written decision of each level of Your two level appeal process within a reasonable period of time appropriate to the circumstances, but in no event later than 15 days from the date that we receive Your request for our review at that level unless we inform You otherwise in advance.
     - For appeals involving claims arising from the prescription drug benefit - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive Your request for our review unless we inform You otherwise in advance.

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

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

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

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

- We will review Your appeal as follows:
  - For Appeals involving medical claims - Because You have not yet received the services or equipment that You requested, we will review Your Appeal and send You a written decision of each level of Your two level appeal process within a reasonable period of time appropriate to the circumstances, but in no event later than 15 days from the date that we receive Your request for our review at that level unless we inform You otherwise in advance.
  - For appeals involving claims arising from the 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
  Phone: 1-888-567-6847
  Fax: 1-866-338-0266

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

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

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

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

4. Non-urgent Concurrent Care Appeal

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

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

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

- We will review Your appeal as follows:
  - For Appeals involving medical claims - We will review Your Appeal and send You a written decision of each level of Your two level appeal process within a reasonable period of time appropriate to the circumstances, but in no event later than 15 days from the date that we receive Your request for our review at that level unless we inform You otherwise in advance.
  
  - For appeals involving claims arising from the prescription drug benefit - We will review Your Appeal and send You a written decision within a reasonable period of time appropriate to the circumstances, but in no event later than 30 days from the date that we receive Your request for our review unless we inform You otherwise in advance.

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

5. Urgent Concurrent Care Appeal

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

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

o 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.

o 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 non-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.

o 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.

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

6. Appeals of retroactive coverage termination (rescission)

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

Kaiser Permanente
P.O Box 41912
Los Angeles, CA 90041-1912
CLAIM AND APPEALS PROCEDURES

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

Appeal of retroactive coverage termination

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

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

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

Help With Your Appeal
You may contact the state ombudsman:

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

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

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

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

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

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

www.insurance.ca.gov

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

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

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

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

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

If a Covered Person believes a claim has been wrongfully denied or rejected, the Covered Person may have the matter reviewed by the California Department of Insurance. However, the Covered Person should first contact KPIC to try and resolve the dispute. If the dispute is not resolved, the Covered Person may contact the California Department of Insurance. The Department of Insurance should be contacted only after discussions with KPIC, or its agent or other representative.

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

(800) 392-8649

The Covered Person may also write to KPIC at:

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

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

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

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

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

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

www.insurance.ca.gov
YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW

If You believe that health care services have been improperly denied, modified, or delayed, You may have the right to an independent medical review. For more information about how to obtain this review, please call KPIC toll free number at 1-800-392-8649 or call the California Department of Insurance at:

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

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

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

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

www.insurance.ca.gov

You have the right to an independent medical review upon the concurrence of the following:
1. You believe that health care services have been improperly denied, modified, or delayed by the insurer, or by one of its contracting providers;
2. You have a Life-threatening or Seriously Debilitating Condition;
   a) Duly certified by Your Physician, for which:
      i) standard therapies have not been effective in improving Your condition; or
      ii) standard therapies would not be Medically Necessary; or
      iii) there is other beneficial therapy covered under this Group Policy other than the proposed experimental or investigational therapy; and
   b) Your contracting Physician has recommended a drug, device, procedure or therapy duly certified by him in writing that it is likely to be more beneficial than any available standard therapy; or You or Your Physician duly licensed and board certified to practice in the area of practice appropriate for Your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, is likely to be more beneficial to You than any other available therapy.
   c) The Physician’s certification shall contain a statement of the evidence relied upon by him in making the above recommendation;
   d) Such recommendation or request as stated in item number 3 above has been denied, delayed or modified by us based on Medical Necessity;
   e) The therapy, drug, device or procedure would otherwise be covered under the Group Policy were it not determined by us that such therapy, drug, device or procedure is experimental or investigational.
   f) Upon denial of coverage as stated in item c) above, a notice shall be sent to You, explaining in detail Your rights under this process.
YOUR RIGHT TO AN INDEPENDENT MEDICAL REVIEW

3. Your membership was terminated retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.

4. If we continue to deny the payment, coverage or service requested or You do not receive a timely decision.

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

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

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

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

"Life-threatening" means either or both of the following:
1. Sickness or Injury where the likelihood of death is high unless the course of the Sickness is interrupted.
2. Sickness or Injury with potentially fatal outcomes, where the end point of clinical intervention is survival.

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

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

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

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

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

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

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

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

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

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

Rights of a Custodial Parent
If the parents of a covered Dependent child are:
1. divorced or legally separated; and
2. subject to the same Order,
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The custodial parent will have the rights stated below without the approval of the non-custodial parent. However, for this provision to apply the non-custodial parent must be a Covered Person approved for family health coverage under the Policy, and KPIC must receive:

1. a request from the custodial parent who is not a Covered Person under the policy; and
2. a copy of the Order.

If all of these conditions have been met, KPIC will:

A. provide the custodial parent with information regarding the terms, conditions, benefits, exclusions and limitations of the Policy;
B. accept claim forms and requests for claim payment from the custodial parent; and
C. make claim payments directly to the custodial parent for claims submitted by the custodial parent, subject to all the provisions stated in the Policy. Payment of claims to the custodial parent, which are made in good faith under this provision, will fully discharge KPIC’s obligations under the Policy to the extent of the payment.

KPIC will continue to comply with the terms of the Order until We determine that:

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

"Order" means a valid court or administrative order that:

1. determines custody of a minor child, and
2. requires a non-custodial parent to provide the child’s medical insurance coverage or to pay any portion of the medical expenses resulting from medical treatment of the child.

Completion of Covered Services by Terminated Provider

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

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

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

1. For Acute Condition – completion of Covered Services shall be provided until the Acute Condition ends.
2. For Serious Chronic condition – completion of Covered Services shall be provided until the earlier of:
   a. twelve (12) months from the contract termination date with the Participating Provider; or
   b. the first day when it would be safe to transfer Your care to a Participating Provider.
3. For Pregnancy and immediate postpartum care – completion of Covered Services shall be provided until the duration of the pregnancy and immediate postpartum care.
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4. For Terminal illness – completion of Covered Services shall be provided until the duration of the illness

5. For Care of children under age 3 – completion of Covered Services shall be provided until the earlier of:
   a. twelve months from the termination date of the Terminated Participating Provider; or
   b. the child’s third birthday

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

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

For purposes of this subsection, the following definitions apply:

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

**Pregnancy** means the three trimesters of pregnancy.

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

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

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

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

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

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