Summary Plan Description

BMO U.S. Health and Welfare Benefit Plan for Active Employees

Plan 507

Effective January 1, 2025

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About this Summary Plan Description

This Summary Plan Description (SPD) provides an overview of benefits available under the **BMO U.S. Health and Welfare Benefit Plan** (the "Plan") for eligible U.S. Active Employees. This document describes multiple benefit options. All of the benefits are governed by the Employee Retirement Income Security Act of 1974 (ERISA) except for the HSA, DCFSA, commuter benefits, and STD benefits. Those are not part of the Plan and are described in this SPD for convenience only.

This document serves as a consolidated, ERISA-compliant SPD that "wraps" the various health and welfare component benefits into a single, comprehensive resource. It incorporates by reference the benefit booklets, plan details and certificates issued by claims administrators and insurance carriers. Together, this SPD and the referenced materials constitute the official Summary Plan Description. When the term "SPD" is used, it refers collectively to this document and the incorporated booklets, plan details and certificates.

The ERISA-governed component benefits are:

- Medical (including prescription drug)
- Dental
- Vision
- Health Care Flexible Spending Account (HCFSA)
- Limited Purpose Flexible Spending Account (LPFSA)
- Basic Life Insurance
- Supplemental Life Insurance
- Family Life Insurance
- Business Travel Accident Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Group Legal Plan
- Long-Term Disability (LTD)
- Employee Assistance Program (EAP)

For convenience, this SPD also includes descriptions of non-ERISA benefits, which are not subject to ERISA requirements. These are:

- Health Savings Account (HSA)
- Dependent Care Flexible Spending Account (DCFSA)
- Commuter Benefits
- Short-Term Disability (STD)

This SPD is intended to satisfy the disclosure requirements of ERISA. For detailed information about specific benefits - such as coverage levels, deductibles, copayments, exclusions, and limitations - please refer to the applicable benefit booklets, plan details or certificates ("Welfare Program Documents").

The terms and conditions of the Plan are set forth in this document SPD and the Welfare Program Documents related to the benefits under the Plan. Together, the SPD and the Welfare Program Documents constitute the summary plan description. An amendment to one of these documents constitutes an amendment to the Plan.

This SPD should be read in connection with the applicable Welfare Program Documents. Unless otherwise noted, if there is a conflict between a specific provision under the plan document and a Welfare Program Document or this SPD, the plan document controls. If the plan document is silent on a specific issue, then the SPD controls on that issue, except where the SPD refers to a Welfare Program Document, in which case the Welfare Program Document controls. If both the plan document and the SPD are silent, the terms of the applicable Welfare Program Document control. However, with respect to fully insured benefits, the terms of the certificate of coverage/insurance policy control when describing specific benefits that are covered or insurance-related terms. See below to determine whether a particular benefit is self-insured by BMO or fully insured by the insurer.

BMO reserves the right, in its sole discretion, to modify, amend, or terminate any part of the Plan at any time and for any reason, with or without prior notice. Receipt of this SPD does not guarantee eligibility for benefits. To receive benefits, you must meet all applicable eligibility and enrollment requirements.

1.0 Eligibility for Benefits

You and your dependents are eligible to participate in the Plan if you meet the eligibility requirements outlined in Sections 1.1 and 1.2 of this SPD. Some component benefits may have additional requirements, which are detailed in the applicable Welfare Program Documents linked to throughout this SPD and at www.bmousbenefits.com.

1.1 Employee eligibility requirements

Full-time and part-time employees scheduled to work at least 20 hours per week are eligible for the Plan and the component benefits described in this SPD.

You are considered an "employee" only if you are specifically treated or classified as a regular employee on BMO records for payroll purposes of withholding federal employment and income taxes. If BMO classifies you as an independent contractor, consultant, leased employee, temporary agency employee, or similar type of non-employee, you are specifically excluded from participating in the Plan, even if a court, the Internal Revenue Service ("IRS"), or another agency retroactively reclassifies you as an employee.

1.2 Dependent eligibility requirements

Certain benefit options also allow you to cover eligible dependents, provided they meet the applicable requirements and are verified through the Dependent Verification Process (if applicable). These dependents may include:

Your Legal Spouse (same- or opposite-gender)

- Must be recognized as your spouse for federal tax purposes
- Must not be legally separated or divorced from you
- May be a common-law spouse if the marriage is legally recognized in a state that permits common-law marriages

Your Domestic Partner (same- or opposite-gender)

- Must meet all of the specific eligibility requirements, including:
  - Be in a sole, committed relationship with you for at least one year, with the expectation that the relationship will continue indefinitely
  - Share a principal place of residence with you
  - Be at least 18 years old and legally competent to enter into a contract (applies to both of you)
  - Not be related by blood to you in a way that would prohibit legal marriage in the state of residence
  - Not be married to, legally separated from, or in a relationship with another person (applies to both of you)
  - Jointly share responsibility for each other's welfare and financial obligations
- May qualify as a tax-dependent or non-tax dependent (see section 1.2.2 Considerations when covering a Domestic Partner and their Children)

Your Dependent Children may be covered through the end of the month they turn 26. These Include:

- Your biological children
- Your legally adopted children or children placed with you for adoption
- Stepchildren, regardless of where they live
- Children for whom you have legal custody (these children need to qualify as Code section 105(b) dependents in order to have tax-free coverage)
- Foster children living with you
- Your domestic partner's children (these children need to qualify as Code section 105(b) dependents in order to have coverage, see section 1.2.2 Considerations when covering a Domestic Partner and their Children)
- Any other child for whom you are the legal guardian and support in a parent-child relationship (these children need to qualify as Code section 105(b) dependents in order to have tax-free coverage)

Your Disabled Adult Dependent Children age 26 or older who are physically or mentally incapable of self-support.

- Must meet all of the specific eligibility requirements, including:
  - The child is permanently and totally disabled, as defined by Code Section 22(e)(3)
  - The disability began before the child reached age 26
  - The child has the same principal place of residence as you for more than half of the year
  - The child has not provided more than half of their own financial support
  - The child is unmarried
  - The child is a U.S. citizen, resident, or national or a resident of Canada or Mexico
  - You provide proof of your child's disability and dependency within 31 days of the date coverage would have otherwise ended due to age
  - You provide ongoing proof, upon request by the Plan, that the child continues to meet the above conditions

Proof of disabled dependent status may include medical records, a formal determination of disability, and copies of federal tax returns.

1.2.1 Dependent Verification Requirement

To ensure compliance and maintain the integrity of the Plan, all dependents enrolled in BMO's medical, dental, or vision coverage must be verified. The Dependent Verification Process typically occurs when you first enroll a dependent in the Plan, but you may also be asked to recertify eligibility periodically. When verification is required, you will receive a packet from **Dependent Verification Services** with detailed instructions on what documentation to submit, how to submit it, and the applicable deadlines. If you do not provide the required documentation by the deadline or if the documentation shows that the dependents are no eligible, coverage for

unverified/ineligible dependents will be canceled the 1st of the month following the date your final determination letter is sent from Dependent Verification Services.

Once removed, dependents cannot be re-added during the plan year unless you experience a qualified life event or wait until annual enrollment - and verification will still be required at that time. Any dependent removed from your coverage due to lack of verification is not eligible for COBRA coverage.

Dependent Type	Required Documentation
Legal Spouse	• Government Issued marriage certificate including date of marriage **AND** Federal Tax Return issued within last 2 years listing Spouse **OR** • Government Issued marriage certificate including date of marriage **AND** Proof of Financial Partnership issued within last 6 months **OR** • Government Issued marriage certificate only including date of marriage (if married within the last 12 months)
Domestic Partner	• Notarized Affidavit of Domestic Partnership **AND** Proof of Financial Partnership issued within last 6 months **OR** • Certificate of Domestic Partner registration **AND** Proof of Financial Partnership issued within last 6 months **OR** • Certificate of Domestic Partner registration **AND** Federal Tax Return issued within last 2 years listing partner
Common Law Spouse	• Notarized Affidavit of common law marriage **AND** Proof of Financial Partnership issued within last 6 months **OR** • Notarized Affidavit of common law marriage **AND** Federal Tax Return issued within last 2 years listing Spouse
Civil Union partner	• Government Issued of civil union partnership **AND** Federal Tax Return issued within last 2 years listing Partner **OR** • Government Issued of civil union partnership **AND** Proof of Financial Partnership issued within last 6 months
Biological Child	• Government Issued Birth certificate including parent's names
Adopted Child	• Adoption placement agreement (including child's date of birth) **OR**

	• Petition for adoption (including child's date of birth) **OR** • Adoption certificate (including child's date of birth)
Stepchild/Domestic partner Child/Civil Union Partner	• Government Issued Birth Certificate (including spouse or partner's name as a parent) **AND** Both documents to verify Spouse or Partner
Legal Ward	• Government Issued Birth Certificate (including parent's names) **AND** Court ordered document of legal guardianship
Grandchild	• Dependent Government Issued Birth Certificate (including parent's names), Parent Government Issued Birth Certificate (including parent's names), **AND** Federal Tax Return issued within last 2 years claiming Grandchild
Foster Child	• Government Issued Birth certificate **AND** Foster care letter of placement
Disabled Child	Documentation listed above to prove child relationship status **AND** Federal Tax Return issued within last 2 years claiming child **Note:** Disabled adopted child cannot verify with a placement agreement or petition.

Glossary

Term	Definition/Description
Birth Certificate	• Must include names of parents. Certificates that do not include parent's names will not be accepted. • Hospital-issued birth certificates are only accepted for children who are less than 3 months of age.
Government Issued	• An official government record printed on security paper and includes an official raised, embossed, impressed, or multicolor seal.
Proof of Financial Partnership	• May include mortgage statements, bank statements, credit card statements, current rental/lease agreements (including start and end dates and cannot be month to month) or property tax statements with both parties' names as co-owners. • Proof of Financial Partnership includes separate documents in participant's name and spouse or partner's name, both showing the same address.

	• Proof of Financial Partnership cannot be delinquent or past due.
Federal Tax Return	• Send only the **first page** of your recent Federal Tax Return (Form 1040) that shows your dependent.

1.2.2 Considerations when covering a Domestic Partner and their Children

If you choose to cover a domestic partner or their eligible children under BMO's medical, dental or vision plans, it's important to understand the potential tax implications. The IRS treats employee and employer-paid premiums for a domestic partner and their children differently than for a legal spouse or tax-qualified dependents.

Tax Treatment

Under federal law, coverage for domestic partners and their children is not automatically tax-free. To receive pre-tax benefits:

- The enrolled individual must qualify as the employee's federal tax dependent for health coverage purposes.
- If they do not qualify, the value of coverage (including employer-paid premiums) will be treated as taxable income, subject to withholding and reported on the employee's W-2.

State Tax Treatment: State tax rules may differ. You should consult a tax advisor for guidance on your state's rules.

Tax-Qualified vs. Non-Tax-Qualified Dependents: You are responsible for notifying BMO whether your domestic partner and/or their children qualify as your tax dependents under Code Section 105(b). This determination affects how premiums are taxed and reported.

Tax Status	Tax-Qualified Dependent	Non-Tax Qualified Dependent
Employee paid Premiums	Employee premiums are deducted pre-tax	Employee paid premiums for the domestic partner/domestic partner's child's portion are after-tax
Employer paid Premiums	Not taxable	Employer paid premiums are treated as imputed income and added to your taxable wages
W-2 Reporting	No additional income reported	Imputed income is reported as taxable wages on your Form W-2

Criteria for Tax-Qualified Dependent Status

Your domestic partner and/or the domestic partner's child may qualify as a tax-dependent under Code Section 105(b) if all of the following are true with respect to the person:

1. They share your principal place of residence for the entire taxable year and are a member of your household (not in violation of local law);
2. They are a U.S. citizen, national, or resident, or a resident of Canada or Mexico;
3. They are not a qualifying child of another taxpayer; and
4. You provide more than half of their financial support during the year.

Important: Determining tax-dependent status can be complex. You are encouraged to consult a tax advisor to understand how these rules apply to your personal situation.

Domestic Partner and Child Tax Certification Requirement

You must complete a Domestic Partner Tax Certification Form for your domestic partner and each of their children to declare their tax-dependent status the first time you enroll them under your coverage.

If your domestic partner or their child's tax status changes in the future such that they are no longer a tax dependent, you will need to notify BMO by completing a new Domestic Partner Tax Certification Form.

If no Domestic Partner Tax Certification Form is received from you, BMO will assume that the enrolled individual does not qualify as your federal tax dependent for health coverage purposes for that year and treat the coverage as taxable.

1.2.3 Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a legal judgment, decree, or order issued by a court or authorized state agency under domestic relations law. A QMCSO requires an employee to provide health care coverage for a child under the employer's group health plan.

BMO will comply with all valid QMCSOs and ensure that affected children are enrolled in the applicable medical, dental, or vision plans as required. If BMO is notified that one of your children is subject to a QMCSO, you will be required to remain enrolled in the relevant benefit plans and maintain coverage for the child(ren) named in the order until the QMCSO is no longer in effect.

For more information about the procedures governing QMCSOs, or to request a copy of the Plan's QMCSO procedures, please contact the Human Resources Centre at 1-888-927-7700.

1.2.4 Non-duplication of coverage

If your spouse, domestic partner, or eligible dependent child is also employed by BMO and eligible to participate in the Plan, the following rules apply:

- An individual may be covered under the component plans as either an employee or a dependent, but not both.

- You and your spouse or domestic partner may each elect your own coverage under any of the component plans, or one of you may elect coverage and enroll the other as a dependent.
- If both you and your spouse or domestic partner elect your own coverage under any of the component plans, only one of you may enroll your eligible children as dependents on that same plan.
- You and your spouse or domestic partner may choose to split enrollment across component plans and cover each other as dependents. For example, one of you may enroll the family in medical coverage, while the other enrolls the family in dental coverage.
- If your eligible child is also employed by BMO and qualifies for coverage under the Plan as an employee, they may elect own coverage. In that case, they cannot also be covered as a dependent under another employee's Plan enrollment.

2.0 Health and Welfare Benefits

BMO is committed to supporting the health, well-being, and financial security of our employees by offering a comprehensive suite of health and welfare benefits. These benefits are a key part of your total rewards package and reflect our investment in your overall well-being. Some benefits are provided automatically, while others require you to actively enroll based on your personal needs. BMO also provides generous employer contributions and subsidies to help make coverage more affordable and accessible for you and your family.

2.0.1 List of Health & Welfare Benefit Plans Offered

BMO's health and welfare benefits include:

- Medical
- Dental
- Vision
- Health Savings Account (HSA)
- Health Care Flexible Spending Account (HCFSA)
- Limited Purpose Flexible Spending Account (LPFSA)
- Dependent Care Flexible Spending Account (DCFSA)
- Basic Life Insurance
- Supplemental Life Insurance
- Family Life Insurance
- Business Travel Accident Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Group Legal Plan

- Commuter Benefits
- Short term Disability
- Long term Disability
- Employee Assistance Program (EAP)

2.0.2 Earnings Used for Benefits

Some of BMO's component plans rely on compensation elements to calculate your premiums or coverage amounts.

Compensation Element	Definition	What it is used for
Annual Base Salary This amount is viewable in your Workday profile > Compensation > Total Base Pay	Your salary used to calculate your bi-weekly paycheck amounts.	Calculation of your: • Short Term Disability pay Maternity Leave pay • Parental Leave pay • Business Travel Accident coverage
Base Benefit Rate (BBR) ***Used for certain commissioned employees only*** This amount is viewable in your Workday profile > Actions > Benefits > View Benefits Annual Rate	Your BBR is the greater of: • Your base pay/draw plus average of two previous calendar years' commissions (incentive pay is excluded unless otherwise noted); or • The midpoint of your salary range Note: IRS Annual Compensation Limits may apply The BBR is recalculated annually in February.	Calculation of your: • Short Term Disability pay • Maternity Leave pay • Parental Leave pay
Total Compensation Base Benefit Rate (TCBBR) This amount is viewable in your Workday profile > Actions > Benefits > View Benefits Annual Rate	Your TCBBR is an accumulation of your base salary, overtime, shift differential and any variable pay that is related to work performance that is paid to you between October 1 and September 30 of the prior year. The TCBBR is recalculated annually in October.	Calculation of your: • Medical Premium Tier • Life Insurance coverage and premium amounts • Long Term Disability pay • Supplemental Long Term Disability premiums

2.1 Medical

BMO offers different medical benefit designs to provide employees with flexibility in managing their healthcare needs. Through Blue Cross Blue Shield of Illinois (BCBSIL), all employees can choose between a High Deductible Health Plan (HDHP) and a Preferred Provider Organization (PPO) plan.

For employees in regions (California, Colorado, and Oregon) served by Kaiser Permanente, BMO also provides an additional HDHP and a Deductible Health Maintenance Organization (DHMO) plan to choose from.

Medical: At-a-glance				
In-Network Plan Features	**BCBSIL**		**Kaiser Permanente**	
	HDHP	**PPO**	**HDHP**	**DHMO**
Eligibility based on location	All employees, nationwide		Only employees in CA, CO, & OR	
Provider Network	You can see any provider you choose, but you'll get higher benefits and pay less when you see in-network providers.		The plan uses a provider network; most benefits are *only* covered when you see Kaiser providers.	
HSA Eligible Plan	Yes	No	Yes	No
Annual Deductible* **HDHPs:** includes medical and prescription drugs **PPO/DHMO:** includes medical only (separate Rx deductible)	Individual: $1,750 Family: $3,500**	Individual: $750 Family: $1,500 ***	Individual: $1,750 Family: $3,500**	Individual: $750 Family: $1,500 ***
Annual Out-Of-Pocket Maximum* Includes deductible, copays, and coinsurance for medical and prescription drugs	Individual: $3,425 Family: $6,850	Individual: $3,000 Family: $6,000	Individual: $3,425 Family: $6,850	Individual: $3,000 Family: $6,000

Annual Benefit Maximum	None		None	
Lifetime Benefit Maximum	None		None	
What you pay				
Office Visit	20% after deductible	Copay: $25 PCP, $40 specialist	20% after deductible	Copay: $25 PCP, $40 specialist
Well Care/ Preventive Care	You pay nothing			
Lab Test and X-rays	20% after deductible			
Inpatient Care	20% after deductible			
Urgent Care	20% after deductible	$150 copay	20% after deductible	$150 copay
Emergency Room	$100 copay and 20% coinsurance after deductible (copay waived if admitted)	$300 copay (copay waived if admitted)	$100 copay and 20% coinsurance after deductible (copay waived if admitted)	$300 copay (copay waived if admitted)

** Annual deductibles and out-of-pocket limits for in-network and out-of-network must be met separately.*

***Under the HDHPs, the entire family deductible must be met before the plan will pay benefits for any covered family members. If combined expenses for the family meet the family deductible, the deductible is met for the entire family.*

**** Under the PPO/DHMO, each covered person has an individual deductible. Once the individual deductible is met, the plan begins to pay benefits for that person. Once the total family deductible is reached, the plan starts to pay benefits for all covered family members, even if some members still need to meet their individual deductible.*

Prescription coverage included with BMO Medical Plans

When you enroll in a BMO medical plan, prescription drug coverage is automatically included.

- **BCBSIL Plans**: Prescription benefits are managed by **Express Scripts**.
- **Kaiser Plans**: Prescription services are provided directly through the **Kaiser plan.**

Prescription: At-a-glance				
In-Network Plan Features	**BCBSIL**		**Kaiser Permanente**	
	HDHP	**PPO**	**HDHP**	**DHMO**
Prescription Drug Coverage	Provided by Express Scripts		Provided by Kaiser	
Annual Deductible	Combined with Medical	Individual: $250 Family: $500	Combined with Medical	Individual: $250 Family: $500
Annual Out-Of-Pocket Maximum	Combined with Medical			
What you pay (post-deductible)				
Generic	Retail Pharmacy: $10 copay Home Delivery: $25 copay		Retail: $10 copay Mail order: $20 copay	
Preferred Brand	30% coinsurance Retail Pharmacy: $25 minimum; $100 maximum Home Delivery: $62.50 minimum; $250 maximum		Slight variances based on region, see SBC for details: Review your regional Kaiser SBC: • 2025 Kaiser HDHP California • 2025 Kaiser HDHP Colorado • 2025 Kaiser HDHP Northwest • 2025 Kaiser DHMO California • 2025 Kaiser DHMO Colorado • 2025 Kaiser DHMO Northwest	
Non-Preferred Brand	40% coinsurance Retail Pharmacy: $50 minimum; no maximum Home Delivery: $125 minimum; no maximum			
Specialty Drugs	Based on category (generic, formulary, non-formulary). Must be filled through Express Script's specialty home delivery			

	pharmacy, **Accredo,** which provides 24/7 access to speciality-trained pharmacists and nurses who understand your condition.	
Express Scripts: Retail Pharmacy: Up to 30 day supply; Home Delivery: Up to 90 day supply *Kaiser: Retail: Up to 30 day supply, Mail order: Up to 100 day supply*		

Medical Plan Coverage Levels

You may choose to enroll yourself and any eligible dependents in the medical plan. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

This a high-level overview of **in-network benefits** for the BMO medical plans. For more detailed information including how out-of-network claims are covered, review the following:

2025 BCBSIL HDHP Booklet, 2025 BCBSIL PPO Booklet,

Kaiser-CO-HSA, Kaiser-S.CA-HSA, Kaiser-N.CA-HSA, Kaiser-NW-HSA,

Kaiser-CO-DHMO, Kaiser-S.CA-DHMO, Kaiser-N.CA-DHMO, Kaiser-NW-DHMO

BCBSIL/Kaiser Summaries of Benefits and Coverage.

For more information on the prescription drug coverage for the BCBSIL plans, review the 2025 Prescription Drug Plan Details

2.2 Dental

BMO offers comprehensive dental benefits through Delta Dental of Illinois, offering flexibility and cost-saving opportunities. Employees may visit any licensed dental provider; however, greater savings are available by choosing a provider within the Delta Dental's PPO or Premier networks.

Dental: At-a-glance	
Provider Networks	• **Delta Dental PPO**: Lowest out-of-pocket costs and network protection

Dental: At-a-glance	
	• **Delta Dental Premier:** Higher out-of-pocket costs than PPO, but may be lower than non-network and network protection • **Non-network**: You may have the highest out-of- pocket costs
Annual deductible	Individual: $50 Family coverage: $150 (three individual deductibles per family)
Annual benefit maximum	$2,000 per person
Lifetime non-surgical TMJ Maximum	$1,000 per person
What you pay (post-deductible)	
Preventive services	You pay nothing
Basic services	20% coinsurance
Major services	50% coinsurance
Orthodontia services	50% coinsurance (maximum of $2,000 for children up to age 19)

Dental Plan Coverage Levels

You may choose to enroll yourself and any eligible dependents in the dental plan. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

This a high-level overview of **in-network benefits** for the BMO dental plan. For more detailed information including how out-of-network claims are treated, review the 2025 Delta Dental Benefits Booklet.

2.3 Vision

BMO offers two vision plan options through VSP: the Base Plan and the Premier Plan. Both plans allow employees to visit any licensed vision care provider; however, using an in-network

VSP provider offers enhanced value, including higher reimbursement rates, lower out-of-pocket costs, and simplified claims processing. These options are designed to support varying needs for routine eye care and eyewear.

Vision: At-a-glance		
In Network Features	**VSP Base Plan**	**VSP Premier Plan**
WellVision exam (every year)	$10 copay	$0 copay
Retinal imaging/screening	$20 copay	
Additional exams as needed	$20 copay	
Treatment of eye conditions (e.g., pink eye, vision loss, cataracts)	$20 copay	
Lenses (every calendar year) • Single vision • Lined bifocal • Lined trifocal	Included with prescription glasses	
Lens Enhancements (every calendar year) • Progressive lenses • Tinted lenses • Scratch-resistant coating • Ultraviolet coating	You pay nothing	
Premium and custom progressive lenses	$50	$95 – $175
Retail frame	$150 allowance, every other calendar year	$175 allowance, every calendar year

Vision: At-a-glance		
Featured frame brand	$200 allowance, every other calendar year	$225 allowance, every calendar year
Frame discount	20% savings on amount over allowance, every other calendar year	20% savings on amount over allowance, every calendar year
Contact lens exam (every calendar year)	Up to $40	
Contact lenses (every calendar year)	$150 allowance, copay does not apply	$175 allowance, copay does not apply
VSP EasyOptions	Not included	Choose one of the following upgrades when purchasing glasses or contact lenses*: • Additional $75 frame allowance • Fully covered premium or custom progressive lenses • Fully covered light-reactive lenses • Fully covered anti-glare coating • Additional $75 contact lens allowance *Upgrade is available every calendar year. Copay is included in prescription glasses
VSP Lightcare	Not Included	$250 allowance for ready-made non-prescription sunglasses or non-prescription blue light filtering glasses (instead of prescription glasses or contacts)* *Allowance available every calendar year. $0 copay
VSP also offers extra savings on additional glasses and sunglasses, laser vision correction and frames, lens enhancements and more. *If you see a non-VSP provider, services are either paid based on an allowance or not covered.*		

Vision Plan Coverage Levels

You may choose to enroll yourself and any eligible dependents in the vision plan. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

This a high-level overview of **in-network benefits** for the BMO vision plan. For more detailed information including how out-of-network claims are treated, review the VSP Vision Coverage Overview.

2.4 Health Savings Account

If you enroll in one of BMO's HDHPs, you may be eligible to open and contribute to a Health Savings Account (HSA). BMO contributes, and allows you to contribute pre-tax through payroll, to an HSA administered by Alight Smart-Choice Accounts. An HSA lets you use pre-tax dollars to pay for qualified medical, prescription, dental, and vision expenses, reducing your out-of-pocket burden and taxable income.

Employer Contribution: BMO provides a lump-sum **Core Contribution** to your HSA - regardless of whether you choose to contribute yourself (unless you are ineligible to contribute to an HSA). You'll receive:

- **$500** if you're enrolled in **Employee-only** coverage
- **$1,000** if you're enrolled in **Family** coverage

This upfront contribution gives you a head start in covering healthcare expenses and maximizing the benefits of your HSA paired with your HDHP.

Each year, the IRS sets contribution limits based on your HDHP coverage level. The 2025 IRS Limits are as follows:

HDHP Coverage Level	BMO Core Contribution	Maximum Employee Contributions	IRS Limits
Employee Only	$500	Under Age 55: $3,800	Under Age 55: **$4,300**
		55 or Older: $4,800	55 or Older: **$5,300**
Family	$1,000	Under Age 55: $7,550	Under Age 55: **$8,550**
		55 or Older: $8,550	55 or Older: **$9,550**

This a high-level overview of BMO's HSA plan. For more detailed information, review the Health Savings Account Plan Details.

2.5 Health Care Flexible Spending Account

BMO offers a Health Care Flexible Spending Account (HCFSA) administered by Alight Smart-Choice Accounts that allows you to set aside pre-tax dollars to pay for eligible **health care** expenses for you and your Code Section 105(b) dependents. These out-of-pocket expenses include deductibles, coinsurance, and copays from your medical, dental, or vision plans.

Each year, the IRS sets annual contribution and carryover limits for the HCFSA, and it's important to plan carefully - any unused funds above the carryover limit will be forfeited if you do not submit eligible claims by the plan's deadline. This "use it or lose it" feature makes thoughtful budgeting essential. If you elect the HDHP for the following plan year, your carryover will be to the Limited Purpose Flexible Spending Account.

The 2025 IRS annual pre-tax limits for HCFSA are:

Annual Contributions		Allowable Carryover
Minimum:	$100	$660
Maximum:	$3,300*	

*See Health Care and Limited Purpose Flexible Spending Account Plan Details for certain limitations.

You have until April 30 of the following year to submit any HCFSA claims incurred in the previous calendar year while you were actively participating.

This benefit is especially beneficial if you are not enrolled in BMO's HDHP or are ineligible to contribute to an HSA.

Important: You are unable to enroll in the HCFSA and contribute to an HSA. Instead, you may enroll in the Limited Purpose Flexible Spending Account (LPFSA) to maximize your tax savings.

This a high-level overview of BMO's HCFSA plan. For more detailed information and how to submit claims, review the Health Care and Limited Purpose Flexible Spending Account Plan Details.

2.6 Limited Purpose Flexible Spending Account

BMO offers a Limited Purpose Flexible Spending Account (LPFSA) administered by Alight Smart-Choice Accounts that allows you to set aside pre-tax dollars to pay for eligible **dental and vision expenses** for you and your Code Section 105(b) dependents. You can use LPFSA funds

before meeting your HDHP deductible, making it a smart way to manage out-of-pocket dental and vision costs while preserving your HSA for broader medical needs.

Once you've met your HDHP deductible, you can then use the LPFSA to cover a wider range of qualified medical, dental, prescription, vision, and Code Section 213(d) expenses. You need to contact SmartChoice to allow for these additional expenses once you've met your deductible.

Each year, the IRS sets annual contribution limits for the LPFSA, and it's important to plan carefully—any unused funds above the carryover limit will be forfeited if you do not submit eligible claims by the plan's deadline. This "use it or lose it" feature makes thoughtful budgeting essential. If you elect the HDHP for the following plan year, your carryover will be to the Limited Purpose Flexible Spending Account.

The 2025 IRS annual pre-tax limits for the LPFSA are:

Annual Contributions		Allowable Carryover
Minimum:	$100	$660
Maximum:	$3,300*	

*See Health Care and Limited Purpose Flexible Spending Account Plan Details for certain limitations.

You have until April 30 of the following year to submit any LPFSA claims incurred in the previous calendar year while you were actively participating.

This a high-level overview of BMO's LPFSA plan. For more detailed information and how to submit claims, review the Health Care and Limited Purpose Flexible Spending Account Plan Details.

2.7 Dependent Care Flexible Spending Account

BMO offers a Dependent Care Flexible Spending Account (DCFSA) administered by Alight Smart-Choice Accounts that allows you to set aside pre-tax dollars to pay for eligible **child care and elder care expenses** that enable you (and your spouse, if applicable) to work, look for work, or attend school full-time. Eligible expenses may include daycare, preschool, before- and after-school programs, and adult day care services.

The Code contains annual contribution limits for the DCFSA, and it's important to plan carefully - any unused funds will be forfeited if you do not submit eligible claims by the applicable deadline. This "use it or lose it" feature makes thoughtful budgeting essential.

The 2025 annual pre-tax limits for the DCFSA are:

Annual Contributions		Allowable Carryover
Minimum:	$100	$0
Maximum:	$5,000 if single or married and filing jointly* or	

$2,500 if married and filing separately*	

*See Dependent Care Flexible Spending Account Details for certain limitations for highly compensated employees.

You have until April 30 of the following year to submit any DCFSA claims incurred in the previous calendar year while you were actively participating.

This a high-level overview of BMO's DCFSA plan. For more detailed information and how to submit claims, review the Dependent Care Flexible Spending Account Plan Details.

2.8 Basic Life Insurance

BMO provides employer-paid Basic Life Insurance coverage equal to two times your Total Compensation Benefits Base Rate (TCBBR), up to $500,000. This coverage is administered by Voya under a group policy issued by ReliaStar Life Insurance Company.

Under the Code, employer-paid life insurance coverage over $50,000 is considered taxable imputed income. To avoid this tax impact, you have the option to cap your coverage at $50,000.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your TCBBR calculation.

You will want to **assign and regularly review your beneficiaries** for this benefit to ensure benefits are paid according to your wishes.

This a high-level overview of BMO's Basic Life Insurance benefit. For more detailed information, review the Life Insurance Schedule of Benefits.

2.9 Supplemental Life Insurance

To increase your life insurance coverage, you can purchase one to eight times your TCBBR through the Supplemental Life Insurance benefit, up to a combined maximum of $3 million (including your employer-paid Basic Life Insurance). Rates are based on your tobacco user status, with lower premiums available to non-tobacco users. This coverage is administered by Voya under a group policy issued by ReliaStar Life Insurance Company.

If you elect Supplemental Life Insurance when you are first eligible, you are not required to provide Evidence of Insurability (EOI). However, EOI is required if you enroll in or increase coverage later - such as during annual enrollment or following a qualifying life event.

Limit without proof: You may elect up to $1 million or five times your TCBBR, whichever is less, without providing EOI during your initial eligibility period.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your TCBBR calculation.

You will want to **assign and regularly review your beneficiaries** for this benefit to ensure benefits are paid according to your wishes.

This a high-level overview of BMO's Supplemental Life Insurance plan. For more detailed information, review the Life Insurance Schedule of Benefits.

2.10 Family Life Insurance

BMO offers optional Family Life Insurance to provide financial protection for your loved ones in the event of an unexpected loss. Electing coverage for your spouse/domestic partner and child(ren) can help ease the financial burden of final expenses and provide peace of mind during a difficult time. This benefit allows you to extend life insurance protection beyond yourself, ensuring you and your family has added support when needed most. This coverage is administered by Voya under a group policy issued by ReliaStar Life Insurance Company.

- **Spouse/Domestic Partner Life Insurance**: You can purchase coverage in the amount of $25,000, $50,000, $100,000, or $150,000.

    If you elect this coverage when you are first eligible for benefits, no EOI is required. However, EOI is required for coverage amounts of $100,000 or $150,000, or if you enroll or increase coverage later- such as during annual enrollment or following a qualifying life event.

- **Child Life Insurance**: You can purchase coverage in the amount of $10,000, $15,000, $20,000, or $25,000. EOI is not required for child life insurance coverage.

You are automatically the beneficiary of your Family Life Insurance policies, meaning the benefit is paid to you if a covered family member passes away.

This a high-level overview of BMO's Family Life Insurance plan. For more detailed information, review the Life Insurance Schedule of Benefits.

2.11 Business Travel Accident Insurance

BMO provides Business Travel Accident Insurance insured by AIG Insurance Company of Canada to help protect you in the event of a serious injury or accident while traveling for work. This coverage reflects BMO's commitment to employee safety and well-being, recognizing that business travel - whether across the country or around the globe - can carry unexpected risks. The insurance offers financial protection and peace of mind, ensuring that you and your loved ones are supported if an accident occurs while you're away on business.

Coverage is automatic from your first day of employment, and no enrollment is required.

It begins when you leave your home, office, or other location to start a business trip and ends when you return or begin a personal side trip. This benefit is in addition to any personal accident coverage you may have elected through employee, spouse, or child accident insurance plans.

Note: This benefit does not cover your regular commute to and from work.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your annual base pay calculation for purposes of this benefit.

This a high-level overview of BMO's Business Travel Accident Insurance plan. For more detailed information, review the AIG Business Travel Accident Insurance Policy and the AIG Business Travel Accident Insurance Policy Schedule.

2.12 Accident Insurance

BMO offers Accident Insurance to provide financial support when you or a covered family member experiences an unexpected injury. Offered by Voya and insured by Reliastar Life Insurance Company, this coverage pays benefits for specific, covered accidents and related treatments that occur on or after your coverage effective date. It's designed to help offset out-of-pocket costs such as emergency care, hospital stays, and follow-up visits - helping to reduce the financial stress that often comes with accidental injuries.

You may choose to enroll yourself and any eligible dependents in the Accident Insurance benefit. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

Covered accidents include:

- Injuries such as fractures, burns, lacerations, and dislocations (e.g., hip, knee, shoulder).
- Treatment-related expenses including emergency room visits, ambulance services, surgery, doctor visits, and hospital admission.
- A Sports Accident Benefit: If your injury occurs during an organized sporting activity, your benefit is increased by 25%, up to an additional $1,000.

Benefit payments can be used however you choose - whether for everyday expenses, lost income, child care, deductibles, or copays - and are paid in addition to any other coverage you may already have.

Benefit amounts vary based on:

- The nature and severity of the injury
- The type of treatment received
- The plan level you select- **Low Plan** or **High Plan**

Note: This plan includes a **Wellness Benefit**. If you or your spouse/domestic partner complete a health screening, you will each receive $50, payable once a year from Voya. Each child who completes a health screening will also receive $50.

This benefit is portable when you leave or retire from BMO.

This a high-level overview of BMO's Accident Insurance benefit. For more detailed information, review the Accident Insurance Certificate of Coverage or visit Voya's site: www.presents.voya.com/EBRC/BMO.

2.13 Critical Illness Insurance

BMO offers Critical Illness Insurance to provide financial support if you or a covered family member is diagnosed with a serious medical condition. Offered by Voya and insured by Reliastar Life Insurance Company, this coverage pays a lump-sum benefit for specific, covered illnesses that occur on or after your coverage effective date. It's designed to help offset the financial impact of a major health event - such as a heart attack, stroke, or cancer- by providing funds you can use however you choose.

You may choose to enroll yourself and any eligible dependents in the Critical Illness Insurance benefit. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

Covered illnesses and conditions include:

- Heart attack, stroke, cancer, organ transplant, infectious disease, paralysis, advanced Alzheimer's, and more.

Benefit payments can be used however you choose - whether for everyday expenses, lost income, child care, deductibles, or copays - and are paid in addition to any other coverage you may already have.

Benefit amounts vary based on:

- The nature and severity of the illness or condition
- The plan level you select - **Low Plan** or **High Plan**

Low Plan:

- You and your spouse/domestic partner: Up to $10,000
- Your children: Up to $5,000

High Plan:

- You and your spouse/domestic partner: Up to $20,000
- Your children: Up to $10,000

Note: This plan includes a **Wellness Benefit**. If you or your spouse/domestic partner complete a health screening, you will each receive $50, payable once a year from Voya. Each child who completes a health screening will also receive $50.

This benefit is portable if you leave or retire from BMO.

This is a high-level overview of BMO's Critical Illness Insurance benefit. For more detailed information, review the Critical Illness Insurance Certificate of Coverage or visit Voya's site: www.presents.voya.com/EBRC/BMO.

2.14 Hospital Indemnity Insurance

BMO offers Hospital Indemnity Insurance to complement your medical coverage by providing additional financial support if you or a covered family member needs to stay in the hospital. Offered by Voya and insured by Reliastar Life Insurance Company, this voluntary benefit pays daily cash benefits for hospital-related stays that occur on or after your coverage effective date. It's designed to help offset out-of-pocket costs such as deductibles, copays, and lost income - helping to reduce the financial stress that often comes with inpatient care.

You may choose to enroll yourself and any eligible dependents in the Hospital Indemnity Insurance benefit. The following coverage levels are available:

- Employee Only
- Employee + Spouse
- Employee + Domestic Partner
- Employee + Child(ren)
- Employee + Family
- Employee + Domestic Partner + Children

Covered situations include:

- Hospital admission and confinement
- Critical care unit admission and confinement
- Rehabilitation facility confinement
- Daily benefit for observation unit stays

Benefit payments can be used however you choose—whether for everyday expenses, child care, travel costs, or medical bills—and are paid in addition to any other coverage you may already have.

Benefit amounts vary based on:

- The type of facility and length of stay
- The plan level you select - **Low Plan** or **High Plan**

Note: This plan includes a **Wellness Benefit**. If you or your spouse/domestic partner complete a health screening, you will each receive $50, payable once a year from Voya. Each child who completes a health screening will also receive $50.

This benefit is portable if you leave or retire from BMO.

This is a high-level overview of BMO's Hospital Indemnity Insurance benefit. For more detailed information, review the Hospital Indemnity Insurance Certificate of Coverage or visit Voya's site: www.presents.voya.com/EBRC/BMO.

2.15 Group Legal Plan

BMO offers the UltimateAdvisor® Legal Plan to provide access to legal experts and self-help resources for a wide range of personal legal matters. Administered by ARAG, this voluntary benefit helps you navigate everyday legal situations with confidence and support.

You may cover yourself, your spouse/domestic partner, and/or dependent children.

Covered legal matters include:

- Wills and trusts
- Divorce and family law
- Traffic violations
- Sale or purchase of a home
- Consumer protection
- Bankruptcy and civil damage defense
- Property issues
- Identity theft resolution
- Caregiving support
- Tax services
- Immigration assistance

Benefit payments and discounts:

- When you work with a network attorney, fees for covered services are 100% paid-in-full.
- For legal matters not covered under the plan, you receive at least 25% off the network attorney's normal rate.

This is a high-level overview of BMO's Group Legal Plan. For more detailed information, review the ARAG Legal Certificate or visit ARAG's website and enter the access code: 18694bmo.

2.16 Commuter Benefits

BMO offers Commuter Benefits to allow employees to pay for commuting expenses using pre-tax dollars, helping you save money on your annual taxes. Commuter Benefits are administered by Alight and EdenRed Benefits.

The 2025 IRS monthly pre-tax limits for Commuter Benefits are:

Commuter Benefits Type	Monthly pre-tax limits
Mass transit	$325
Parking	$325

Your Commuter Benefits contributions are deducted once a month, taken from your first paycheck of the month.

Eligible Expenses Include:

- **Public Transit**: Train, Bus, Subway, Ferry, Trolley, Water Taxi, and Vanpools.
- **Parking**: Near your workplace or near your transit location; Discounts available through SpotHero (where applicable).

This is a high-level overview of BMO's Commuter Benefits. For more detailed information including how to enroll and make changes to your Commuter Benefits, review the Commuter Benefits Plan Details.

2.17 Short-Term Disability

BMO automatically provides Short-Term Disability (STD) income replacement benefits to support you when you're unable to work due to a non-work-related illness or injury lasting more than 10 consecutive business days. The STD plan is administered by Reliance Matrix Absence Management.

- **Benefit Duration**: Up to 100 business days.
- **Income Replacement**: 70% to 100% of your base salary (or Benefits Base Rate for eligible commissioned employees), based on your years of service.
- **Waiting Period**: 10 business days unpaid, unless you elect to use available paid sick or vacation time during the waiting period.
- **When Benefits Begin**: On the 11th business day of disability, if approved.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your base salary (or Benefits Base Rate) calculation.

This is a high-level overview of BMO's STD plan. For more detailed information including how to apply for STD, review the Short-Term Disability Plan Details.

2.18 Long-Term Disability

BMO automatically provides Long-Term Disability (LTD) income replacement benefits to support you if your illness or injury prevents you from returning to work after your Short-Term Disability period ends. The LTD plan is administered by Matrix Absence Management.

- **Benefit Start:** After STD benefits are exhausted and your LTD claim is approved.
- **Income Replacement**: Typically, 60% of your Total Compensation Base Benefits Rate (TCBBR) is automatically provided to you by BMO.
- **Maximum Monthly Benefit**: The total LTD benefit (basic + supplemental) is capped at $20,000 per month.
- **Duration**: As long as you remain eligible under the plan terms, up to age 65 or Social Security Normal Retirement Age.

2.18.1 Supplemental Long-Term Disability

You can elect to purchase Supplemental LTD coverage to increase your income protection while on Long Term Disability. This optional coverage enhances your total LTD benefit to **75%** of your TCBBR.

- **Income Replacement**: Combined basic and supplemental LTD coverage provides up to 75% of your TCBBR.
- **Maximum Monthly Benefit**: The total LTD benefit (basic + supplemental) is capped at $20,000 per month.
- **Coverage Limitations**:
    - If your TCBBR is **$400,000 or more**, you will not receive any additional benefit from electing Supplemental LTD.
    - If your TCBBR is between **$320,000 and $399,999**, you may elect coverage, but will receive less than the full 15% supplemental benefit due to the monthly cap.

See the 2.1 Earnings Used for Benefits section for the definition of what is included in your TCBBR calculation.

This is a high-level overview of BMO's LTD benefit. For more detailed information including how to apply for LTD, review the Long-Term Disability Plan Details.

2.19 Employee Assistance Program

BMO offers a free and confidential Employee Assistance Program (EAP), administered by TELUS Health, to support you and your immediate family with personal challenges that may

affect your well-being or work. Available 24/7 - the EAP provides short-term counseling online, in-person, or by phone, and can help with:

- Stress, anxiety, and depression
- Relationship and parenting issues
- Financial concerns
- Addiction support
- Child and elder care
- Work-related conflicts
- Coping with change

The EAP is intended to short-term needs. Longer-term counseling may be covered under your medical plan.

This is a high-level overview of BMO's Employee Assistance Program. For more detailed information on the resources available to you, review the Employee Assistance Program Plan Details.

3.0 Enrolling and changes

Some benefits are provided to eligible employees **automatically**, without the need for enrollment:

- Basic Life Insurance
- Business Travel Accident Insurance
- Short-Term Disability (STD)
- Basic Long-Term Disability (LTD)
- Employee Assistance Program (EAP)

Other benefits require **active enrollment** during your initial eligibility period, newly enrolling during annual enrollment or during a qualifying life event to participate:

- Medical (including prescription drug)
- Dental
- Vision
- Health Savings Account (HSA)
- Health Care Flexible Spending Account (HCFSA)
- Limited Purpose Flexible Spending Account (LPFSA)
- Dependent Care Flexible Spending Account (DCFSA)
- Supplemental Life Insurance
- Family Life Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Group Legal Plan
- Supplemental Long-Term Disability

You may enroll in or make changes to your health and welfare benefit plans during the following events:

- **Initial Eligibility**: When you first become eligible for benefits, such as upon hire or a change in employment status that grants eligibility.
- **Rehire**: If you are rehired and meet the eligibility criteria.
- **Qualifying Life Event (QLE)**: When you experience a life event that qualifies for a mid-year change (e.g., marriage, birth of a child, loss of other coverage).
- **Annual Enrollment**: During the designated annual enrollment period, when you may review and update your benefit elections for the upcoming plan year.

3.1 Enrollment Deadlines and Coverage Effective Dates

Event	Enrollment Deadline	Effective Date of Coverage
New hire	31 days from hire date	1st of the month following 30 days from your hire date
Newly eligible for benefits status change	31 days from your status change date	1st of the month following 30 days from your status change date
Rehire within 30 days	Not applicable, your benefit elections in effect on the date of your termination are automatically reinstated.	Reinstated back to the benefit end date (no break in coverage).
Rehire greater than 30 days, but within 13 weeks of termination	31 days from rehire date	1st of the month from your rehire date
Rehire greater than 13 weeks of termination	31 days from rehire date	1st of the month following 30 days from your rehire date
QLE – excluding birth/adoptions	31 days from the QLE date	On the QLE date
Birth or Adoption QLE	90 days from the child's birth or adoption date*	On the child's birth or adoption date
Annual Enrollment (AE)	Varies but elections must be made during the communicated AE window	January 1st following AE
** For the critical illness, your child must be added within 60 days of the birth/adoption date.*		

For Commuter Benefits: Commuter Benefits are unique in that enrollment occurs outside of the standard health and welfare benefits enrollment process. You may enroll, change, or cancel your Commuter Benefits at any time, based on your commuting needs.

Enrollment Deadlines for Commuter Benefits:

- For most transit and parking options, changes must be submitted by the 10th of the month to be effective the following month.
- If you are using the Long Island Railroad or Metro-North Railroad in New York, changes must be submitted by the 4th of the month for benefits to be effective the following month.

3.2 How to enroll

You will enroll and make changes to your health and welfare benefits through the My Benefits & Retirement app via Workday.

To access the *My Benefits & Retirement* homepage:

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network*)

**You can access Workday from outside the BMO firewall using a standard internet browser or the Workday mobile app. Before doing so, you must first complete your initial setup while connected to the BMO network. This setup includes logging in with your Employee Identification Number (EIN) as your username; creating a password; and setting up your security challenge questions. Once this setup is complete, you'll be able to securely access Workday from any location.*

3.2.1 Enrollment as a new hire, rehire or newly eligible employee

When you initially become eligible for BMO's benefits, you will have the opportunity to enroll in the coverage you and your family needs. An enrollment event in *My Benefits & Retirement* will automatically appear for you to make changes and you have 31 days from your hire, rehire or status change date to enroll in your health and welfare benefits.

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network)
4. From the *My Benefits & Retirement* homepage, click the **Enroll in your benefits** tile
5. Click **Go to Enrollment** and follow the prompts to navigate through the benefits election process

3.2.2 Mid-year Changes due to a Qualifying Life Event

In most cases, the benefits you choose during enrollment stay the same all year. However, certain life events - like getting married or having a baby - may allow you to make changes mid-year. You will log your QLE and make changes to your health and welfare benefits through the My Benefits & Retirement app via Workday.

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network)
4. From the *My Benefits & Retirement* homepage, click the **Change Your Coverage** tab
5. Select the life event type from the list that fits your QLE
6. Enter the event date and click **Continue**
7. Click **Go to Enrollment** and follow the prompts to navigate through the benefits election process

Important: Your QLE must be entered AND any changes to your benefits must be completed within 31 days of the event (or 90 days for a birth or adoption). For HIPAA special enrollment events related to CHIP or Medicaid, you have 60 days to request enrollment. If you miss the deadline, you won't be able to make changes until the next open enrollment period (unless another QLE occurs).

You can make changes due to a QLE if you or your dependent(s) experience a:

Change in	QLE types
Legal Marital Status	Marriage, divorce, legal separation, annulment, or death of a spouse
Number of Eligible Dependents	Birth, adoption, placement for adoption, legal guardianship, or death
Employment Status	Gaining or losing eligibility due to a job change (you or your dependents)
Dependent Status	Changes in eligibility due to age, disability, or similar factors
Residence Change	Moving outside your medical plan's network service area
HIPAA Special Enrollment Event	Loss of other coverage; gaining a new dependent through marriage, birth, adoption, or placement for adoption; gaining eligibility for Medicaid or CHIP coverage or a state premium assistance program under Medicaid or CHIP
Entitlement to Medicare or Medicaid	Gaining or losing eligibility to Medicare or Medicaid
Judgment, Decree, or Order	A judgment, decree, or order (such as a QMCSO) requires you to cover your dependent child under the Plan
Change Under Another Employer's Plan	Loss or gain of coverage due to another employer's plan (e.g., loss of coverage or a change associated with a different open enrollment period) (must be allowed under both plans)
Loss of Coverage Under Government/Educational Plan	Includes CHIP, Indian Health Service, state risk pools, or foreign government plans
Significant Change in Coverage	If the cost of coverage is significantly increase or decreased, or if benefits are

	significantly improved or curtailed (this event does not apply to the HCFSA or LPFSA)

Note: Under Code Section 125 rules, changes to your benefits must be consistent with the QLE and limited to the affected individual(s).

For example, if you child loses eligibility for coverage due to age or other reasons, you can remove coverage for that child only and cannot remove coverage for yourself or any other covered dependents, unless they are also affected by the same event.

Note about HSA mid-year changes: Unlike most other benefits, you can start, change or end your HSA contributions at any point during the year - as long as you're enrolled in the HDHP. See the Health Savings Account Plan Details for details on how to make mid-year changes.

3.2.3 Changes during Annual Enrollment

Each fall, you'll have a chance to review and update your benefit elections for the upcoming calendar year. During the two-week Annual Enrollment (AE) window, an enrollment event in *My Benefits & Retirement* will automatically appear for you to make changes.

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network)
4. From the *My Benefits & Retirement* homepage, click the **Enroll in your benefits** tile
5. Click **Go to Enrollment** and follow the prompts to navigate through the benefits election process

Once the window closes, your elections are locked in for the year - unless you experience a QLE.

Passive vs. Active Elections during Annual Enrollment

For your convenience, most benefits will **automatically renew** during Annual Enrollment unless you make changes. Flexible Spending Account (FSA) benefits do not automatically renew and **require you to re-enroll** each year.

Passive (Automatically renew)	Active (Require re-enrollment)
• Medical • Dental • Vision • Health Savings Account • Supplemental Life Insurance • Family Life Insurance • Accident Insurance • Critical Illness Insurance • Hospital Indemnity Insurance	• Health Care FSA • Limited Purpose FSA • Dependent Care FSA

• Group Legal Plan • Supplemental Long-Term Disability	

If you do not take any action during AE, your current elections for benefits that are passive will carry over at the **new plan year rates**. Your current elections for FSA benefits that require active re-enrollment will be waived for the new plan year.

3.2.4 Enrolling and making changes to Commuter Benefits

You may enroll, change, or cancel your Commuter Benefits at any time, based on your commuting needs through the *My Benefits & Retirement* app in Workday.

1. Go to **Workday** (https://wd3.myworkday.com/bmo/login.htmld)
2. Click the **My Benefits & Retirement** app
3. Select your network status (on or off BMO network)
4. From the *My Benefits & Retirement* homepage, click the **Reimbursement Accounts** tab
5. Click **Commuter Account** and **Manage my commuter benefits** to navigate through the election process

3.3 When coverage ends

Your coverage under the Plan (and most component plans) ends on the **last day of the month** in which any of the following occur:

- Your employment with BMO ends for any reason*
- You become ineligible to participate* (see 1.1 Employee Eligibility Requirements)
- You fail to pay premiums when due
- The Plan terminates coverage for employees

Your **dependent's coverage** ends on the **last day of the month** in which any of the following occur:

- Your employment with BMO ends for any reason*
- You or your covered dependents become ineligible to participate* (see 1.2 Dependent Eligibility Requirements)
- You divorce or become legally separated from your spouse
- You no longer share a sole, committed relationship with your domestic partner
- You fail to pay premiums when due
- The Plan terminates coverage for employees, dependents, or domestic partners
- Your dependent fails the verification process

***Note:** Coverage will end on your termination date or the date you became ineligible for benefits for the DCFSA, life insurance benefits, Business Travel Accident, Accident Insurance, Group Legal benefit, disability benefits, and Commuter Benefits.

In most cases, you and your dependents may be eligible to continue coverage through **COBRA** when coverage ends. It is your responsibility to notify BMO of any change in your or your dependent's status that affects eligibility (e.g., a divorce, legal separation, end of domestic partnership, or a dependent child aging out) within **60 days** of the change in order for COBRA coverage to be offered.

Retroactive Cancellation of Coverage

BMO relies on the accuracy and completeness of the information you provide. If you or your dependents engage in fraud or make material misrepresentations in connection with the Plan, the Plan reserves the right to take appropriate corrective actions. These actions may include the denial or reversal of benefits, retroactive cancellation of coverage, and/or termination of eligibility under the Plan.

3.4 What happens to benefits during a Leave of Absence

Approved Leave

If your leave is approved (e.g., FMLA, Short Term Disability, Maternity, Parental, Military), your benefits coverage generally continues. Here's how it works:

- **Paid Leave**:
  Coverage continues uninterrupted. Premiums and contributions are deducted from your pay as usual.
- **Unpaid Leave**:
  Coverage continues, and you are responsible for payments for any premiums and contributions missed during your leave. Missed deductions will accumulate in arrears and be collected when you return (typically one extra deduction per pay period until paid in full).

  For extended unpaid leave, you may be contacted to arrange direct payment to maintain your coverage.
- **Military Leave**:
  Coverage continues at active employee rates for the full duration of your approved military leave.
    - During your one year of paid military leave, premiums and contributions are deducted from your pay as usual.
    - If you continue to be on military leave longer than one year, you are responsible for payments for any premiums and contributions missed during your unpaid military leave. Missed deductions will accumulate in arrears and be collected

when you return (typically one extra deduction per pay period until paid in full).

For an extended military leave, you may be set-up to make direct payments through our Billing Administrator to maintain your coverage.

At the onset of your military leave you may also choose to waive your coverage. When you return to work following your leave, your coverage will be reinstated without a waiting period as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Unapproved Leave

If your leave is not approved or you do not return as expected:

- Coverage ends on the last day of the month in which your employment ends.

Long-Term Disability Leave

If you are on an approved Long-Term Disability (LTD) leave, your medical, dental, and vision coverage will continue for 3 years from the date you are approved for LTD income replacement benefits. At the end of the 3 years of coverage, you will be offered COBRA continuation coverage and/or Retiree Medical, if eligible.

4.0 Paying for benefits

Some benefits under the Plan are paid entirely by BMO, some are paid entirely by employees, and others are shared between BMO and employees.

If you're responsible for part of the cost, your contributions will be deducted from your **bi-weekly paycheck**, either **pre-tax or after-tax**, depending on IRS rules.

Most BMO-paid contributions are **non-taxable**, but there are a few exceptions where IRS regulations require the value of employer-paid premiums or coverage to be treated as **taxable income**.

Component plan	Type of Plan	Who contributes	Tax Treatment of Premiums
Medical	Self Insured (BCBSIL/ESI) Fully-Insured (Kaiser)	You & BMO	Pre-tax & Non-taxable*
Dental	Self Insured	You & BMO	Pre-tax & Non-taxable*
Vision	Fully Insured	You	Pre-tax*
Health Savings Account	Not Applicable	You & BMO	Pre-tax & Non-taxable
Health Care Flexible Spending Account	Self Insured	You	Pre-tax

Limited Purpose Flexible Spending Account	Self Insured	You	Pre-tax
Dependent Care Flexible Spending Account	Not Applicable	You	Pre-tax
Basic Life Insurance	Fully Insured	BMO	Non-taxable & taxable**
Supplemental Life Insurance	Fully Insured	You	After-tax
Family Life Insurance	Fully Insured	You	After-tax
Business Travel Accident Insurance	Fully Insured	BMO	Non-taxable
Accident Insurance	Fully Insured	You	After-tax
Critical Illness Insurance	Fully Insured	You	After-tax
Hospital Indemnity Insurance	Fully Insured	You	After-tax
Group Legal Plan	Not Applicable	You	After-tax
Commuter Benefits	Not Applicable	You	Pre-tax & After-tax***
Short term Disability	Self Insured	BMO	Non-taxable
Long term Disability	Self Insured	BMO	Non-taxable
Supplemental Long term Disability	Self Insured	You	Pre-tax
Employee Assistance Program	Fully Insured	BMO	Non-taxable

** If you elect to cover a Non-Tax Dependent Domestic Partner under your Medical, Dental, or Vision plans, the portion of premiums attributed to their coverage will be treated as after-tax and taxable income.*

*** The first $50,000 of Basic Life Insurance coverage is non-taxable. Any coverage amounts exceeding $50,000 are treated as taxable income in accordance with IRS regulations.*

**** Contributions toward commuter benefits are considered pre-tax up to the applicable IRS limits. If you choose to exceed these limits for certain products, the excess amounts will be treated as after-tax.*

Missed Contributions during a Leave, during a Suspension without pay, or due to Low Earnings

If you miss a paycheck due to a leave of absence or a suspension without pay, or don't have enough earnings to cover your benefit deductions, you're still responsible for paying your share of premiums.

Your missed deductions for the following benefits will be tracked and collected in **arrears** and repayments will be added to future paychecks (at a rate of one additional deduction per payroll until your arrears balance is zero) along with your regular deductions for the following benefits:

- Medical, Dental, Vision
- Supplemental Life Insurance & Family Life Insurance
- Accident, Critical Illness & Hospital Indemnity Insurance
- Group Legal Plan
- Supplemental Long-Term Disability
- Commuter Benefits

If your arrears balance reaches a certain threshold, you may receive a notification from Inspira, our billing vendor, with instructions to make payments outside of payroll to resolve the owed premiums.

Your HSA and FSA contributions will automatically recalculate and adjust based on the number of remaining pay periods in the year. This ensures your total deductions align with your annual election amount.

5.0 Administrative Information about the Plan

This SPD outlines the provisions of the Plan, a group health plan governed by ERISA. The Plan offers a comprehensive suite of benefits to eligible employees, including medical, prescription drug, dental, vision, employee assistance program, life insurance, disability coverage, and health flexible spending accounts. These benefits are administered in accordance with applicable federal regulations and internal policies to ensure consistent, equitable, and compliant delivery of services.

5.1 Plan Identification

Plan number: 507

Employer Identification Number: 51-0275712

Plan year: January 1 – December 31

Plan sponsor: BMO Financial Corp.

Plan administrator: Benefits Administration Committee (“Committee”)

The Plan sponsor and Plan administrator can be contacted at:

BMO Financial Corp.
Benefits Administration Committee
320 South Canal Street, Floor 8
Chicago, IL 60606
Human Resources Centre (HRC): 1-888-927-7700
Email: usbenefits@bmo.com

Plan Administration and Discretionary Authority: The Plan Administrator has full discretionary authority to interpret and apply the terms of the Plan, including making determinations regarding eligibility for benefits and resolving factual questions. This authority extends to interpreting Plan provisions and ensuring that the Plan is administered in accordance with its terms and applicable laws.

Oversight of the Plan is entrusted to the Committee, whose principal duty is to ensure the Plan is carried out for the exclusive benefit of Plan participants. Unless delegated to another named fiduciary or claims administrator, the Committee retains full discretionary power to administer the

Plan in all respects. The Committee's decisions regarding the interpretation of the Plan and related matters are final and binding on all parties.

The Plan administrator has delegated certain responsibilities to the claims administrators and insurers, including the authority to interpret and apply Plan provisions, make factual determinations, and decide claims and appeals. Benefits under the Plan will only be paid if the Plan administrator or claims administrator, or insurer, as applicable, determines in its discretion that the claimant is entitled to them.

Plan trustee: The Plan trustee for the Plan is BNY Mellon and can be reached at:

BNY Mellon Client Service Center
500 Ross Street, 8th Floor
Pittsburgh, PA 15262-0001

Agent for service of legal process: The Plan administrator is the agent for legal process against the Plan. Legal process may also be served upon the Plan trustee.

Type of funding: The Plan is funded by the employer's general assets, employee contributions, and a trust.

Future of the Plan Statement: BMO reserves the right to amend, modify, replace, or terminate the Plan or any part of it at any time, for any reason. Such actions may be taken by the Board of Directors, an authorized administrative committee, or other designated individuals.

If changes occur, you will be properly notified.

Please note:

- Health and welfare benefits do not vest like retirement benefits.
- If the Plan is terminated, you will only receive benefits for covered expenses incurred before the Plan termination date.

5.2 Claims Administrators, Third Party Administrators, and Service Providers

The applicable claims administrators, insurers, and service providers are listed below.

Company	Services Provided	Contact Information
Alight Solutions	Benefits System and Human Resources Center (HRC) System Service Provider and Benefits Administrator	Alight Solutions – HR Benefits Dept 14613 PO Box 64050 The Woodlands, TX 77387-4050 HRC: 1-888- 927-7700

Strada	HR System (Workday) and Payroll Processing Service Provider	HRC: 1-888- 927-7700
Inspira Financial Health, Inc	COBRA & Direct Billing Administrator	Inspira Financial Health, Inc Benefits Billing Department PO Box 953374 St. Louis, MO 63195-3374 www.inspirafinancial.com Member Services: 1-888-678-7835 BMO Employer ID: 139888
Blue Cross Blue Shield of Illinois (BCBSIL)	Self-Insured Medical Plan Claims Administrator	bcbsil.com Member Services: 1-888-979-4516 Network Information: • **FL residents:** Blue, Group #266889 (HDHP), #323728 (PPO) • **WI residents:** Blue Preferred POS (Wisconsin), Group #266820 (HDHP), #323729 (PPO) • **NJ residents:** Horizon Managed Care Network Group #323722 (HDHP), #323733 (PPO) • **All other state residents:** Participating Provider Organization (PPO), Group #190565 (HDHP), #323725 (PPO)
Express Scripts	Prescription Benefit Manager for Self-Insured Medical Plan	express-scripts.com/bmofinancialgroup Member Services: 1-877-795-2926 Group #: BMOFGRX; BIN#610014
Kaiser Permanente	Fully Insured Medical Plan Provider and Prescription Coverage	kp.org Member Services by region: • N. California: #1932: 1-800-464-4000 • S. California: #102000: 1-800-464-4000 • Oregon: #3992: 1-800-813-2000 • Colorado: #22343: 1-800-632-9700
GeoBlue	Fully Insured Medical and Dental Plan Provider for U.S. Expatriates	Member Services: Outside the U.S.: 1-610-230-2406 Within the U.S.: 1-888-304-8898 customerservice@geo-blue.com

Delta Dental of Illinois	Self-Insured Dental Plan Claims Administrator	Delta Dental of Illinois PO Box 5402 Lisle, IL 60532 www.deltadentalil.com Member Services: 1-800-323-1743 Group #: 20246
VSP Vision	Fully Insured Vision Insurer	bmo.vspforme.com Member Services: 1-800-877-7195 Group #: 30028445
Alight Dependent Verification Center	Dependent Verification Service Provider	Dependent Verification Center PO Box 299109 Lewisville, TX 75029-9109 HRC: 1-888- 927-7700
Alight SmartChoice Accounts	HSA trustee & FSA Claims Administrator	HRC: 1-888- 927-7700
EdenRed Benefits	Commuter Benefits Service Provider	HRC: 1-888- 927-7700
AIG Insurance Company of Canada	Business Travel Accident Plan Insurer	AIG Insurance Company of Canada 2000 McGill College Ave, Suite #920 Montreal, Quebec H3A 3H3 AHClaimsCan@aig.com Policy #: 9906-96-62 For BMO Internal Support on Business Travel Accident Claims contact Corporate Risk at: CorporateRisk.Insurance@bmo.com
Voya (Reliastar Life Insurance Company)	Life Insurance & Voluntary Benefits (Accident Insurance, Critical Illness Insurance, & Hospital Indemnity Insurance) Insurer	voya.com Member Services for: • Life Insurance: 1-800-955-7736 • Voluntary Benefits: 1-877-236-7564 Group #: 29316-4
ARAG Legal	Group Legal Plan Service Provider	araglegal.com/account/login Member Services: 1-800-247-4184
Reliance Matrix Absence Management	Leave of Absence and Disability Claims Administrator	Matrix Absence Management, Inc. 2421 W. Peoria Avenue, Suite 200 Phoenix, AZ 85029 matrixabsence.com

		Member Services: 1-888-295-7862
ALLSUP	SSDI Advocacy & Coordination Service Provider	www.allsup.com Customer Service (SSDI Benefits): 1-800-405-8339
TELUS Health	Employee Assistance Program Service Provider	one.telushealth.com User ID: BMO_US Password: Wellness@BMO EAP Member Support: 1-800-757-0327

5.3 Claims and Appeals Procedures

Claims for benefits (e.g., group health plan or other ERISA benefit claims/appeals) under the Plan are governed by ERISA. Other claims and appeals (e.g., eligibility and enrollment requests without a claim for benefits, dependent verification appeals) are governed by the rules in 5.3.1 (Coverage Appeal), 5.3.2 (Eligibility Appeal), and 5.3.3 (Dependent Verification Denial Appeal). BMO and its delegates will administer the Plan in a fair, consistent, and compliant manner. As such, the Plan must adhere strictly to the rules and criteria outlined in this SPD and related plan documents. **Exceptions to these rules are not permitted.**

However, you have the right to appeal a decision made by the Plan or its delegate if you believe an error occurred or if there were extenuating circumstances that impacted the outcome. The Plan provides a formal appeals process to ensure that all decisions are reviewed fairly and consistently.

There are four types of appeals available under the Plan:

- Coverage Appeal
- Eligibility Appeal
- Dependent Verification Denial Appeal
- Claim Denial Appeal

5.3.1 Coverage Appeal

A Coverage Appeal applies when you are denied the opportunity to enroll in the Plan or any of the component benefits. This may occur if:

- You miss your initial enrollment deadline as a newly eligible employee
- You do not take action during AE
- You fail to act within the required timeframe following a QLE
- You do not have a valid QLE that would allow you to enroll or make changes
- You made an unintentional change/omission during an enrollment event

Filing a First Level Coverage Appeal

1. Initial Contact
    - Call the Human Resources Centre (HRC) at 1-888-927-7700 to discuss your concern.
    - If the issue is not resolved to your satisfaction, proceed to file a formal appeal.
2. Prepare Your Appeal
    - Your appeal must be submitted in writing and include:
        - Your name
        - Your employee ID
        - A clearly written explanation of the issue
        - Any supporting documents showing:
            - Extenuating circumstances that prevented timely action
            - Evidence of an error
3. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
          BMO Financial Corp.
          C/O Appeals DEPT 14613
          PO Box 64050
          The Woodlands, TX 77387-4050
        - By Fax: 1-866-894-6684
4. Review Process
    - The Benefits Administrator (Alight) will respond to your appeal within 30 days.
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

Filing a Second Level Coverage Appeal

If your first level coverage appeal is denied by the Benefits Administrator, you have the right to receive a secondary review by the Plan Administrator, BMO's Benefits Administration Committee.

1. Timing
    - You must submit your second level appeal **within 60 days** of receiving the denial of your first-level coverage appeal.
2. Prepare Your Second Level Appeal
    - Your appeal must be submitted in writing and include:
        - Your name
        - Your employee ID
        - A clearly written explanation of the issue including why your coverage denial should be reconsidered
        - Any supporting documents showing:

        - Extenuating circumstances that prevented timely action or justification why your situation falls outside of Plan rules
        - Evidence of an error
        - Any additional supporting documentation not submitted during the first level appeal that you feel helps your case
    - Upon request, you can receive copies of all documents and information relevant to your appeal free of charge by contacting usbenefits@bmo.com.

3. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
          BMO Financial Corp.
          Benefits Administration Committee
          C/O BMO U.S. Benefits Team
          395 N. Executive Drive, 3rd Floor - HR
          Brookfield, WI 53005
        - By Email: usbenefits@bmo.com

4. Review Process
    - The Benefits Administration Committee will respond with a **final and binding decision** within:
        - 60 days, or
        - 120 days if an extension is required
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

5.3.2 Eligibility Appeal

An eligibility appeal applies when you or your dependents are denied eligibility to participate in the Plan or any of the component benefits. This may occur if:

- You do not meet the employee eligibility criteria outlined in Section 1.1 Employee eligibility requirements.
- You attempt to enroll a dependent who does not meet the criteria outlined in Section 1.2 Dependent eligibility requirements.

Filing a First Level Eligibility Appeal

1. Initial Contact
    - Call the Human Resources Centre (HRC) at 1-888-927-7700 to discuss your concern.
    - If the issue is not resolved to your satisfaction, proceed to file a formal appeal.

2. Prepare Your Appeal
    - Your appeal must be submitted in writing and include:

        - Your name
        - Your employee ID
        - A clearly written explanation of the issue
        - Any supporting documents showing:
            - Extenuating circumstances that justify your case falls outside Plan rules
            - Evidence of an error

3. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
            BMO Financial Corp.
            C/O Appeals DEPT 14613
            PO Box 64050
            The Woodlands, TX 77387-4050
        - By Fax: 1-866-894-6684

4. Review Process
    - The Benefits Administrator (Alight) will respond to your appeal within 30 days.
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

Filing a Second Level Eligibility Appeal

If your first level eligibility appeal is denied by the Benefits Administrator, you have the right to receive a secondary review by the Plan Administrator, BMO's Benefits Administration Committee.

1. Timing
    - You must submit your second level appeal **within 60 days** of receiving the denial of your first-level eligibility appeal.

2. Prepare Your Second Level Appeal
    - Your appeal must be submitted in writing and include:
        - Your name
        - Your employee ID
        - A clearly written explanation of the issue including why your eligibility denial should be reconsidered
        - Any supporting documents showing:
            - Extenuating circumstances that justify why your situation falls outside of Plan rules
            - Evidence of an error
            - Any additional supporting documentation not submitted during the first level appeal that you feel helps your case

- Upon request, you can receive copies of all documents and information relevant to your appeal free of charge by contacting usbenefits@bmo.com.

3. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
          BMO Financial Corp.
          Benefits Administration Committee
          C/O BMO U.S. Benefits Team
          395 N. Executive Drive, 3rd Floor - HR
          Brookfield, WI 53005
        - By Email: usbenefits@bmo.com

4. Review Process
    - The Benefits Administration Committee will respond with a **final and binding decision** within:
        - 60 days, or
        - 120 days if an extension is required
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

5.3.3 Dependent Verification Denial Appeal

A dependent verification denial appeal applies when one or more of your dependents are denied coverage during the dependent verification process (see Section 1.2.1 Dependent Verification Requirement). This may occur if:

- All of the required documentation is not submitted by the deadline
- Submitted documentation does not clearly demonstrate the dependent's eligibility
- You dependent has been determined to be ineligible based on the criteria outlined in Section 1.2 Dependent eligibility requirements

Filing a First Level Dependent Verification Denial Appeal

1. Initial Contact
    - Call the Dependent Verification Center via the HRC at 1-888-927-7700 to discuss your concern.
    - If the issue is not resolved to your satisfaction, proceed to file a formal appeal.

2. Timing
    - You must submit your appeal **within 60 days** from the later of:
        - The coverage termination date, or
        - The eligibility enrollment date

3. Prepare Your Appeal

- Your appeal must be submitted in writing and include:
  - Your name
  - Your employee ID
  - A clearly written explanation of the issue
  - Any supporting documents showing:
    - The required documentation has been/is now being provided
    - Comments or records
    - Evidence of extenuating circumstances that prevented timely completion of the verification process
    - Evidence of an error

Note: Submitting an appeal does **not guarantee reinstatement** of your dependent(s). You must demonstrate a valid reason for missing the verification deadline.

4. Submit Your Appeal
   - Send your appeal and documentation to:
     - By Mail:
       Dependent Verification Claims and Appeals Team
       PO Box 299102
       Lewisville, TX 75029-9102
5. Review Process
   - The Dependent Verification Claims and Appeals Team will respond to your appeal within 30 days of receiving your appeal.
   - If more information is needed, you'll be notified.
   - You must provide any requested information within 30 days, or your appeal will be considered invalid.

Filing a Second Level Dependent Verification Denial Appeal

If your first level dependent verification denial appeal is denied by the Dependent Verification Claims and Appeals Team, you have the right to receive a secondary review by the Plan Administrator, BMO's Benefits Administration Committee.

5. Timing
   - You must submit your second level appeal **within 60 days** of receiving the denial of your first level dependent verification denial appeal.
6. Prepare Your Second Level Appeal
   - Your appeal must be submitted in writing and include:
     - Your name
     - Your employee ID
     - A clearly written explanation of the issue including why your dependent verification denial should be reconsidered
     - Any supporting documents showing:

        - Extenuating circumstances that justify why your situation falls outside of Plan rules
        - Evidence of an error
        - Evidence that all required documentation has been/is being submitted now
        - Any additional supporting documentation not submitted during the first level appeal that you feel helps your case
    - Upon request, you can receive copies of all documents and information relevant to your appeal free of charge by contacting usbenefits@bmo.com.

7. Submit Your Appeal
    - Send your appeal and documentation to:
        - By Mail:
            BMO Financial Corp.
            Benefits Administration Committee
            C/O BMO U.S. Benefits Team
            395 N. Executive Drive, 3rd Floor - HR
            Brookfield, WI 53005
        - By Email: usbenefits@bmo.com

8. Review Process
    - The Benefits Administration Committee will respond with a **final and binding decision** within:
        - 60 days, or
        - 120 days if an extension is required
    - If more information is needed, you'll be notified.
    - You must provide any requested information within 30 days, or your appeal will be considered invalid.

5.3.4 Claim Denial Appeals

Claims for Benefits: Deadline to File Claims

Unless otherwise provided in the applicable Welfare Program Document, you must file a claim for benefits within 365 days following the date the service was rendered. For details regarding the claims submission process of a specific component benefit, see the applicable Welfare Program Document listed in the chart below.

Claims Administrator	Where to find Appeal Procedures
Blue Cross Blue Shield of Illinois	• HDHP: 2025 BCBSIL HDHP Booklet • PPO: 2025 BCBSIL PPO Booklet
Express Scripts	2025 Prescription Drug Plan Details
Kaiser Permanente	HDHPs:

	• Kaiser Permanente Colorado HSA Evidence of Coverage • Kaiser Permanente S. California HSA Evidence of Coverage • Kaiser Permanente N. California HSA Evidence of Coverage • Kaiser Permanente Northwest HSA Evidence of Coverage DHMOs: • Kaiser Permanente Colorado DHMO Evidence of Coverage • Kaiser Permanente S. California DHMO Evidence of Coverage • Kaiser Permanente N. California DHMO Evidence of Coverage • Kaiser Permanente Northwest DHMO Evidence of Coverage
Delta Dental of Illinois	2025 Delta Dental Benefits Booklet
VSP Vision	VSP Vision Certificate of Coverage
Smart-Choice Accounts (FSAs)	HCFSA and LPFSA Plan Details
Voya	• Life Insurance: Life Insurance Schedule of Benefits • Accident Insurance: Accident Insurance Certificate of Coverage • Critical Illness Insurance: Critical Illness Insurance Certificate of Coverage • Hospital Indemnity Insurance: Hospital Indemnity Insurance Certificate of Coverage
AIG Insurance Company of Canada (Business Travel Accident Insurance)	To appeal a decision about a denied claim, contact AIG at (416) 596-4005 or 1-877-317-8060. If you need to further appeal your denied claim, follow the "Standard Claim for Benefits procedure – Appeals".
ARAG Legal	To appeal a decision about a denied or uncovered claim or service, contact ARAG Legal at 1-800-247-4184. If you need to further appeal your denied claim, follow the "Standard Claim for Benefits procedure - Appeals".
Matrix Absence Management	STD: 2025 Short-Term Disability Plan Details LTD: 2025 Long-Term Disability Plan Details
TELUS Health	For Appeals related to denied EAP services, contact EAP Member Support: 1-800-757-0327. If you need to further appeal your denied claim, follow the "Standard Claim for Benefits procedure – Appeals".

Standard Claims for Benefits procedure: Initial Claims

Unless otherwise provided in the applicable Welfare Program Document, your claim for benefits will be processed under the procedures described below. ****Note: the procedures listed below are default claims procedures and apply only when the applicable Welfare Program Document does not provide for a specific claims procedure (Where it does, you must follow the specific claims procedure provided there).****

Medical, Dental, and/or Vision ***Urgent Claims*** Any claim for medical care or treatment where making a	Notice of the Plan's determination will be sent as soon as possible considering the medical exigencies, and in no case later than 72 hours after receipt of the claim. You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive

determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.	a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.
Medical, Dental, and/or Vision ***Pre-Service Claims*** A claim for services that have not yet been rendered and for which the Plan requires prior authorization.	If your pre-service claim is improperly filed, you will be notified within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If the insurer or claims administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the insurer or claims administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The insurer or claims administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Medical, Dental, Vision, Employee Assistance Program, and/or Health FSAs ***Post-Service Claims*** A claim for services that already have been rendered, or where the Plan does not require prior authorization.	Notice of the Plan's determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. If the insurer or claims administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the insurer or claims administrator expects to render a determination. If

	the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The insurer or claims administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Disability Claims	Notice of the Plan's determination will be sent within a reasonable time period, but not longer than 45 days from receipt of the claim. If the insurer or claims administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended for two additional 30-day periods. You will receive notice prior to each extension that indicates the circumstances requiring the extension, the date by which the insurer or claims administrator expects to render a determination, the standards on which entitlement to a benefit is based, and the unresolved issues that prevent a decision on the claim. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The insurer or claims administrator then will make its determination within 30 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Life, AD&D, Business Travel Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance, and/or Legal	Notice of the Plan's determination will be sent within a reasonable time period, but not longer than 90 days from receipt of the claim. If the insurer determines that an extension is necessary due to special circumstances, this time may be extended for an additional 90 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the insurer expects to render a determination.

Standard Claims for Benefits procedure: Appeals

Refer to the Welfare Program Document for procedures to file claim for benefits or related appeal.

Unless otherwise stated in the applicable Welfare Program Document, you must file your appeal related to a specific coverage, treatment, eligibility determination, or benefit within the deadline

set out in the chart below. Requests for appeals should be sent to the address specified in the denial notice.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will have access to all documents that are relevant to your claim. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, the insurer or claims administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the insurer or claims administrator will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on appeal will be made within the time periods specified below.

****Note: the procedures listed below are default appeal procedures and apply only when the applicable Welfare Program Document does not provide for a specific appeal procedure (Where it does, you <u>must</u> follow the specific appeal procedure provided there).****

Medical, Dental, and/or Vision ***Urgent Claims***	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). You will be notified of the determination as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
Medical, Dental, and/or Vision **Pre-Service Claims**	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). For both the first and second levels of appeal of a Pre-Service claim, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 15 days from the date your request is received (30 days if there is only one level of appeal).
Medical, Dental, Vision, Employee Assistance Program, and/or Health FSAs **Post-Service Claims**	You must submit your appeal within 180 days of the date of your initial denial notice (or first level appeal notice, for second level appeals). For both the first and second levels of appeal of a Post-Service claim, you will be notified of the determination within a reasonable period of time, but no later than 30 days from

	the date your request is received (60 days from the date if there is only one level of review).
Disability Claims	You must submit your appeal within 180 days of the date of your initial denial notice. You will be notified of the determination within a reasonable time, but not later than 45 days from receipt of the request for review. If the insurer or claims administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 45 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the insurer or claims administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The insurer or claims administrator then will make its determination within 45 days from the date it receives your information, or, if earlier, the deadline to submit your information.
Life, AD&D, Business Travel Accident Insurance, Critical Illness Insurance, Hospital Indemnity Insurance, and/or Legal	You must submit your appeal within 60 days of the date of your initial denial notice. You will be notified of the determination within a reasonable time, but not later than 60 days from receipt of the request for review. If the insurer determines that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the insurer expects to render a determination.

Concurrent Care

If an ongoing course of treatment was previously approved for a specific period or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated.

If the claim is a request for an urgent extension of concurrent care and the request is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, you will be notified of the decision, whether adverse or not, as soon as possible but no later than 24 hours after receipt of the claim. If your request for extended treatment is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as an urgent care claim and decided according to the urgent care time frames listed above.

If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Plan does not involve urgent care, your request will be considered a new claim and will be decided according to pre-service or post-service timeframes, whichever applies.

Appeals of concurrent care claims will be governed according to applicable timeframes (urgent care, pre-service, or post-service) listed in the tables above.

Standard Claims for Benefits procedure: Notice of Determination

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will, where applicable:

- State specific reason(s) for the adverse determination;
- Reference specific Plan provision(s) on which the benefit determination is based;
- Describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim);
- Describe the Plan's claims review procedures and the time limits applicable to such procedures (initial claim);
- Include a statement of your right to bring a civil action under ERISA section 502(a) following appeal. For appeals of claims for disability benefits, this statement will also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action and the calendar date on which the contractual limitations period expires for the claim;
- State that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (all appeals and disability claims);
- Describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (all appeals);
- Disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request) (group health plan claims and appeals);
- If the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or state that such information will be

provided free of charge upon request (group health plan claims and appeals and disability claims and appeals);

- Include the following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.” (group health plan appeals);
- Include a description of an expedited review process for group health plans concerning a claim involving urgent care;
- Include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount (medical claims and appeals);
- Include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning (medical claims and appeals);
- Include the denial code and its corresponding meaning and a description of the Claims Administrator’s or Insurer’s standard, if any, that was used in denying the claim (medical claims and appeals);
- Describe any internal appeals and the external review process, if applicable, including information regarding how to initiate an appeal (medical claims and appeals);
- Include a statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (medical claims and appeals);
- Include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made by the Social Security Administration regarding the claimant (disability claims and appeals); and
- Include either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist (disability claims and appeals).

5.3.5 Limitation of Legal Action

You may not bring legal action against BMO Financial Corp., the Benefits Administration Committee, any Claims Administrator, or the Plan unless you have completed the full appeal

process. Legal action must be filed within **12 months** of the final appeal decision; otherwise, your right to sue is waived.

Mandatory Venue
All lawsuits related to the Plan - including claim disputes - must be filed in **federal court in Cook County, Illinois**, which has exclusive jurisdiction over the Plan.

5.4 Coordination of Benefits

Coordination of Benefits (COB) applies when you or your covered dependents are enrolled in more than one group health plan, including medical, dental, or vision coverage. The purpose of COB is to ensure that you receive the full benefits to which you are entitled without exceeding the actual cost of care. Total payments from all plans combined will not exceed the provider's billed charges.

It is your responsibility to notify the claims administrator/insurer of any other group coverage that may apply.

Plans Subject to COB

COB applies if you are covered by more than one health benefits plan, including but not limited to:

- Another employer-sponsored medical, dental, or vision plan
- A medical component of a group long-term care plan (e.g., skilled nursing care)
- No-fault or fault-based auto insurance medical benefits
- Medical payment benefits under premises liability or other liability coverage
- Medicare or other government-sponsored health benefits

How COB Works

When you have a claim, determine which plan is your **primary plan** (see *Determining Your Primary Plan* below). Submit your claim to the primary plan first. Once processed, send the Explanation of Benefits (EOB) and itemized bills to the **secondary plan**, which will consider payment for any remaining eligible expenses.

Determining Your Primary Plan

The following rules determine which plan pays first:

1. **Employee vs. Dependent**: The plan covering the individual as an employee pays before a plan covering the individual as a dependent.
2. **Dependent Children (Birthday Rule)**:
    - The plan of the parent whose birthday (month and day only) falls earlier in the year pays first.

- If both parents share the same birthday, the plan covering the parent for the longer period pays first.
- If one plan uses a gender-based rule and the other uses the birthday rule, the gender-based rule applies.

3. **Divorced or Separated Parents**:
    - First: Plan of the parent with custody
    - Second: Plan of the custodial parent's spouse
    - Third: Plan of the non-custodial parent
    - If a court decree assigns responsibility for health coverage, that parent's plan pays first (if the plan is aware of the decree).
    - If joint custody is assigned without specifying responsibility, the birthday rule applies.
4. **Active vs. Retired/Laid Off**: The plan of an active employee pays before that of a retired or laid-off employee.
5. **Length of Coverage**: If none of the above rules apply, the plan that has covered the individual for the longest time pays first.

Claims Processing

If your BMO plan provides **secondary coverage**, the claims administrator/insurer is not obligated to pay until it receives proof of payment and benefit calculation from the **primary carrier**.

In all cases, the combined benefits from both plans will not exceed the provider's billed fees. The Plans will not be liable for more than they would have paid if no other coverage existed.

Right of Recovery

This Plan reserves the right to recover benefit payments made for an allowable expense that exceed the maximum amount the Plan is required to pay under the COB provisions. This right of recovery may be exercised against:

1. Any person to, for, or with respect to whom such payments were made; or
2. Any other insurance company or organization that, under these provisions, owes benefits for the same allowable expense under another plan.

The Plan alone will determine against whom this right of recovery will be exercised.

5.5 Subrogation and Reimbursement

This section applies to the Blue Cross Blue Shield of Illinois self-insured medical plans only.

The Plan has rights to subrogation and reimbursement when benefits are paid for an illness or injury caused by a third party. References to "you" and "your" include any covered person

(including spouses, domestic partners, and dependents) and their estate, heirs, and beneficiaries unless otherwise noted.

Subrogation

If the Plan pays benefits for an illness or injury caused by a third party, it may pursue recovery from that party in your name.

> **Example:**
> You're injured in a car accident caused by another driver. The Plan may seek reimbursement from that driver or their insurer for the cost of your treatment.

Reimbursement

If you receive a settlement, judgment, or other recovery from a third party for an illness or injury for which the Plan paid benefits, you must repay the Plan 100% of those benefits.

> **Example:**
> You're injured in a boating accident and receive a settlement. You must use those funds to reimburse the Plan for any benefits paid related to that injury.

Third Parties Include:

- Individuals or entities responsible for your illness or injury
- Their insurers or indemnifiers
- Workers' compensation carriers
- Auto, homeowners', or other insurers (including underinsured/uninsured motorist coverage)
- Parties liable under legal or equitable theories
- Those involved in malpractice claims related to your illness or injury

Subrogation and Reimbursement Obligations

By participating in the Plan, you agree to support the Plan's rights to recover costs from third parties responsible for your illness or injury. This includes:

Your Responsibilities

- Cooperate fully with the Plan, including:
  - Notifying the Plan of potential third-party claims
  - Providing requested information
  - Signing documents to secure recovery rights
  - Responding to inquiries and attending legal proceedings
  - Obtaining Plan consent before releasing liability or settling claims
- Hold recovered funds in trust until the Plan is reimbursed
- Assign rights to the Plan for any applicable insurance benefits (e.g., auto, no-fault, PIP)
- Do not accept settlements that fail to fully reimburse the Plan without written approval

Enforcement Actions

If you fail to comply with these terms, the Plan may:

- Terminate or deny future benefits for you, your dependents, or the subscriber
- Take legal action and recover attorneys' fees, costs, and interest
- Offset future benefits equal to unrecovered amounts

Plan's Recovery Rights

- The Plan has a first-priority right to recover 100% of benefits paid, before any other claims (including provider liens)
- Recovery applies to all types of damages, regardless of how proceeds are labeled
- The Plan's rights are not limited by doctrines such as "made whole," "common fund," or "collateral source"
- These rights apply even if:
    - You are no longer covered under the Plan
    - You or your estate receive funds after death
    - A dependent child is involved

Administrative Authority

The Plan and its administrators have full discretionary authority to:

- Interpret and enforce subrogation and reimbursement provisions
- Determine amounts owed to the Plan

Legal Enforcement

- The Plan may take legal action, including filing suit in your name or your estate's name
- You and your representative are considered fiduciaries under ERISA for any recovered amounts

5.6 Your Rights Under ERISA

As a participant in the Plan, you are entitled to certain rights and protections under **ERISA**. These include:

Access to Plan Information

- Review, at no cost, Plan documents (including insurance contracts and the latest annual report) at the Plan administrator's office or designated locations.
- Request copies of Plan documents and reports in writing; reasonable fees may apply.
- Receive a summary of the Plan's annual financial report.

Continuation of Coverage

- Elect COBRA continuation coverage for yourself, your spouse, or dependents following a COBRA qualifying event. You may be required to pay for this coverage. Refer to section 5.7 Information about COBRA Continuation for details.

Fiduciary Responsibilities

- Plan fiduciaries must act prudently and in your best interest.
- No one may interfere with your rights under the Plan or ERISA, including through discrimination or termination.

Enforcing Your Rights

- If your request for documents is ignored for more than 30 days, you may file suit in federal court. The court may impose penalties unless the delay was beyond the Plan administrator's control.
- If your benefit claim is denied or ignored, you may file suit after exhausting the Plan's claims process.
- You may also take legal action if:
    - You disagree with decisions about domestic relations or medical child support orders.
    - Plan fiduciaries misuse Plan assets.
    - You are retaliated against for asserting your rights.

ERISA Assistance and Questions

For help with ERISA rights or obtaining documents, contact the Employee Benefits Security Administration (EBSA) at:

- **U.S. Department of Labor**
  Division of Technical Assistance and Inquiries
  200 Constitution Avenue, N.W.
  Washington, D.C. 20210
- Phone: 1-866-444-3272
- Website: www.dol.gov/ebsa

5.7 Information about COBRA Continuation

COBRA (Consolidated Omnibus Budget Reconciliation Act) is a federal law that allows employees and their covered spouses and dependent children ("qualified beneficiaries") to temporarily continue their group health coverage after it would otherwise end due to certain life events.

COBRA Covered Plans

The extension of coverage through COBRA applies to medical, dental, vision, HCFSA, LPFSA, and the EAP.

COBRA continuation coverage for medical, dental, vision, HCFSA, and LPFSA is offered at the qualified beneficiary's expense and is designed to help bridge the gap in coverage during transitions, such as employment changes or other qualifying circumstances.

COBRA coverage for the HCFSA or LPFSA is only available if the account is “underspent” (i.e., the maximum benefit available for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the plan year) at the time of the qualifying event. COBRA continuation for the HCFSA or LPFSA is limited to the end of the plan year in which the COBRA qualifying event occurred; however, any carryover amount is available for the maximum COBRA continuation period (as outlined below). If COBRA is elected, the qualified beneficiary must pay the remaining HCFSA/LPFSA contributions on an after-tax basis, plus a 2% administrative fee. This allows access to the full annual election amount for eligible expenses incurred through the end of the plan year (plus carryover amounts for the maximum COBRA continuation period).

COBRA continuation for the Employee Assistance Program is provided automatically and at no cost to qualified beneficiaries for the duration of the COBRA continuation period. To access EAP services during your COBRA continuation period, contact **TELUS Health** directly.

COBRA Qualifying Events

COBRA qualifying events include job loss, reduction in work hours, divorce, or a dependent child aging out of coverage. The following table outlines COBRA qualifying events and the maximum duration of COBRA coverage.

COBRA qualifying event	Who can elect COBRA coverage (Qualified Beneficiaries)	Maximum continuation period
Loss of benefits eligibility: your work schedule is reduced below 20 hours per week***	You and any of your covered dependents	18 months*
Termination of your employment (except in the case of gross misconduct)***	You and any of your covered dependents	18 months*
Your death	Your covered dependents	36 months
Divorce or legal separation from your spouse	Your spouse and your covered children (if they lose eligibility under the Plan due to the divorce or legal separation)	36 months
End of relationship status with your domestic partner	Your domestic partner and their covered children	36 months
Your entitlement to Medicare (Parts A, B, or both)	Your covered dependents**	36 months
Your child no longer meets the criteria to be a dependent under the Plan (due to age, child’s disability status or other loss of dependency)	Your child that lost eligibility under the Plan	36 months

** Coverage may be extended by an additional 11 months if a qualified beneficiary is deemed disabled by the Social Security Administration within the first 60 days of COBRA coverage. Coverage for covered dependents who elect COBRA can also be extended for 18 additional months if the qualified beneficiary experiences a second qualifying event. See section above regarding the maximum continuation period for the HCFSA and LPFSA.*

*** Medicare entitlement is only a qualifying event if it results in loss of coverage.*

****If, within 18 months after becoming entitled to Medicare, you subsequently lose coverage under the Plan due to your termination of employment or reduction in hours, your spouse/domestic partner and dependent child become entitled to COBRA coverage for a maximum period that ends 36 months after you become entitled to Medicare. You remain entitled to a maximum period that ends 18 months after the termination of employment or reduction of hours.*

Note: While domestic partners are not federally recognized as qualified beneficiaries under COBRA, BMO and the Plan treats them as such.

COBRA Coverage Notification and Election

If you or any of your covered dependents lose coverage under the Plan (for the benefit options outlined above), and you timely provide notice of the qualifying event (if required), a COBRA election notice packet will be sent via mail. This notice includes instructions for enrolling and outlines the monthly premium cost. COBRA benefits match those offered to active employees, but you pay the full premium (both employee and employer portion) plus a 2% administrative fee.

Qualified COBRA beneficiaries have **60 days** from the later of the date COBRA election notice packet is received or the date the coverage ends to elect COBRA coverage. If the election deadline is missed, you and/or your dependents will lose the right to continue coverage.

Payment and Coverage Activation

Your first COBRA payment is due within **45 days** of your election and must cover the period from the date your coverage ended through the current month. Coverage is retroactive once both the enrollment form and payment are received by Inspira Financial and may take 7–10 business days to be reinstated by the claims administrator or insurer.

Each qualified beneficiary has the right to elect coverage independently. For example, a spouse may elect COBRA even if the employee does not.

COBRA Notification Requirements

You or your dependents must notify the BMO within **60 days** of the following qualifying events:

- Divorce or legal separation
- End of a relationship with a domestic partner
- A dependent losing eligibility

Failure to notify within 60 days will result in loss of COBRA continuation rights for those covered dependents (qualified beneficiaries). They will be removed from your active coverage backdated to the event date (the date they no longer meet the criteria to be a covered dependent) but will not be offered extended coverage through COBRA.

Special Circumstances for COBRA Coverage Extension

COBRA continuation coverage generally lasts 18 or 36 months but may be extended in certain cases. You must notify Inspira Financial of these events within required timeframes to qualify.

Disability Extension

If a qualified beneficiary is deemed disabled by the Social Security Administration (SSA) within the first 60 days of COBRA coverage, an **11-month extension** may apply. Notify Inspira within **60 days** of the latest of:

1. SSA's disability determination
2. The qualifying event
3. Loss of coverage
4. Receipt of COBRA notice

Notice must be submitted before the initial 18-month period ends. If SSA later determines the individual is no longer disabled, notify Inspira within 30 days. Coverage ends when SSA disability status ends.

Second Qualifying Event

Spouses/domestic partners and dependent children may receive an **additional 18 months** (up to 36 months total) if a second qualifying event occurs during the initial 18-month period. Events include:

- Death of the covered employee
- Divorce/separation or end of domestic partnership
- Employee's Medicare entitlement (but only if this would have caused the loss of active coverage)
- Dependent child losing eligibility

Notify Inspira within **60 days** of the second event. Late notice may result in loss of your extended coverage opportunity.

Send all extension notices to:

Inspira Financial Health, Inc.
Benefits Billing Department
P.O. Box 953374
St. Louis, MO 63195-3374
Phone: 1-888-678-7835

COBRA Continuation Coverage Termination

COBRA coverage will automatically end when the maximum continuation period is reached but may end sooner if:

- A qualified beneficiary chooses to cancel COBRA coverage sooner
- Required premiums are not paid on time
- A qualified beneficiary becomes covered under another group health plan
- A qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) after electing COBRA
- BMO stops offering group health coverage
- Coverage would have ended for reasons such as fraud or other disqualifying actions
- SSA determines the individual is no longer disabled (if receiving the 11-month disability extension)

Once COBRA coverage is canceled, re-enrollment is not allowed.

Special Enrollment Rights under other group plans

When you are deciding whether to enroll in COBRA continuation coverage, you should consider that you may qualify for special enrollment in another group health plan (e.g., through a spouse's employer), Medicaid, or the Health Insurance Marketplace (www.healthcare.gov) within 30 days of losing coverage due to a qualifying event. These options may be more affordable than COBRA.

- More information is available in the COBRA Continuation of Rights legal notice on www.bmousbenefits.com.

COBRA Implications if you are Eligible for BMO's Retiree Plan

If you are eligible for coverage under the BMO U.S. Health and Welfare Benefit Plan for Retirees ("The Retiree Plan") and you elect COBRA continuation coverage for medical at retirement, you will permanently forfeit your right to enroll in the Retiree Plan.

However, you may elect COBRA continuation coverage for your dental, vision, HCFSA or LPFSA at retirement without impacting your eligibility for the Retiree Plan.

Medicare and COBRA: What You Need to Know

If you delay enrolling in Medicare Part A or B because you're still employed, you'll have an 8-month special enrollment period to sign up beginning on the earlier of:

- The month after your employment ends.
- The month after your active employer-based group health coverage ends.

Important Considerations:

- If you elect COBRA instead of enrolling in Medicare, you may face a late enrollment penalty and a gap in coverage if you later decide to enroll.

- If you enroll in Medicare Part A or B after electing COBRA, your COBRA coverage may be terminated early.
- However, if Medicare Part A or B is effective before your COBRA election, COBRA coverage cannot be terminated due to Medicare entitlement.

Coordination of Benefits:

- If you are enrolled in COBRA and are eligible for Medicare, Medicare pays first (primary), and COBRA pays second (secondary). Therefore, if you do not enroll in Medicare, you will be responsible for the costs that Medicare would have paid.

For more details about Medicare, visit www.medicare.gov/medicare-and-you.

5.7.1 Subsidized COBRA for Survivors

Survivors of deceased employees may continue medical coverage for up to 36 months by applying for continuation coverage under COBRA. During the 36-month period, covered dependents will pay the active medical employee premiums. In a mailing from Inspira, you will receive information regarding COBRA including monthly premiums and enrollment forms. If the employee met the requirements for medical coverage under the Retiree Medical Plan at the time of their death and both the employee and the survivors were enrolled in the medical plan immediately before the employee's death; surviving dependents have the option to enroll in the Retiree Medical Plan or elect continuation coverage under COBRA.

It is important to know that if you choose to enroll in subsidized COBRA coverage for medical instead of Retiree Medical Plan coverage, your rights to enroll in Retiree Medical Plan coverage in the future are forfeited.

5.8 Other Important Legal Notices Governing the Plan

BMO and the Plan are required to provide certain legal notices, including:

- COBRA Continuation of Rights
- Creditable Coverage Notice
- Employee Rights Under FMLA
- HIPAA Notice of Privacy Practices
- Marketplace Health Insurance Coverage Options Notice
- Notice of Special Enrollment Rights
- Medicaid and the Children's Health Insurance Program (CHIP)
- Women's Health and Cancer Act of 1998
- Notice for Illinois Employees

These notices will be provided to you in October of each year and are also available at any time on www.bmousbenefits.com. You may also contact the HRC at 1-888-927-7700 to request paper copies of these notices or this SPD at any time.

5.9 Privacy and Protected Health Information

During the administration of the Plan, certain BMO personnel, claims administrators, and insurers may have access to information classified as “protected health information” (PHI) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To support our compliance with HIPAA, the Plan annually provides employees with a HIPAA Notice of Privacy Practices outlining how PHI may be used and disclosed, as well as your rights and protections under the law. This Privacy Notice is also available online at any time on www.bmousbenefits.com.

If you would like to request a paper copy of the Privacy Notice, have questions about how your PHI is handled or have concerns, please contact the HIPAA Privacy Officer:

Head of U.S. Benefits
395 N. Executive Drive, 3rd Floor-HR
Brookfield, WI 53005
usbenefits@bmo.com

5.10 Uncashed Claims Reimbursement Checks

If a benefit payment or reimbursement check remains uncashed after **180 days** (or the expiration date printed on the check, if later), it will be handled as follows:

- **Paid from BMO Assets**:
  The funds will be returned to the bank or BMO.
- **Paid from a Trust Fund**:
  The funds will be returned to the trust fund.
- **Paid by an Insurer**:
  Treatment of uncashed checks will follow the insurer’s policies.

5.11 Employment Disclaimer

Participation in this Plan does not create a contract of employment between BMO Financial Corp. and any employee.

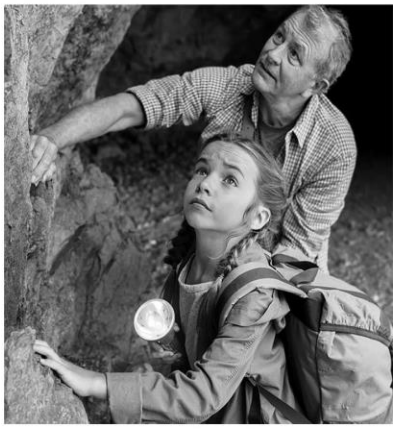
Being a Plan participant does not grant current or future employment rights, and Plan participation is not a condition of employment.

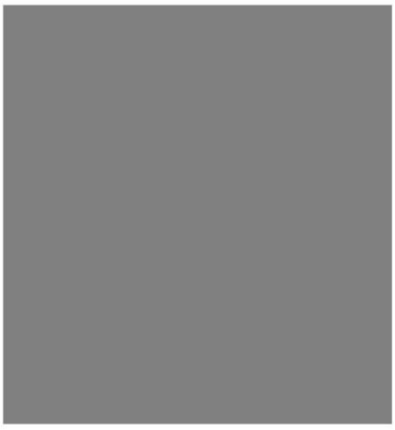
BMO U.S. Health and Welfare Benefit Plan

2025 BCSIL HDHP Booklet

Administered by:

BlueCross BlueShield of Illinois








Your Health Care Benefits Program

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BMO Financial Corp

190565 266820 26689 323722

A message from

BMO Financial Corp

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department..

Sincerely,

BMO Financial Corp

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to the Plan's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the Plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your Identification Card.

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

UTILIZATION MANAGEMENT AND REVIEW	A special program designed to assist you in determining the course of treatment that will maximize your benefits described in this benefit booklet
Lifetime Maximum for all Benefits	Unlimited

The state of Utah's definition of what is an "essential health benefit" shall be the controlling definition used by the Plan in determining whether a particular benefit is an essential health benefit for purposes of compliance with the Patient Protection and Affordable Care Act.

Individual Coverage Deductible**	
— Participating Provider	$1,750 per benefit period
— Non-Participating and Non-Administrator Provider	$3,500 per benefit period
Family Coverage Deductible**	
— Participating Provider	$3,500 per benefit period
— Non-Participating and Non-Administrator Provider	$7,000 per benefit period
Individual Coverage Out-of-Pocket Expense Limit**	
— Participating Provider	$3,425 per benefit period
— Non-Participating Provider	$6,850 per benefit period
— Non-Administrator Provider	No limit
Family Coverage Out-of-Pocket Expense Limit**	
— Participating Provider	$6,850 per benefit period
— Non-Participating Provider	$13,700 per benefit period
— Non-Administrator Provider	No limit
Private Duty Nursing Service Benefit Maximum	60 visits per benefit period
Chiropractic and Osteopathic Manipulation Benefit Maximum	20 visits per benefit period
Naprapathic Services Benefit Maximum	20 visits per benefit period
Physical, Occupational, and Speech Therapies Combined Benefit Maximum***	60 visits per benefit period

Temporomandibular Joint Dysfunction and Related Disorders Benefit Maximum	No maximum
HOSPITAL BENEFITS	
Payment level for Covered Services from a **Participating Provider:**	
— Inpatient Covered Services	80% of the Eligible Charge
— Outpatient Covered Services	80% of the Eligible Charge
Payment level for Covered Services from a **Non-Participating Provider:**	
— Inpatient Covered Services	60% of the Eligible Charge
— Outpatient Covered Services	60% of the Eligible Charge
Payment level for Covered Services from a **Non-Administrator Provider**	60% of the Non-Participating Hospital Benefit Payment Level
Hospital Emergency Care	
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider	80% of the Eligible Charge
— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider	80% of the Eligible Charge
Emergency Room	$100 Copayment (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)

PHYSICIAN BENEFITS

Payment level for Surgical/
Medical Covered Services After you meet the Annual Deductible

— **Participating Provider**	80% of the Maximum Allowance
— **Non-Participating Provider**	60% of the Maximum Allowance
Payment level for Emergency Accident Care	80% of the Maximum Allowance
Payment level for Emergency Medical Care	80% of the Maximum Allowance

OTHER COVERED SERVICES

Payment level	80% of the Eligible Charge or Maximum Allowance

BLUE DISTINCTION CENTERS (BDC) &
BLUE DISTINCTION CENTERS PLUS (BDC+)
BENEFIT DIFFERENTIAL

(YOUR PROGRAM DEDUCTIBLE APPLIES TO THE BELOW BENEFITS, UNLESS OTHERWISE SPECIFIED.)

Payment level for Transplants

— BDC+ Designated Center	80% of the Eligible Charge
— BDC Designated Center	80% of the Eligible Charge
— Participating Provider	60% of the Eligible Charge
— Non-Participating Provider	60% of the Eligible Charge

TELEHEALTH AND TELEMEDICINE
Payment level for Telehealth Services

— Participating Provider (other than a specialist)	80% of the Maximum Allowance
— Participating Provider (Specialist)	80% of the Maximum Allowance
— Non-Participating Provider	60% of the Maximum Allowance

Payment level for Telehealth Services
for the treatment of Mental Illness

— Participating Provider (other than a specialist)	80% of the Maximum Allowance
— Non-Participating Provider	60% of the Maximum Allowance

HEARING BENEFITS

Benefit Payment Level	100% after Deductible of the U&C Fee*

Hearing Aids	
Lifetime Maximum	$5,000

***BENEFITS FOR AUTISM SPECTRUM DISORDER(S) WILL NOT APPLY TOWARDS AND ARE NOT SUBJECT TO ANY PHYSICAL, SPEECH OR OCCUPATIONAL THERAPY VISITS MAXIMUM.

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

*Usual and Customary Fee

***Should the Federal Government adjust the Deductible for High Deductible Plans as defined by the Internal Revenue Service, the Deductible amount in this benefit booklet will be adjusted accordingly.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

A1C TESTING....means blood sugar level testing used to diagnose prediabetes, type I diabetes, and type II diabetes, and to monitor management of blood sugar levels.

ACUPUNCTURIST.....means a duly licensed acupuncturist operating within the scope of their license.

ACUTE TREATMENT SERVICES.....means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of their certification.

AMBULANCE TRANSPORTATION.....means local transportation in specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means i) for ambulance providers that bill for Ambulance Transportation services through a Participating Hospital the Ambulance Transportation Eligible Charge is the applicable ADP, and ii) for all other ambulance providers, the Ambulance Transportation Eligible Charge is such provider's Billed Charge.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis, and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them, respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA experimental/investigational new drug application.

AUDIOLOGIST.....means a duly licensed Audiologist operating within the scope of their license.

A "Participating Audiologist" means an Audiologist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time Covered Services are rendered.

A "Non-Participating Audiologist" means an Audiologist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered.

AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a

particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness or Substance Use Disorders and is operating within the scope of such license.

BEHAVIORAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Prior Authorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Use Disorder.

BILLED CHARGES.....means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payer, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a "chargemaster."

BIOMARKER TESTING.....means the analysis of tissue, blood, or fluid biospecimen for the presence of a biomarker, including, but not limited to singly-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

BLUE DISTINCTION CENTERS (BDC).....means a health care Provider, Hospital, or medical facility recognized for their expertise in delivering specialty care. Please see the section entitled "Blue Distinction Centers" for more information.

BLUE DISTINCTION CENTERS+ (BDC+).....means a health care Provider, Hospital, or medical facility recognized for their expertise and efficiency in delivering specialty care. Please see the section entitled "Blue Distinction Centers" for more information.

BLUE DISTINCTION CENTERS (BDC) and BLUE DISTINCTION CENTERS+ (BDC+) BENEFIT DIFFERENTIAL PRODUCT.....means your employer has chosen to provide a lower out-of-pocket cost when you utilize a BDC or BDC+ designated provider for certain specialty care procedures and treatment.

CARE COORDINATION.....means organized, information-driven patient care activities intended to facilitate the appropriate responses to participant's health care needs cross the continuum of care.

CARE COORDINATION FEE.....means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A "Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A "Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A "Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse and is operating within the scope of such license; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A "Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor and is operating within the scope of their license.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of their license.

A "Participating Clinical Professional Counselor" means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker operating within the scope of their license.

A "Participating Clinical Social Worker" means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL STABILIZATION SERVICES.....means a 24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

CLINICIAN.....means a person operating within the scope of their license, registration or certification in the clinical practice or medicine, psychiatry, psychology, or behavior analysis.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders. Congenital or Genetic Disorders may also include, but is not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

CONTRACTED PROVIDER.....means a Participating Provider and a Participating Professional Provider, collectively.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician, a Physician Assistant who has been authorized by a Physician to prescribe those services, or an advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. This program includes physical, occupational and speech therapists and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service or Custodial Care Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health plan under Section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (including but not limited to dressings, administration of routine medications, ventilator suctioning and other care) and are to assist with activities of daily living (including but not limited to bathing, eating and dressing).

DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services before benefits are provided.

DENTIST.....means a duly licensed dentist operating within the scope of their license.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease, or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans, positron emission tomography (PET) scans.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services, when operating within the scope of such license.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Dialysis Facility" means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of at least a year with indefinite duration with a person of the same or opposite sex which meets the following criteria:

- you share a sole, committed relationship with each other that has existed for at least one year and is expected to last indefinitely;
- you are jointly responsible for each other's welfare and financial obligations;
- you share your principal place of residence;
- you are both at least 18 years old and mentally competent to consent to a contract;
- neither of you is married to, legally separated from or in another domestic partner relationship with anyone else; and
- you are not related to each other in a way that would prohibit a legal marriage from being recognized in the state in which you live.

The following documentation that demonstrates you meet the eligibility requirements is required. Two of the items listed must be provided, however, additional documentation may be requested if necessary to determine eligibility.

- Federal and State Tax Returns
- Domestic Partnership Agreement
- Joint mortgage, lease or ownership of real estate property
- Primary beneficiary designation for will, life insurance and/or retirement benefits
- Assignment of durable power of attorney
- Joint ownership of motor vehicle or investments
- Joint checking or credit account
- Joint responsibility for debts
- Other document stating common residency

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider, when operating within the scope of such license.

A "Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

EARLY ACQUIRED DISORDER.....means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to covered persons in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services for medical benefits are rendered by a Participating Provider, such Participating Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services for medical benefits are rendered ("Non-Participating Provider"), the following amount (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

(i) the lesser of (a) the Provider's Billed Charges, and (b) an amount determined by the Claim Administrator to be approximately 150% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be 150% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Eligible Charge cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 135% of the Provider's Billed Charges, provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to the covered person.

The Claim Administrator will utilize the same Claim processing rules, edits, or methodologies that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator Providers which may also alter the non-contracting Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The non-contracting Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Eligible Charge amount does not equate to the Non-Participating Provider's Claim Charge, you will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance, and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing, and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions, or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER or COMPANY.....means the company with which you are employed and which sponsors this Plan.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL or EXPERIMENTAL/INVESTIGA TIONAL SERVICES AND SUPPLIES.....means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, medical treatment includes medical, surgical, mental health treatment, Substance Use Disorder Treatment, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed programs in making its determination.

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HABILITATIVE SERVICES.....means Occupational Therapy, Physical Therapy, Speech Therapy, and other health care services that help an eligible person keep, learn, or improve skills and functioning for daily living, as prescribed by a Physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for an eligible person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this benefit booklet.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider, when operating within the scope of such license.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

A "Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care

Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

A "Non-Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special hospice care unit.

HOSPITAL.....means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for your-self but not your spouse and/or dependents.

INFERTILITY.....the inability to conceive a child after one year of unprotected sexual intercourse or the inability to attain or maintain a viable pregnancy.

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INTENSIVE OUTPATIENT PROGRAM.....means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Requirements: the Claims Administrator requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Claims Administrator, as set forth in the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.

LIFE-THREATENING DISEASE OR CONDITION.....means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury, or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist operating within the scope of their license.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service, or the reimbursement amount set by the Claim Administrator, or the Host Blue Plan for Providers designated as Participating Professional Providers for a particular Covered Service. All benefit payments for Covered Services rendered by Participating Professional Provider will be based on the Schedule of Maximum Allowances which such Provider has agreed to accept as payment in full (b) for Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with Non-Participating Providers):

(i) the Provider's Billed Charges, or;

(ii) the Claim Administrator's non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 150% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim. Notwithstanding the preceding sentence, (1) the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Provider's Billed Charges for such Covered Services, (2) the non-contracting Maximum Allowance for Ambulance Transportation services provided by Providers (other than Providers that bill through a Participating Provider, which use "Eligible Charge") will be such provider's Billed Charge, as described in the definition of Ambulance Transportation Eligible Charge, and (3) the non-contracting Maximum Allowance for other unsolicited Providers will be the same as the Maximum Allowance described in (a) above.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 100% of the Claim Administrator's rate for such Covered Services according to its current Schedule of Maximum Allowances. If there is no rate according to the Schedule of Maximum Allowances, then the Maximum Allowance will be 25% of Claim Charges.

The Claim Administrator will utilize the same Claim processing rules, edits, or methodologies that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the non-contracting Maximum Allowance for a particular Covered Service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The non-contracting Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Maximum Allowance amount does not equate to the Non-Participating Professional Provider's Claim Charge, you will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance, and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY/MEDICAL NECESSITY.....means that a specific medical, health care, supply or Hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply, or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies. Please refer to the *Exclusions – What Is Not Covered* section of this booklet for additional information.

The Claim Administrator will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of this Plan, the Claim Administrator will take into account the information submitted to the Claim Administrator by your Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessary to the circumstances surrounding the hospitalization or other health care, it is determined that the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's condition.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so as described in the *Claim Filing and Appeals Procedures* section of this booklet.

Below are some examples, not an exhaustive list, of hospitalization or other health care services and supplies that are not Medically Necessary:

1. Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
2. Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

3. Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
4. Hospitalization or admission to a Skilled Nursing Facility or Residential Treatment Center, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
5. The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL ILLNESS.....means a condition or disorder that involves a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

NAPRAPATH.....means a duly licensed Naprapath operating within the scope of such license.

A "Participyating Naprapath" means a Naprapath who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Naprapath" means a Naprapath who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-EMERGENCY FIXED-WING AMBULANCE TRANSPORTATION.....means Ambulance Transportation on a fixed-wing airplane from a Hospital emergency department, other health care facility or Inpatient setting to an equivalent or higher level of acuity facility when transportation is not needed due to an emergency situation. Non-Emergency Fixed-Wing Ambulance Transportation may be considered Medically Necessary when you require acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Non-Emergency Fixed-Wing Ambulance Transportation provided

primarily for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this Health Care Plan.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist operating within the scope of their license.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist operating within the scope of their license.

A "Participating Optometrist" means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Optometrist" means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider operating within the scope of their license.

A "Participating Orthotic Provider" means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Orthotic Provider" means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment in which patients spend days or nights. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an Inpatient unit, i.e., medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24-hour supervision and are not considered a resident at the program. Requirements: The Claim Administrator requires that any Mental Illness and/or Substance Use

Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means a state and federally licensed establishment that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which they practice.

PHYSICAL THERAPIST.....means a duly licensed physical therapist operating within the scope of their license.

PHYSICAL THERAPY.....means the treatment of a disease, injury, or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of their license.

PHYSICIAN ASSISTANT.....means a duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of their license.

PODIATRIST.....means a duly licensed podiatrist operating within the scope of their license.

PRIOR AUTHORIZATION.....means a requirement that you must obtain authorization from the Claim Administrator before you receive certain types of Covered Services designated by the Claim Administrator.

PRIOR AUTHORIZATION or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Behavioral Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider operating within the scope of their license.

A "Participating Prosthetic Provider" means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Prosthetic Provider" means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you and operating within the scope of such license.

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A "Participating Provider" means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A "Non-Participating Provider" means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A "Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

PROVIDER INCENTIVE.....means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed upon procedural and/or outcome measures for a particular population of participants.

PSYCHOLOGIST.....means a Registered Clinical Psychologist operating within the scope of such license.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois "Psychologists Registration Act" or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

QUALIFIED ABA PROVIDER.....means a Provider operating within the scope of their license registration or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

(i) Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without applied behavior analysis (ABA) service techniques; or

(ii) Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e., Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D), to supervise and provide treatment planning, with ABA services techniques; or

(iii) Health Care Practitioner who is certified as a provider under the TRICARE military health system, if requesting to provide ABA services; or

(iv) Master's level Clinician with a specific professional credential or certification recognized by the state in which the clinician is located; or

1. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or
2. If the Doctor or Medicine (MD) prescribes ABA, writes a MD order for services to be provided by a specific person.

For the para-professional/line therapist:

(i) Two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCABA) for the para-professional/therapist; or

(ii) A bachelor level or high school graduate having obtained a GED, OR a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist; or

(iii) A person who is "certified as a provider under TRICARE military health system," if requesting to provide ABA services.

RECOMMENDED CLINICAL REVIEW.....means an optional voluntary review of Provider's recommended medical procedure, treatment, or test, which does not require Prior Authorization, to make sure it meets approved Claim Administrator medical policy guidelines and Medical Necessity requirements.

REGISTERED DIETICIAN.....means a duly licensed clinical professional counselor operating within the scope of their license.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of their certification.

A "Participating Registered Surgical Assistant" means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Registered Surgical Assistant" means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESCISSION.....means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if

counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

A "Participating Retail Health Clinic" means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Retail Health Clinic" means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services and operating within the scope of such license.

An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the

lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist operating within the scope of their license.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

SUBSTANCE USE DISORDER.....means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

SUBSTANCE USE DISORDER TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An "Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by the Claim Administrator.

TELEHEALTH AND TELEMEDICINE SERVICES.....means a health care service delivered by a health care professional licensed, certified, or registered to practice in Illinois and acting within the scope of their license, certification, or entitlement to a patient at a different physical location than the health care professional using telecommunications or information technology.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves and other tissues relating to that joint.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your Identification Card or visit our website at *www.bcbsil.com*.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

VALUE BASED PROGRAM.....means an out-come based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

VIRTUAL PROVIDER.....means a licensed Provider who has a written agreement with the Claim Administrator to provide diagnosis and treatment of injuries and illnesses through either i) interactive audio communication (via telephone or other similar technology) or ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology) to you at the time Covered Services are rendered, operating within the scope of such license.

VIRTUAL VISIT.....means a service provided for the diagnosis or treatment of non-emergency medical and/or behavioral health illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

VITAMIN D TESTING....means vitamin D blood testing that measures the level of vitamin D in a person’s blood.

ELIGIBILITY SECTION

Please refer to BMO Plan Documents.

UTILIZATION MANAGEMENT AND REVIEW

The Claim Administrator has established the Utilization Management and Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on the Claim Administrator's Medical Policy and, site or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Please refer to the definition of Medically Necessary under the *Definitions* section of this booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

The Utilization Management and Review Program requires a review of Inpatient Hospital Covered Services **before** maximum benefits for such services are available:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services
- Certain Outpatient Procedures

For In-Network benefits your Participating Provider is required to obtain Prior Authorization. There is no penalty to you for failure to notify the Claim Administrator.

For Non-Network Benefits you must obtain Prior Authorization from the Claims Administrator as soon as is reasonably possible. If you fail to obtain Prior Authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

PRIOR AUTHORIZATION

Prior Authorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Service designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled "THE BLUECARD PROGRAM."

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-

pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Identification Card.

Please read the provisions below very carefully. The provisions of this section do not apply to the treatment of Mental Illness and Substance Use Disorder Treatment. The provisions for the treatment of Mental Illness and Substance Use Disorder Treatment are specified in the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  Whenever a non-emergency or non-maternity Inpatient Hospital admission is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In the event of an emergency admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

- **Pregnancy/Maternity Admission Review**

  Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan.

  In the event of a maternity admission, in order to receive maximum benefits under this benefit booklet, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred. If the call is made any later than the specified time period, you will not be eligible for maximum benefits.

Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

  Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

  Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

  Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever Private Duty Nursing Service is recommended by your Physician, in order to receive maximum benefits under this benefit booklet, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

Outpatient Service Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan.

Whenever the following Outpatient procedure(s)/services(s), received from a Participating Provider, are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Coordinated Home Care Program services
- Home hemodialysis
- Home Hospice
- Home Infusion Therapy

- Home Health
- Private Duty Nursing
- Transplant Evaluations and Transplants
- Cardiology Lipid Apheresis

Ears, Nose and Throat (ENT):

- Bone Conduction Hearing Aids
- Cochlear Implant
- Nasal and Sinus Surgery

Gastroenterology (Stomach):

- Gastric Electrical Stimulation (GES)

Neurology:

- Deep Brain Stimulation
- Sacral Nerve Neuromodulation/Stimulation

Pain Management:

- Occipital Nerve Stimulation

Specialty Pharmacy:

- Specialty Pharmacy Medications covered by Medical Benefits including Infusion Site of Care, Medical Oncology & Supportive Care and Provider Administered Drug Therapies.

Surgical Procedures:

- Outpatient Surgery Jaw
- Outpatient Breast
- Surgical Deactivation of Headache Trigger Sites

Wound Care:

- Hyperbaric Oxygen (HBO2) Therapy-Systemic

Non-Emergency Fixed-Wing Ambulance Transportation:

Non-Emergency Fixed-Wing Ambulance Transportation - Please refer to the definition of "Non-Emergency Fixed-Wing Ambulance Transportation" under the DEFINITIONS section of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Whenever the following Outpatient services(s), received by a Non-Participating Provider, are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Dialysis

- Elective Surgery

If an Inpatient Emergency Hospital Admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Claim Administrator.

The Claim Administrator will send a letter to you, your Physician and the Hospital or facility with a determination of your Prior Authorization review no later than fifteen (15) calendar days after the Claim Administrator receives the request for Prior Authorization review. However, in some instances depending on the timing of the request for review, these letters will not be received prior to your scheduled date of service or procedure.

For specific details about the Prior Authorization requirements for any of the above referenced Outpatient services, please call the customer service toll-free telephone number on the back of your Identification Card. The Claim Administrator reserves the right to no longer require Prior Authorization during your benefit period for any or all of the listed services. Updates to the list of services requiring Prior Authorization may be confirmed by calling the customer service number.

RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of medical necessity for coverage determinations that may occur prior to services rendered, during care, or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. The Claim Administrator will review the request to determine if it meets approved Claim Administrator medical policy and, site, or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management.com for the Required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review.

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under this Plan. Please coordinate with your Provider to submit a written request for a Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. No Guarantee of Payment

A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by the plan. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example,

the member may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. Request for Additional Information

The Recommended Clinical Review process may require additional documentation from the member's health care Provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms member eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. Post-Service Medical Necessity Review does not guarantee payment of benefits by the plan, for instance a member may become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from the member's health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the Inpatient or emergency admission review, the Claim Administrator will send a letter to you, your Physician, Provider of services, Behavioral Health Practitioner and/or the Hospital or facility with a determination on the approved length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the Plan for continued services. If you, your Provider, or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an Ongoing Course of Treatment, the Plan will make a determination on the request/appeal as soon as possible but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Plan will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information, as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.
3. will provide notification of the determination.

APPEAL PROCEDURE

If you, your Physician, Provider of health services, or Behavioral Health Practitioner disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your Identification Card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician, Provider of health services, or Behavioral

Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Blue Cross and Blue Shield of Illinois
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Management and Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

For In-Network benefits your Participating Provider is required to obtain Prior Authorization. There is no penalty to you for failure to notify the Claim Administrator.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Management and Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

The Claim Administrator's Behavioral Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Prior Authorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorders.

Failure to contact the Behavioral Health Unit or to comply with the determinations of the Behavioral Health Unit may result in a reduction of benefits. The Behavioral Health Unit, as described in this section, may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

Prior Authorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Service designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled "THE BLUECARD PROGRAM."

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Identification Card.

CONTACTING BEHAVIORAL HEALTH

You, your Physician, Provider of services, or your authorized representative may contact the Claim Administrator for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of your Identification Card and follow the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same behavioral health line is answered by clinicians available for Inpatient acute reviews only. Requests for residential or Partial Hospitalization are reviewed only during regular business hours.

PRIOR AUTHORIZATION REVIEW

- **Inpatient Hospital Prior Authorization Review**

  Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  To receive maximum benefits under this Health Care Plan, you must obtain Prior Authorization for your non-emergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Behavioral Health Unit. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Residential Treatment Center Prior Authorization Review**

  Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your Physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Behavioral Health Unit. This call must be made at least one day prior to scheduling of the admission. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

  Emergency Mental Illness or Substance Use Disorder Admission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Behavioral Health Unit no later than two business days or as soon as reasonably possible after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred.

  If the call is made any later than the specified time period, you may not be eligible for maximum benefits. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section.

- **Partial Hospitalization Treatment Program Review**

  Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you must notify the Behavioral Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied, as described in this section. The Behavioral Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

  If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

  Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Upon completion of the Prior Authorization or Emergency Mental Illness or Substance Use Disorder Review, the Behavioral Health Unit will send you a letter confirming that you or your representative called the Behavioral Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Behavioral Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Behavioral Health Unit Physician for review.

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

- **Outpatient Service Prior Authorization Review**

  Outpatient service Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  In order to receive maximum benefits under this Health Care Plan for Outpatient services for the treatment of Mental Illness or Substance Use Disorder, you must, except as otherwise provided, obtain Prior Authorization for the following Outpatient service(s) by calling the Behavioral Health Unit:

  - Psychological testing
  - Neuropsychological testing
  - Electroconvulsive therapy
  - Intensive Outpatient Programs

- Repetitive Transcranial Magnetic Stimulation
- Applied Behavior Analysis (ABA) Therapies (Please see coverage details as described in the Autism Spectrum Disorder(s) provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.)

Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the scheduling of the planned Outpatient services(s). The Behavioral Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Behavioral Health Unit. If the Behavioral Health Unit concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, benefit for some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner, and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Behavioral Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The Behavioral Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Behavioral Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Behavioral Health Unit determines that all or any portion of an Inpatient Hospital admission, Outpatient service, or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission, Outpatient service, or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders,

recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Behavioral Health Unit decides they were not Medically Necessary.

BEHAVIORAL HEALTH UNIT PROCEDURE

When you contact the Behavioral Health Unit to obtain Prior Authorization for your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and
4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Behavioral Health Unit to obtain Prior Authorization for your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Behavioral Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Prior Authorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Behavioral Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Behavioral Health Unit and requesting an expedited appeal. The Behavioral Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Behavioral Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Behavioral Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Behavioral Health Unit, you may appeal that decision by having your Behavioral Health

Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30-day period, you may review any relevant documents held by the Claim Administrator if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review, and you will be notified of this during the first 30-day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO OBTAIN PRIOR AUTHORIZATION OR NOTIFY

For In-Network benefits your Participating Provider is required to obtain Prior Authorization.

For Non-Network Benefits you must obtain Prior Authorization from the Claims Administrator as soon as is reasonably possible. If you fail to obtain Prior Authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

The final decision regarding your course of treatment is solely your responsibility and the Behavioral Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Behavioral Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

For Outpatient behavioral health services, there is no penalty to you for failure to notify the Claim Administrator. For Substance Use Disorder Treatment, there is no penalty to you for failure to notify the Claim Administrator for Inpatient Hospital admissions, Residential Treatment Centers and Partial Hospitalization Treatment Programs.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

CASE MANAGEMENT

You may call the Behavioral Health Unit at the number shown on your Identification Card to access a case manager. They may answer questions about your behavioral condition, help you understand what to expect when you are discharged from a behavioral health facility to your home or to another care facility and help coordinate special care you may need. The behavioral health case management program is designed to help those with mental health and/or substance use concerns manage the unique challenges of those conditions. A case manager may reach out to you via phone or letter to offer case management assistance.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois website at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location, and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

If you have Individual Coverage, each benefit period you must satisfy a $1,750 benefit program deductible for Covered Services rendered by Participating Provider(s) and a separate $3,500 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s) before receiving benefits. After you have Claims for Covered Services in a benefit period which exceed this deductible amount, your benefits will begin. The deductible will be referred to as the program deductible.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has satisfied the family deductible amount of $3,500 for Covered Services rendered by Participating Provider(s) and a separate $7,000 family deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet a benefit program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) will be required to meet the benefit program deductible before receiving benefits. No one is eligible for benefits under Family Coverage until the entire family deductible amount has been satisfied.

BLUE DISTINCTION® AND BLUE DISTINCTION SPECIALTY CARE PROGRAM

Blue Distinction® ("Blue Distinction") is a national designation awarded by Blue Cross and Blue Shield Plans to health care Providers. The Blue Distinction Specialty Care program includes two levels of designation: Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+).

The Blue Distinction Specialty Care program focuses on BDC and BDC+ providers that excel in providing safe, effective treatment for specialty care needs.

BLUE DISTINCTION CENTERS

The Blue Distinction designation uses nationally consistent criteria to designate high-performing providers based on objective, evidence-based selection criteria. The Blue Distinction Specialty Care program's purpose is to assist you in finding BDC and BDC+ providers that have met overall quality measures for patient safety and outcomes, fewer medical complications, lower readmission rates, and higher survival rates in the administration of specialty care.

Blue Distinction Centers provide care in the following specialty care areas:

- Cardiac Care
- Cellular Immunotherapy (CAR-T)
- Fertility Care*
- Substance Use Treatment and Recovery
- Gene Therapy
- Spine Surgery
- Bariatric Surgery
- Knee and Hip Replacement Surgery
- Maternity Care
- Transplants (Stem cell/bone marrow, solid organ (heart, liver, lung, kidney) and combination solid organ (heart/lung, liver/kidney, pancreas/kidney)

* BDC and BDC+ Fertility Care programs are currently supported by plans with Fertility Care programs at the professional level.

BDC and BDC+ Benefit Differential

Your plan offers lower out-of-pocket costs when you receive treatment at a BDC or BDC+ Provider for certain services related to Transplant service. You may choose to receive treatment at a non-BDC and/or non-BDC+ provider; however, your out-of-pocket costs will be higher. Please refer to your Benefit Highlights section to review the payment levels for procedures performed at a BDC or a BDC+ designated Provider, and procedures performed at other facilities. Blue Distinction benefit levels apply to Blue Distinction facility benefits only, except for Fertility, which offers Professional Provider services.

For additional information regarding Blue Distinction Centers for specialty care, please contact a customer service representative at the toll-free telephone number shown on your Identification Card or visit the following website: www.bcbs.com/blue-distinction-center/facility.

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board, and general nursing care when you are in:
   - a semi-private room
   - a private room
   - an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings, and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

You are entitled to benefits for 120 visits in a Coordinated Home Care Program per benefit period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider, benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery. In addition, benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient, and these services are related to Surgery or Medical Care
7. Urgent Care
8. Emergency Accident Care
9. Emergency Medical Care
10. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis
11. Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 80% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Accident Care will be subject to the Participating Provider program deductible.

Benefits for Emergency Medical Care will be provided at 80% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Medical Care will be subject to the Participating Provider program deductible.

Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of $100. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your Claim.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary, and you must receive such services on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

Certain services are covered pursuant to the Claim Administrator's medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by the Claim Administrator when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the benefit Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsil.com, or call customer service at the number listed on the back of your Identification Card.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them, and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth, including dental implants and;
4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

For non-accident related dental services, if any of the qualifiers below apply to the patient, anesthesia and facility charges related to the dental services are covered:

- Covered Person under age 6.
- Covered Person with a chronic disability and the following three conditions must be met:
- Attributable to medical or physical impairment.
- Likely to continue indefinitely.
- Results in substantial functional limitation (i.e. self-care, learning, ((no age restriction applies)).
- Covered Person has medical condition which requires hospitalization or general anesthesia for dental care (no age restriction applies).

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Surgical removal of cataracts.
4. Sterilization Procedures (even if they are voluntary).
5. Gender reassignment—benefits for Covered Services for gender reassignment Surgery, including related service and supplies, will be provided the same as any other condition.

A1C Testing

This plan provides benefits for A1C testing for prediabetes, type I diabetes, and type II diabetes mellitus.

Biomarker Testing

This plan provides benefits for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition, including Medically Necessary home saliva cancer screenings, once every twenty-four (24) months, if you are at high risk or showing symptoms of the disease being tested for.

Biomarker Testing means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes single-analyte tests, multiplex panel tests and whole genome sequencing.

Blood Glucose Monitors for Treatment of Diabetes

This plan provides benefits for Medically Necessary blood glucose monitors (including non-invasive monitors and monitors for the blind) if a Physician has provided a written order.

Comprehensive Cancer Testing

This plan provides benefits for Medically Necessary Comprehensive Cancer Testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene panels.

Pancreatic Cancer Screening

This plan provides benefits for Medically Necessary pancreatic cancer screenings.

Vitamin D Testing

This plan provides benefits for Vitamin D Testing in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or a Residential Treatment Center or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office, or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education, and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1C level within the ranges identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered, or licensed health care professionals with expertise in diabetes management, operating within the scope of their license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist for paraplegic covered persons who have a disease that requires them to wear leg braces; covered persons who are taking blood thinners; covered persons with decreased circulation; covered persons with severe cardiac health problems; covered persons at high risk for infections such as diabetes.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Occupational Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a licensed professional Physical Therapist; provided, however, when the therapy is beyond the scope of the Physical Therapist's license, the Physical Therapist must be under the supervision of a Physician, and the therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Physical Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 20 visits per benefit period.

Naprapathy—Benefits will be provided for naprapathy when rendered by a Naprapath. Benefits for naprapathy will be limited to a maximum of 20 visits per benefit period.

Radiation Therapy Treatments

This plan provides benefits for Medically Necessary radiation therapy treatments.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Speech Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Telehealth and Telemedicine Services

This plan provides benefits for Telehealth and Telemedicine Services as defined under the BENEFIT HIGHLIGHTS and DEFINITIONS section of this booklet.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Diagnostic Colonoscopies

Benefits will be provided for diagnostic colonoscopies, when determined to be Medically Necessary by a Physician, Advanced Practice Nurse, or Physician Assistant.

Benefits for diagnostic colonoscopies will be provided at no charge after your program deductible has been met.

Ovarian Cancer Screening

Benefits will be provided for annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or pap smear test.

Prostate Cancer Screening

Benefits will be provided for an annual routine prostate cancer screening.

Routine Liver Screening

Benefits will be provided at no charge for routine liver screenings, including liver ultrasounds and alpha-fetoprotein blood tests, for individuals who are at high risk for liver disease, every six months, after your program deductible has been met.

Bone Mass Measurement and Osteoporosis—Benefit will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Experimental/Investigational Treatment—Benefits will be provided for routine patient care in conjunction with experimental/investigational treatments when medically appropriate and you have cancer or a terminal condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an Approved Clinical Trial program. You and/or your Physician are encouraged to call customer service at the toll-free number on your Identification Card in advance to obtain information about whether a particular clinical trial is qualified.

Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Acupuncture—Benefits will be provided for acupuncture when rendered by a licensed acupuncturist. Benefits for acupuncture will be limited to 20 visits per calendar year.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), compression sleeves to prevent or mitigate lymphedema, bone screws, bolts,

nails, plates, and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck, or extremities, including but not limited to, leg, back, arm and neck braces, and those determined by your Provider to be most appropriate for physical activities, such as running, biking, swimming, and lifting. In addition, benefits will be provided for adjustments, repairs, or replacement of the device because of a change in your physical condition, as Medically Necessary.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants, and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures, and medical services provided on an Outpatient basis and related to the use of contraceptive methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, including those determined by your Provider to be most appropriate for physical activities, such as running, biking, swimming, and lifting, special appliances, and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Routine Pediatric Hearing Examination—Benefits will be provided for routine pediatric hearing examinations.

Pulmonary Rehabilitation Therapy—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Reconstructive Services

This plan provides benefits for Medically Necessary reconstructive services to restore physical appearance due to trauma.

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet. Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided at 60% of the Maximum Allowance after you have met your program deductible.

Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Medical Care will be provided at 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

However, Emergency Medical Care Covered Services for the examination and testing of a victim of criminal sexual assault or abuse to determine whether sexual contact occurred, and to establish the presence or absence of sexually transmitted disease or infection, will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible.

If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your Claim.

Participating and Non-Participating Professional Providers are:

- Acupuncturists
- Audiologists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Naprapaths
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Other Professional Providers
- Physical Therapists

- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Dentists*
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Physicians
- Podiatrists
- Psychologists
- Prosthetic Providers
- Registered Surgical Assistants
- Registered Dieticians
- Retail Health Clinics
- Speech Therapists

* Dentists are Non-Participating Providers, and will be treated as such for purposes of benefit payment made under this benefit booklet. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

Participating Providers have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the Covered Service—that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Professional Provider, or the Claim Administrator.

OTHER COVERED SERVICES

This section of your benefit booklet describes "Other Covered Services" and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service are limited to a maximum of 60 visits per benefit period.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration.
- Medical and surgical dressings, supplies, casts, and splints.
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia. Benefits for wigs will be limited to a lifetime maximum of $500.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible. For ambulances, if not related to a true emergency, the charges should be paid at 60% of Eligible Charge or 60% of the Maximum Allowances after you have met your program deductible.

Notwithstanding anything else described herein, Providers of ambulance services will be paid based on the amount that represents the billed charges from the majority of the ambulance Providers in the Metro area as submitted to the Claim Administrator. Benefits for Ambulance Transportation will be paid at the highest level available under this benefit program. However, you will be responsible for any charges in excess of this amount.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Participating and Non-Participating Professional Providers are:

- Acupuncturists
- Audiologists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Dentists*
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Naprapaths
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Other Professional Providers
- Physical Therapists
- Physicians
- Podiatrists
- Psychologists
- Prosthetic Providers
- Registered Surgical Assistants
- Registered Dieticians
- Retail Health Clinics
- Speech Therapists

* Dentists are Non-Participating Providers, and will be treated as such for purposes of benefit payment made under this benefit booklet. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

Participating Providers have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider, or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

— If both the donor and recipient have coverage each will have their benefits paid by their own program.

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation, and delivery of the donor organ.

— the removal of the organ from the donor.

— the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants will be provided as follows:

— **Whenever a heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 100 miles from the Hospital where the transplant will be performed.

— The maximum amount that will be provided for lodging is $50 per person per day with a maximum of $100 per day if more than one person.

— In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
- Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

Benefit Value Advisor

The Benefit Value Advisor (BVA) program has been established to assist members in maximizing their benefits under this benefit booklet. Benefit Value Advisors are trained customer service representatives who assist members by comparing coast and providing information on Participating Providers for certain types of health care services. A BVA helps member navigate their benefits.

In addition to calling the BVA, you may also have other call requirements. A call to the BVA does not satisfy any other call requirements you may have.

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this benefit booklet, (and notwithstanding anything in your benefit booklet to the contrary), the following preventive care services will be considered Covered Services and will not be subject to any deductible, Coinsurance, Copayment or dollar maximum (to be implemented in the quantities and within the time period allowed under applicable law or regulatory guidance) when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

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 (“USPSTF”);
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents;

4. with respect to women, such additional preventive care, and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA; and
5. Preventive Drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

A copay waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

For purposes of this Preventive Care Services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described in items 1. through 5. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator's website at *www.bcbsil.com* or contact customer service at the toll-free number on your Identification Card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must be provided, the Claim Administrator may use reasonable medical management techniques, including but not limited to, those related to setting and medical appropriateness to determine coverage.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.

Preventive Care Services for Adults (or others as specified):

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked
2. Unhealthy alcohol and drug use screening and counseling
3. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions
4. Aspirin use for prevention of cardiovascular disease for certain ages
5. Blood pressure screening
6. Cholesterol screening for adults of certain ages or at higher risk
7. Colorectal cancer screening for adults over age 45
8. Depression screening

9. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease
10. HIV screening for all adults at higher risk
11. HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition including baseline and monitoring services
12. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - Haemophilus influenzae type b (Hib)
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster (Shingles)
    - Human papillomavirus
    - Influenza (Flu shot or flu mist)
    - Measles, Mumps, Rubella
    - Meningococcal
    - MPOX
    - Pneumococcal
    - RSV
    - Tetanus, Diphtheria, Pertussis
    - Varicella
    - COVID-19
13. Obesity screening and counseling
14. Sexually transmitted infections (STI) counseling
15. Tobacco use screening and cessation interventions for tobacco users
16. Syphilis screening for adults at higher risk
17. Exercise interventions to prevent falls in adults aged 65 years and older who are at increased risk for falls
18. Hepatitis C virus (HCV) screening of infection in adults aged 19 to 79 years
19. Hepatitis B virus screening for persons at high risk for infection
20. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
21. Lung cancer screening in adults 50 and older who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
22. Screening for high blood pressure in adults aged 18 years or older
23. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese

24. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history of CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking) and (c) a calculated 10-year CVD risk of 10% or greater
25. Tuberculin testing for adults 18 years or older who are at risk of tuberculosis
26. Whole body skin examination for lesions suspicious for skin cancer

Preventive Care Services for Women (including pregnant women or others as specified):

1. Bacteriuria urinary tract screening or other infection screening for pregnant women
2. Perinatal depression screening and counseling
3. BRCA counseling about genetic testing for women at higher risk
4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive lactation support and counseling from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to one per benefit period.
6. Cervical cancer screening
7. Chlamydia infection screening for younger women and women at higher risk
8. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
9. Domestic and interpersonal violence screening and counseling for all women
10. Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant
11. Diabetes screening after pregnancy
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. HIV screening and counseling for women
16. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
17. Osteoporosis screening for women over age 65, and younger women with risk factors
18. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened
21. Sexually transmitted infections (STI) counseling
22. Syphilis screening for all pregnant women or other women at increased risk
23. Well-woman visits to obtain recommended preventive services

24. Urinary incontinence screening
25. Breast cancer mammography screenings, including breast tomosynthesis and, if determined to be Medically Necessary by a Physician, Advanced Practice Nurse or a Physician Assistant, a screening MRI and comprehensive ultrasound
26. Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal
27. Aspirin use for pregnant women to prevent preeclampsia
28. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
29. Behavioral counseling to promote healthy weight gain during pregnancy
30. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older

Preventive Care Services for Children (or others as specified):

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Critical congenital heart defect screening for newborns
7. Depression screening for adolescents
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children ages 9-11 and 17-21
10. Bilirubin screening in newborns
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns, children, and adolescents
15. Height, weight, and body mass index measurements
16. Hematocrit or hemoglobin screening
17. Hemoglobinopathies or sickle cell screening for all newborns
18. HIV screening for adolescents at higher risk
19. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B
    - Human papillomavirus

- Influenza (Flu shot or Flu mist)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Varicella
- Haemophilus influenzae type b
- Rotavirus
- RSV
- Inactivated Poliovirus
- Diphtheria, tetanus, and acellular pertussis
- COVID-19

20. Lead screening for children at risk for exposure
21. Medical history for all children throughout development
22. Obesity screening and counseling
23. Oral health risk assessment for younger children up to six years old
24. Phenylketonuria (PKU) screening for newborns
25. Sexually transmitted infections (STI) prevention and counseling for adolescents
26. Tuberculin testing for children at higher risk of tuberculosis
27. Vision screening for children and adolescents
28. Autism screening
29. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
30. Newborn blood screening
31. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision
32. Whole body skin examination for lesions suspicious for skin cancer

The FDA-approved contraceptive drugs and devices currently covered under this benefit provision are listed on the *Contraceptive Coverage List*. This list is available on the Claim Administrator's website at *www.bcbsil.com* and/or by contacting customer service at the toll-free number on your Identification Card. Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the *Contraceptive Coverage List*. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The *Contraceptive Coverage List* and the preventive care services covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Routine pediatric care, women's preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the

deductible, Coinsurance, Copayments and/or benefit maximums previously described in your benefit booklet, if applicable.

Preventive care services received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other routine Covered Services not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximums.

Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayments and/or benefit maximum when such services are received from a Participating Provider or Participating Pharmacy.

Vaccinations that are received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other vaccinations that are not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximum.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine laboratory tests;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray;
- Routine Pap smear;
- Routine Prostate Test;
- Routine digital rectal examinations and prostate tests.

Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge or 60% of the Maximum Allowance after you have met your program deductible.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board, and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 60% of the Eligible Charge once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

You are entitled to benefits for 60 days of care in a Skilled Nursing Facility per benefit period.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at 60% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder (a) by a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) by a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s), including but not limited to, a health care professional who is eligible as a Qualified ABA Provider by state regulation and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;
- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self-care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

Please review the Occupational Therapy, Physical Therapy and Speech Therapy provisions in this benefit booklet.

Note: Covered benefits for clinically appropriate Autism Spectrum Disorder services and Habilitative services will not be denied solely on the basis of where those services are provided.

HABILITATIVE SERVICES

Your benefits for Habilitative Services with Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met:

- a physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
- treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, or Psychologist upon the referral of a Physician; and
- treatment must be Medically Necessary and therapeutic and not Investigational.

SUBSTANCE USE DISORDER TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these covered services will also be provided for substance Use Disorder Treatment in a Residential Treatment Center. Substance Use Disorder Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder Treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefit for these Covered services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness or Substance Use Disorder in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet, the same as for any other condition.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your

newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 90 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and availability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

Your coverage also includes benefits for elective abortions.

FERTILITY CARE

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of infertility, or to promote fertility, including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, assisted insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer and intracytoplasmic sperm injection.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm, or embryos from you will be covered if you choose to use a surrogate.
2. Expenses incurred for cryo-preservation or storage of sperm, eggs, or embryos, except for those procedures which use a cryo-preserved substance. Please note, that benefits may be provided for fertility preservation as set forth in the FERTILITY PRESERVATION SERVICES provision of this benefit booklet.
3. Non-medical costs of an egg or sperm donor.
4. Fertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
5. Fertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in vitro fertilization.

Benefits for treatments that include oocyte retrievals are limited to lifetime maximum of four completed oocyte retrievals.

FERTILITY PRESERVATION SERVICES

Fertility preservation is covered when planned cancer or other medical treatment is likely to produce infertility/sterility (letter of medical necessity will need to be supplied). Coverage is limited to: collection of sperm, cryopreservation of sperm, ooctye cryopreservation, ovarian tissue cryopreservation, embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are the responsibility of the member.

ROUTINE MAMMOGRAMS

Benefits will be provided for routine mammograms for all women. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. Benefits for routine mammograms will be provided as follows:

— one baseline mammogram

— an annual mammogram

Benefits for routine mammograms will be provided for women who have a family history of breast cancer, prior personal history of breast cancer, positive genetic testing or other risk factors at the age and intervals considered Medically Necessary by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening and magnetic resonance imaging (MRI) screening of an entire breast or breasts, when determined to be Medically Necessary by your Physician.

Participating Providers

Benefits for routine mammograms when received from a Participating Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible.

Non-Participating Providers

Benefits for routine mammograms when received from a Non-Participating Provider will be provided at 60% of the Eligible Charge or Maximum Allowance after you have met your program deductible.

Benefit Maximum

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all Covered Services previously described under this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

PORT-WINE STAIN TREATMENT

Benefits for all of the Covered Services previously described under this benefit booklet are available for the treatment to eliminate or provide maximum feasible treatment of nevus flammeus, also known as port-wine stains, including, but not limited to, port-wine stains caused by Sturge-Weber Syndrome. This benefit does not apply to Port-Wine Stain Treatment, solely for cosmetic reasons.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge;
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered cosmetic surgery.

VIRTUAL VISITS

Benefits will be provided for Covered Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical and/or behavioral health injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care, emergency room or behavioral health office visit. Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with the Claim Administrator to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit the Claim Administrator's website at *www.bcbsil.com* or call customer service at the number on the back of your Identification Card.

Benefits for Covered Services you receive through a Virtual Visit from a Participating Virtual Provider will be provided at the same general payment level for Participating Providers as described under the BENEFIT PAYMENT FOR PHYSICIAN SERVICES provision in the PHYSICIAN BENEFIT SECTION of this benefit booklet.

Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with the Claim Administrator to provide Virtual Visits.

Note: Not all medical or behavioral health conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

TRAVEL BENEFITS

You will be reimbursed for travel expenses for transportation and lodging that you incur for travel that is necessary to obtain any Covered Service rendered by a Participating Provider if there is no Participating Provider able to perform that service located within 100 miles of your home address (such benefits referred to herein as "Travel Benefits"). Coverage is available for you and up to one companion, or, if the person receiving the Covered Service is under age 18, up to two companions. Reimbursement for lodging is limited to $50 per night for you and an additional $50 per night for each permitted companion. To obtain reimbursement, you will need to submit a form, which includes receipts and supporting documentation of your expenses. Meals are not reimbursable. Travel Benefits are limited to a cap of $4,000 per occurrence. Reimbursement is subject to the service, travel, and reimbursement being in accordance with all applicable laws or regulations.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $3,425, any additional eligible Claims for Participating Providers (except for those charges specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care, and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or Non-Administrator Provider
- Copayments resulting from noncompliance with the provisions of the UTILIZATION MANAGEMENT AND REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $6,850 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

For Non-Participating Providers

If you have Individual Coverage and your out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) during one benefit period equals $6,850, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid at 100% of the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the emergency room Copayment
- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services you may receive from a Participating Provider
- the Coinsurance resulting from Hospital services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility for Covered Services
- Copayments resulting from noncompliance with the provisions of the UTILIZATION MANAGEMENT AND REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

If you have Family Coverage and your family's out-of-pocket expense (the amount remaining unpaid for Covered Services after benefits have been provided) equals $13,700 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for eligible Covered Services (except for those charges specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. Benefits under Family Coverage will not be provided at the 100% payment level until the entire family out-of-pocket expense limit has been met.

The out-of-pocket expense limit amount may be adjusted based on the cost-of-living adjustment determined under the Internal Revenue Code and rounded to the nearest $50.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial Hospitalization Treatment Program, Residential Treatment Center or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

HEARING CARE PROGRAM

Your coverage includes benefits for hearing care when you receive such care from a Physician, Otologist, Audiologist or Hearing Aid Dealer.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For hearing care benefits to be available, such care must be Medically Necessary and you must receive such care on or after your Coverage Date.

In addition to the Definitions of this benefit booklet, the following definitions are applicable to this Benefit Section:

AUDIOLOGIST.....means a duly licensed audiologist.

HEARING AID DEALER.....means a Provider licensed to make and provide hearing aids to you.

OTOLOGIST.....means a duly licensed otologist or otolaryngologist.

Benefit Period

Your hearing care benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

Covered Services

Benefits will be provided under this Benefit Section for the following:

Audiometric Examination
Hearing Aid Evaluation
Conformity Evaluation
Hearing Aids

Benefits will be limited to one Covered Service(s) of each type listed above per benefit period.

Special Limitations

Benefits will not be provided for the following:

1. Audiometric examinations by an Audiologist when not ordered by your Physician within 6 months of such examination.
2. Medical or surgical treatment.
3. Drugs or other medications.
4. Replacement for lost or broken hearing aids, except if otherwise eligible under frequency limitations.
5. Hearing aids ordered while covered but delivered more than 60 days after termination.

Benefit Payment for Hearing Care

Benefits for hearing care Covered Services will be provided at 100% of the Usual and Customary Fee.

Benefits for hearing aids will be provided up to a lifetime maximum of $5,000.

For purposes of this Benefit Section only, the definition of Usual and Customary Fee shall read as follows:

> USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by the Claim Administrator, which is based on the fee which the Physician, Otologist, Audiologist or Hearing Aid Dealer who renders the particular service usually charges his patients or customers for the same service and the fee which is within the range of usual fees other Physicians, Otologists, Audiologists or Hearing Aid Dealers of similar training and experience in the same geographic area charge their patients or customers for the same service, under similar or comparable circumstances.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible Covered Persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled "Medicare Eligible Covered Persons" in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, services and supplies which are not Medically Necessary.**
No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.
- The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation. and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act or similar Legislation of any state.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that were received prior to your Coverage Date or after the date that your coverage was terminated.

— Services and supplies from more than one Provider on the same day(s) to the extent benefits are duplicated.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

— Services or supplies for intersegmental traction; all types of home traction devices and equipment; vertebral axial decompression sessions; surface EMGs; spinal manipulation under anesthesia; muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron; and balance testing through computerized dynamic posturography sensory organization test.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes, paraplegic covered persons who have a disease that requires them to wear leg braces; covered persons who are taking blood thinners; covered persons with decreased circulation; covered persons with severe cardiac health problems; covered persons at high risk of neurological or vascular disease arising from diseases such as diabetes.

— Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet rich plasma.

— Treatment of tissue damage or disease in any location with platelet-rich plasma.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability, or mental disability, except as may be provided under this benefit booklet for Autism Spectrum Disorder(s).

— Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

— Hypnotism.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— This Plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds, or its resin. Cannabis with THC as an active ingredient may be called marijuana.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

— Testing of blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels; urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover; cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby(premature ruptured membranes); and allergen specific IgG measurement.

— Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins, and herbal supplements, other than those specifically named in this benefit booklet.

— Reversals of sterilization.

— Orthotics therapy.

— Any related services to a non-covered service. Related services are a) services in preparation for the non-covered service; b) services in connection with providing the non-covered service; c) hospitalization required to perform the non-covered service; or d) services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

— Self-administered drugs dispensed by a Physician.

— Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses, and group homes, except for Covered Services provided by appropriate Providers as defined in this benefit booklet.

Any of the following applied behavior analysis (ABA) related services:

— Services with a primary diagnosis that is not Autism Spectrum Disorder;

— Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider" in the DEFINITIONS SECTION of this benefit booklet;

— Activities primarily of an educational nature;

— Shadow or companion services; or

— Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
   - — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;
   - — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

     Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.
3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

- pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.
- recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person, or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Please refer to BMO Plan Documents.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

Please refer to BMO Plan Documents.

HOW TO FILE A CLAIM
AND APPEALS PROCEDURES

To obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your Identification Card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed, and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases, the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

In any case, Claims should be filed with the Claim Administrator on or before December 31st of the calendar year following the year in which your Covered Service was rendered. (A Covered Service furnished in the last month of a particular calendar year shall be considered to have been furnished the succeeding calendar year.) **Claims not filed within the required time period will not be eligible for payment.**

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

INTERNAL CLAIM DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIM DETERMINATIONS

When the Claim Administrator receives a properly submitted claim, the Claim Administrator will determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will process claims consistent with administrative practices and procedures established by your Plan. You, your valid assignee, your authorized representative, or Provider will be notified of the Claim Administrator's benefit decision. (For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If a Claim Is Denied or Not Paid in Full

If the claim for benefits is denied, you or your authorized representative shall be notified in writing of the following:

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative, medical policy or protocol for the determination;

c. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review;

f. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

h. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

i. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;

j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the determination was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

k. In the case of a determination of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator's offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, IL 60680-4112
1-800-538-8833 Toll-free phone

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431 or call the number on the back of your Identification Card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INQUIRIES AND COMPLAINTS

An **"Inquiry"** is a general request for information regarding claims, benefits, or membership.

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with an Adverse Benefit Determination (or partial determination), then you have the right to a Claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **customer service** at the number on the back of your Identification Card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by customer service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted. If an Inquiry or Complaint is not resolved to your satisfaction, you may appeal to the Claim Administrator.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees, or a Provider.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

a. **Urgent Care Clinical Claim** is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

b. Pre-Service Claim is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

c. Post-Service Claim is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	**24 hours****
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**48 hours after receiving notice**
The Claim Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**48 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**48 hours**

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

**Notification may be oral unless the claimant requests written notification.

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Claim Administrator must notify you within:	**5 days***
If your Claim is incomplete, the Claim Administrator must notify you within:	**15 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**

The Claim Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	**15 days****
after receiving the completed Claim (if the initial Claim is incomplete), within:	**30 days**
If you require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

*Notification may be oral unless the claimant requests written notification.

**This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	**30 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**
The Claim Administrator must notify you of any adverse Claim determination:	
if the initial Claim is complete, within:	**30 days***
after receiving the completed Claim (if the initial Claim is incomplete), within:	**45 days**

*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

CLAIM APPEAL PROCEDURES - DEFINITIONS

An **"Adverse Benefit Determination"** means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

Urgent Care/Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on their own behalf. Under your health benefit plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of

information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your Identification Card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination.
- In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments, and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

Your Right to Appeal
You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case. Send a written appeal request to: The Claim Administrator Claim Review Section P.O. Box 2401 Chicago, Illinois 60690
To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at *bcbsil.com*

During your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon, or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal appeals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made to give you a reasonable opportunity to respond. The Claim Administrator may extend the time period described in this benefit booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must

exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

Timing of Non-Urgent Appeal Determinations

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, the Claim Administrator will notify the party filing the appeal within five business days of all the information needed to review the appeal.

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 calendar days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 30 calendar days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you have already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
4. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external appeal;
5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;
6. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);
7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

8. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
9. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
11. A description of the standard that was used in denying the claim and a discussion of the decision;
12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on their own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;
13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;
14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the determination and issue a final decision. Your external review rights are described in the **STANDARD EXTERNAL REVIEW** section below.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

Forum Selection

In the event of any dispute relating to or arising from this Plan, the jurisdiction and venue for the dispute is the United States District Court for the Northern District of Illinois. If, and only if, the United States District Court for the Northern District of Illinois lacks subject-matter jurisdiction over such dispute, the jurisdiction and venue for the dispute is the Circuit Court of Cook County, Illinois.

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

An "**Adverse Benefit Determination**" means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting

from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator's internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
    a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
    c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and
    d. You or your authorized representative have provided all the information and forms required to process an external review.

    You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally recognized accrediting organization. Moreover, the Claim Administrator will act against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.

   The IRO must provide the following:

   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

   c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

   d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

   e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719

of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) Your medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;

(4) The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

(6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

(7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. **Request for expedited external review.** Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

   b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must

review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS AND OTHER ENTITIES

The Claim Administrator hereby informs you that it has contracts with certain Providers ("Administrator Providers") in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Provider's work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After considering the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

The Claim Administrator or its subsidiaries or affiliates may also have ownership interests in or financial arrangements with certain Providers who provide Covered Services to covered persons and/or vendors or other third parties who provide services related to the Policy or provide services to certain Providers.

2. INTER-PLAN ARRANGEMENTS

I. Out-of-Area Services

Overview

The Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area the Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Claim Administrator's service area, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("nonparticipating Providers") do not contract with the Host Blue. The Claim Administrator explains below how the Claim Administrator pays both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Claim Administrator to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for doing what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

For Inpatient facility services received in a Hospital, the Host Blue's participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction.

When you receive Covered Services outside the Claim Administrator's service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services, or
- The negotiated price that the Host Blue makes available to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your Identification Card to the provider to let them know that you are covered by the Claim Administrator.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service - the amount applied to your deductible, if any, and your coinsurance percentage - on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over - or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claim Administrator has used for your claim because they will not be applied after a Claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, the Claim Administrator may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to the Claim Administrator by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating Provider, that amount will be the difference between the Provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a Provider's billed charge, you will incur no liability, other than any related patient cost sharing under this agreement.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claim Administrator through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If the Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your Employer on your behalf, the Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or states laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claim Administrator will include any such surcharge, tax, or other fee as part of the Claim Charge passed on to you.

Negotiated (non-BlueCard Program) National Account Arrangements

As an alternative to the BlueCard Program, your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A, BlueCard Program) made available to Claim Administrator by the Host Blue.

E. Non-Participating Healthcare Providers Outside The Claim Administrator's Service Area

a. Member Liability Calculation

(1) In General

When Covered Services are provided outside of the Claim Administrator's service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (a)(1) above); or
2. The following:
    a. For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or
    b. For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. The Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and Professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator,

working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

If considered True Emergency Medical Care Covered Services will pay 80% after you met the Annual Deductible. Non-Emergency Medical Care Covered Services will pay 60% after you meet the Annual Deductible.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered Inpatient services, except for your cost-share amounts/Deductibles, Coinsurances, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for Covered Services. **You must contact the Claim Administrator to obtain Prior Authorization for non-emergency Inpatient services.**

- **Outpatient Services**

  Outpatient Services are available for Emergency Care. Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a Claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Claim Administrator, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Servicing Plans

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on the Claim Administrator's behalf, Claim Payments, and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers ("Servicing Plan Providers") in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider's Eligible Charge for Covered Services rendered to you or the cost agreed upon between the

Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.

Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC. Neither the Employer nor you are entitled to receive any portion of such rebates.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufactures to cover the administrative costs of processing late payments). The Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. The Claim Administrator may receive such rebates from Prime or pharmaceutical manufacturers. You are not entitled to receive any portion of any such rebates.

Note: This applies to drugs that are paid under the medical plan.

3. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A covered person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a covered person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any

other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

4. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator, Preferred or approved in modifying a Provider shall in no way be construed as a recommendation, referral, or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, Preferred, approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

d. Each Provider provides Covered Services only to you and does not interact with or provide any services to your Employer (other than as an individual covered person) or your Employer's ERISA Health Benefit Program.

5. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

6. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

7. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

8. OVERPAYMENT

If your group's benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your group's benefit plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or

b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Contracted Provider; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy, if the future benefit payment owed is to a Contracted Provider; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future payment owed to one or more Contracted Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's or policy's payment to a Contracted Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Contracted Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan or policy.

9. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and your Employer has the right to offer medical management programs, quality improvement programs and health behavior wellness, incentive, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums or a differential in medical, prescription drug or equipment Copayments, Coinsurance or deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such programs. In addition, discount, or incentive programs for various health and wellness-related or insurance-related, or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact your Employer for additional information regarding any value-based programs offered by your Employer.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or their insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents, or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the benefit booklet to which this Amendment is attached and becomes a part of the benefit booklet. Unless otherwise required by Federal or Illinois law, in the event of a conflict between the terms on this Amendment and the terms of the benefit booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The benefit booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the benefit booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the benefit booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the benefit booklet and this Amendment, those terms will apply only to their use in the benefit booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of Illinois (BCBSIL) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider deductible and/or out-of-pocket expense limit, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.



bcbsil.com

ASO-1

Effective Date: January 1, 2025

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

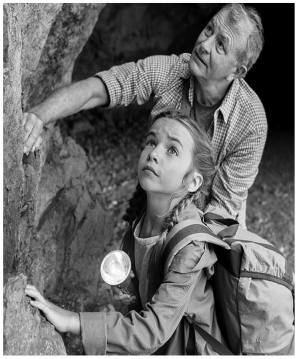
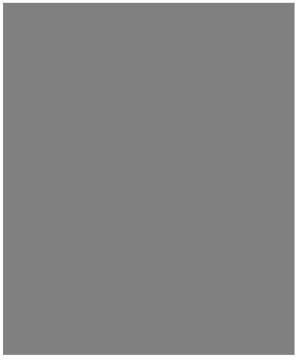
Blue Cross and Blue Shield of Illinois provides administrative services only and does not assume any financial risk or obligation with respect to claims.

BMO U.S. Health and Welfare Benefit Plan

2025 BCSIL PPO Booklet

Administered by:

BlueCross BlueShield of Illinois





Your Health Care Benefits Program

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BMO Financial Corp

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A message from

BMO Financial Corp

This booklet describes the Health Care Plan which we provide to protect you from the financial burden of catastrophic illness or injury.

To assure the professional handling of your health care claims, we have engaged Blue Cross and Blue Shield of Illinois as Claim Administrator.

Please read the information in this benefit booklet carefully so you will have a full understanding of your health care benefits. If you want more information or have any questions about your health care benefits, please contact the Employee Benefits Department.

Sincerely,

BMO Financial Corp

NOTICE

Please note that Blue Cross and Blue Shield of Illinois has contracts with many health care Providers that provide for the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those Providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Please note that the Claim Administrator has contracts, either directly or indirectly, with many prescription drug providers that provide the Claim Administrator to receive, and keep for its own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Please refer to the provision entitled "Claim Administrator's Separate Financial Arrangements with Prescription Drug Providers" in the GENERAL PROVISIONS section of this booklet for a further explanation of these arrangements.

Blue Cross and Blue Shield of Illinois provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a Non-Participating Provider for a Covered Service in non-emergency situations, benefit payments to such Non-Participating Provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED UNDER THIS COVERAGE AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-Participating Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating Providers have agreed to accept discounted payments for services with no additional billing to the member other than Coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll-free telephone number on your Identification Card.

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BENEFIT HIGHLIGHTS

Your health care benefits are highlighted below. However, to fully understand your benefits, it is very important that you read this entire benefit booklet.

UTILIZATION MANAGEMENT AND REVIEW	A special program designed to assist you in determining the course of treatment that will maximize your benefits described in this benefit booklet
Lifetime Maximum for all Benefits	Unlimited
Individual Deductible	
— Participating Provider	$750 per benefit period
— Non-Participating and Non-Administrator Provider	$1,500 per benefit period
Family Deductible	
— Participating Provider	$1,500 per benefit period
— Non-Participating and Non-Administrator Provider	$3,000 per benefit period
Individual Out-of-Pocket Expense Limit **(does not apply to all services)**	
— Participating Provider	$3,000 per benefit period
— Non-Participating Provider	$6,000 per benefit period
— Non-Administrator Provider	No limit
Family Out-of-Pocket Expense Limit	
— Participating Provider	$6,000 per benefit period
— Non-Participating Provider	$12,000 per benefit period
— Non-Administrator Provider	No limit
Private Duty Nursing Service Benefit Maxim	60 visits per benefit period
Naprapathic Services Benefit Maximum	20 visits per benefit period
Chiropractic and Osteopathic Manipulation Benefit Maximum	20 visits per benefit period
Physical, Occupational, and Speech Therapies Combined Benefit Maximum	60 visits per benefit period

Temporomandibular Joint Dysfunction and Related Disorders Benefit Maximum	No maximum
HOSPITAL BENEFITS	
Payment level for Covered Services from a **Participating Provider:**	
— Inpatient Covered Services	80% of the Eligible Charge
— Outpatient Covered Services	80% of the Eligible Charge
— Urgent Care	$150 Copayment, then 100% of the Eligible Charge, no deductible
Payment level for Covered Services from a **Non-Participating Provider:**	
— Inpatient Covered Services	60% of the Eligible Charge
— Outpatient Covered Services	60% of the Eligible Charge
— Urgent Care	60% of the Eligible Charge
Payment level for Covered Services from a **Non-Administrator Provider**	100% of the Non-Participating Hospital Benefit Payment Level
Hospital Emergency Care	
— Payment level for Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider	100% of the Eligible Charge, no deductible
— Payment level for Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider	100% of the Eligible Charge, no deductible
Emergency Room	$300 Copayment (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)

PHYSICIAN BENEFITS

Payment level for Surgical/ Medical Covered Services	
— **Participating Provider**	80% of the Maximum Allowance
— **Non-Participating Provider**	60% of the Maximum Allowance
Payment level for Covered Services received in a Professional Provider's Office	
— Participating Provider (other than a specialist)	$25 per visit, then 100% of the Maximum Allowance, no deductible
— Participating Provider Specialist	$40 per visit, then 100% of the Maximum Allowance, no deductible
Payment level for Emergency Accident Care	80% of the Maximum Allowance
Payment level for Emergency Medical Care	80% of the Maximum Allowance

OTHER COVERED SERVICES

Payment level	80% of the Eligible Charge or Maximum Allowance

BLUE DISTINCTION CENTERS (BDC) &
BLUE DISTINCTION CENTERS PLUS (BDC+)
BENEFIT DIFFERENTIAL
(YOUR PROGRAM DEDUCTIBLE APPLIES TO THE BELOW BENEFITS, UNLESS OTHERWISE SPECIFIED.)

Payment level for Transplants	
— BDC+ Designated Center	80% of the Eligible Charge
— BDC Designated Center	80% of the Eligible Charge
— Participating Provider	60% of the Eligible Charge
— Non-Participating Provider	60% of the Eligible Charge

TELEHEALTH AND TELEMEDICINE

Payment level for Telehealth Services	
— Participating Provider (other than a specialist)	$25 per visit, then 100% of the Maximum Allowance, no Deductible
— Participating Provider (Specialist)	$40 per visit, then 100% of the Maximum Allowance, no Deductible

— Non-Participating Provider	60% of the Maximum Allowance
Payment level for Telehealth Services for the treatment of Mental Illness	
— Participating Provider (other than a specialist)	$25 per visit, then 100% of the Maximum Allowance, no Deductible
— Non-Participating Provider	60% of the Maximum Allowance

HEARING BENEFITS

Benefit Payment level for hearing care Covered Services	
— Participating Provider	100% after Deductible of the U&C Fee*
Hearing Aids	
Lifetime Maximum	$5,000

*BENEFITS FOR AUTISM SPECTRUM DISORDER(S) WILL NOT APPLY TOWARDS AND ARE NOT SUBJECT TO ANY PHYSICAL, SPEECH OR OCCUPATIONAL THERAPY VISITS MAXIMUM.

TO IDENTIFY NON-ADMINISTRATOR AND ADMINISTRATOR HOSPITALS OR FACILITIES, YOU SHOULD CONTACT THE CLAIM ADMINISTRATOR BY CALLING THE CUSTOMER SERVICE TOLL-FREE TELEPHONE NUMBER ON YOUR IDENTIFICATION CARD.

DEFINITIONS SECTION

Throughout this benefit booklet, many words are used which have a specific meaning when applied to your health care coverage. These terms will always begin with a capital letter. When you come across these terms while reading this benefit booklet, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER.

A1C TESTING....means blood sugar level testing used to diagnose prediabetes, type I diabetes, and type II diabetes, and to monitor management of blood sugar levels.

ACUPUNCTURIST.....means a duly licensed acupuncturist operating within the scope of their license.

ACUTE TREATMENT SERVICES.....means a 24-hour medically supervised addiction treatment that provides evaluation and withdrawal management and may include biopsychosocial assessment, individual and group counseling, psychoeducational groups, and discharge planning.

ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

ADMINISTRATOR PROGRAM.....means programs for which a Hospital has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time services are rendered to you. These programs are limited to a Partial Hospitalization Treatment Program or Coordinated Home Care Program.

ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

ADVANCED PRACTICE NURSE.....means Certified Clinical Nurse Specialist, Certified Nurse-Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist operating within the scope of their certification.

AMBULANCE TRANSPORTATION.....means local transportation in specially equipped certified ground and air ambulance options from your home, scene of accident or medical emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary service. Ambulance Transportation provided for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this health care plan.

AMBULANCE TRANSPORTATION ELIGIBLE CHARGE.....means i) for ambulance providers that bill for Ambulance Transportation services through a Participating Hospital the Ambulance Transportation Eligible Charge is the applicable ADP, and ii) for all other ambulance providers, the Ambulance Transportation Eligible Charge is such provider's Billed Charge.

AMBULATORY SURGICAL FACILITY.....means a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis, and which is duly licensed by the appropriate state and local authority to provide such services.

An "Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Ambulatory Surgical Facility" means an Ambulatory Surgical Facility which does not meet the definition of an Administrator Ambulatory Surgical Facility.

ANESTHESIA SERVICES.....means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them, respectively.

APPROVED CLINICAL TRIAL.....means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the preventive, detection or treatment of cancer or other life-threatening disease or condition and is one of the following:

(i) A federally funded or approved trial,

(ii) A clinical trial conducted under an FDA experimental/investigational new drug application, or

(iii) A drug that is exempt from the requirement of an FDA experimental/investigational new drug application.

AUDIOLOGIST.....means a duly licensed Audiologist operating within the scope of their license.

A "Participating Audiologist" means an Audiologist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time Covered Services are rendered.

A "Non-Participating Audiologist" means an Audiologist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Covered Services to you at the time Covered Services are rendered.

AUTISM SPECTRUM DISORDER(S).....means pervasive developmental disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, including autism, Asperger's disorder and pervasive developmental disorders not otherwise specified.

AVERAGE DISCOUNT PERCENTAGE ("ADP").....means a percentage discount determined by the Claim Administrator that will be applied to a Provider's Eligible Charge for Covered Services rendered to you by Hospitals and certain other health care facilities for purposes of calculating Coinsurance amounts, deductibles, out-of-pocket maximums and/or any benefit maximums. The ADP will often vary from Claim-to-Claim. The ADP applicable to a particular Claim for Covered Services is the ADP, current on the date the Covered Service is rendered, that is determined by the Claim Administrator to be relevant to the particular Claim. The ADP reflects the Claim Administrator's reasonable estimate of average payments, discounts and/or other allowances that will result from its contracts with Hospitals and other facilities under circumstances similar to those involved in the particular Claim, reduced by an amount not to exceed 15% of such estimate, to reflect related costs. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.") In determining the ADP applicable to a particular Claim, the Claim Administrator will take into account differences among Hospitals and other facilities, the Claim Administrator's contracts with Hospitals and other facilities, the nature of the Covered Services involved and other relevant factors. The ADP shall not apply to Eligible Charges when your benefits under the Health Care Plan are secondary to Medicare and/or coverage under any other group program.

BEHAVIORAL HEALTH PRACTITIONER.....means a Physician or Professional Provider who is duly licensed to render services for Mental Illness or Substance Use Disorders and is operating within the scope of such license.

BEHAVIORAL HEALTH UNIT.....means a unit established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Prior Authorization, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for Inpatient Hospital admissions and/or review of Outpatient services for the treatment of Mental Illness and Substance Use Disorder.

BILLED CHARGES.....means the total gross amounts billed by Providers to the Claim Administrator on a Claim, which constitutes the usual retail price that the Provider utilizes to bill patients or any other party that may be responsible for payment of the services rendered without regard to any payor, discount or reimbursement arrangement that may be applicable to any particular patient. This list of retail prices is also sometimes described in the health care industry as a "chargemaster."

BIOMARKER TESTING.....means the analysis of tissue, blood, or fluid biospecimen for the presence of a biomarker, including, but not limited to singly-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

BLUE DISTINCTION CENTERS (BDC).....means a health care Provider, Hospital, or medical facility recognized for their expertise in delivering specialty care. Please see the section entitled "Blue Distinction Centers" for more information.

BLUE DISTINCTION CENTERS+ (BDC+).....means a health care Provider, Hospital, or medical facility recognized for their expertise and efficiency in delivering specialty care. Please see the section entitled "Blue Distinction Centers" for more information.

BLUE DISTINCTION CENTERS (BDC) and BLUE DISTINCTION CENTERS+ (BDC+) BENEFIT DIFFERENTIAL PRODUCT.....means your employer has chosen to provide a lower out-of-pocket cost when you utilize a BDC or BDC+ designated provider for certain specialty care procedures and treatment.

CARE COORDINATION.....means organized, information-driven patient care activities intended to facilitate the appropriate responses to participant's health care needs cross the continuum of care.

CARE COORDINATION FEE.....means a fixed amount paid by a Blue Cross and/or Blue Shield plan to Providers.

CERTIFIED CLINICAL NURSE SPECIALIST.....means a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A "Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Clinical Nurse Specialist" means a Certified Clinical Nurse Specialist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE-MIDWIFE.....means a nurse-midwife who (a) practices according to the standards of the American College of Nurse-Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of a program of nurse-midwives accredited by the American College of Nurse Midwives or its predecessor.

A "Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse-Midwife" means a Certified Nurse-Midwife who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED NURSE PRACTITIONER.....means a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration, and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse and is operating within the scope of such license; and

(ii) is a graduate of an advanced practice nursing program.

A "Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Nurse Practitioner" means a Certified Nurse Practitioner who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CERTIFIED REGISTERED NURSE ANESTHETIST or CRNA.....means a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse and is operating within the scope of such license; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of

Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

A "Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Certified Registered Nurse Anesthetist" means a Certified Registered Nurse Anesthetist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CHEMOTHERAPY.....means the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

CHIROPRACTOR.....means a duly licensed chiropractor and is operating within the scope of their license.

CLAIM.....means notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

CLAIM ADMINISTRATOR.....means Blue Cross and Blue Shield of Illinois.

CLAIM CHARGE.....means the amount which appears on a Claim as the Provider's charge for service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

CLAIM PAYMENT.....means the benefit payment calculated by the Claim Administrator, after submission of a Claim, in accordance with the benefits described in this benefit booklet. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claim Administrator and a particular Provider. (See provisions regarding "The Claim Administrator's Separate Financial Arrangements with Providers" in the GENERAL PROVISIONS section of this benefit booklet.)

CLINICAL LABORATORY.....means a clinical laboratory which complies with the licensing and certification requirements under the Clinical Laboratory Improvement Amendments of 1988, the Medicare and Medicaid programs and any applicable state and local statutes and regulations.

A "Participating Clinical Laboratory" means a Clinical Laboratory which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Laboratory" means a Clinical Laboratory which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan provide services to you at the time services are rendered.

CLINICAL PROFESSIONAL COUNSELOR.....means a duly licensed clinical professional counselor operating within the scope of their license.

A "Participating Clinical Professional Counselor" means a Clinical Professional Counselor who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Professional Counselor" means a Clinical Professional Counselor who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL SOCIAL WORKER.....means a duly licensed clinical social worker operating within the scope of their license.

A "Participating Clinical Social Worker" means a Clinical Social Worker who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Clinical Social Worker" means a Clinical Social Worker who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

CLINICAL STABILIZATION SERVICES.....means a 24-hour treatment, usually following acute treatment services for Substance Use Disorder, which may include intensive education and counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for individuals beginning to engage in recovery from addiction.

CLINICIAN.....means a person operating within the scope of their license, registration or certification in the clinical practice or medicine, psychiatry, psychology, or behavior analysis.

COBRA.....means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

COINSURANCE.....means a percentage of an eligible expense that you are required to pay towards a Covered Service.

COMPLICATIONS OF PREGNANCY.....means all physical effects suffered as a result of pregnancy which would not be considered the effect of normal pregnancy.

CONGENITAL OR GENETIC DISORDER.....means a disorder that includes, but is not limited to, hereditary disorders. Congenital or Genetic Disorders may also include, but is not limited to, Autism or an Autism Spectrum Disorder, cerebral palsy, and other disorders resulting from early childhood illness, trauma, or injury.

CONTRACTED PROVIDER.....means a Participating Provider and a Participating Professional Provider, collectively.

COORDINATED HOME CARE PROGRAM.....means an organized skilled patient care program in which care is provided in the home. Care may be provided by a Hospital's licensed home health department or by other licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician, a Physician Assistant who has been authorized by a Physician to prescribe those services, or an advanced practice nurse with a collaborating agreement with a Physician that delegates that authority. This program includes physical, occupational and speech therapists, and necessary medical supplies. The program does not include and is not intended to provide benefits for Private Duty Nursing Service or Custodial Care Service. It also does not cover services for activities of daily living (personal hygiene, cleaning, cooking, etc.).

An "Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide service to you at the time service is rendered to you.

A "Non-Administrator Coordinated Home Care Program" means a Coordinated Home Care Program which does not have an agreement with the Claim Administrator or a Blue Cross Plan but has been certified as a home health agency in accordance with the guidelines established by Medicare.

COPAYMENT.....means a specified dollar amount that you are required to pay towards a Covered Service.

COURSE OF TREATMENT.....means any number of dental procedures or treatments performed by a Dentist or Physician in a planned series resulting from a dental examination in which the need for such procedures or treatments was determined.

COVERAGE DATE.....means the date on which your coverage under the Health Care Plan begins.

COVERED SERVICE.....means a service and supply specified in this benefit booklet for which benefits will be provided.

CREDITABLE COVERAGE.....means coverage you had under any of the following:

(i) A group health plan.

(ii) Health insurance coverage for medical care under any hospital or medical service policy plan, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

(iii) Medicare (Parts A or B of Title XVIII of the Social Security Act).

(iv) Medicaid (Title XIX of the Social Security Act).

(v) Medical care for members and certain former members of the uniformed services and their dependents.

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool.

(viii) A health plan offered under the Federal Employees Health Benefits Program.

(ix) A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country.

(x) A health plan under Section 5(e) of the Peace Corps Act.

(xi) State Children's Health Insurance Program (Title XXI of the Social Security Act).

CUSTODIAL CARE SERVICE.....means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services which do not

require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (including but not limited to dressings, administration of routine medications, ventilator suctioning and other care) and are to assist with activities of daily living (including but not limited to bathing, eating, and dressing).

DEDUCTIBLE.....means the amount of expense that you must incur in Covered Services before benefits are provided.

DENTIST.....means a duly licensed dentist operating within the scope of their license.

DIAGNOSTIC MAMMOGRAM.....means a mammogram obtained using Diagnostic Mammography.

DIAGNOSTIC MAMMOGRAPHY.....means a method of screening that is designed to evaluate an abnormality in a breast, including an abnormality seen or suspected on a screening mammogram or a subjective or objective abnormality otherwise detected in the breast.

DIAGNOSTIC SERVICE.....means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease, or injury. Such tests include, but are not limited to, x-rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests, electromyograms, magnetic resonance imaging (MRI), computed tomography (CT) scans and positron emission tomography (PET) scans.

DIALYSIS FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services, when operating within the scope of such license.

An "Administrator Dialysis Facility" means a Dialysis Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Dialysis Facility" means a Dialysis Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with the guidelines established by Medicare.

DOMESTIC PARTNER.....means a person with whom you have entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP.....means long-term committed relationship of indefinite duration with a person of the same or opposite sex which meets the following criteria:

(i) you and your Domestic Partner have lived together for at least 6 months,

(ii) neither you nor your Domestic Partner is married to anyone else or has another Domestic Partner,

(iii) your Domestic Partner is at least 18 years of age and mentally competent to consent to contract,

(iv) your Domestic Partner resides with you and intends to do so indefinitely,

(v) you and your Domestic Partner have an exclusive mutual commitment similar to marriage, and

(vi) you and your Domestic Partner are not related by blood closer than would bar marriage in the state of your legal residence (i.e., the blood relationship is not one which would forbid marriage in the state of your residence, if you and the Domestic Partner were of the opposite sex).

You and your Domestic Partner must be jointly responsible for each other's common welfare and must share financial obligations. Joint responsibility may be demonstrated by the existence of at least 3 of the following: a signed Affidavit of Domestic Partnership, a joint mortgage or lease, designation of you or your Domestic Partner as a beneficiary in the other partner's life insurance and retirement contract, designation of you or your Domestic Partner as the primary beneficiary in your or your Domestic Partner's will, durable property and health care powers of attorney, or joint ownership of a motor vehicle, checking account or credit account.

DURABLE MEDICAL EQUIPMENT PROVIDER.....means a duly licensed durable medical equipment provider, when operating within the scope of such license.

A "Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Durable Medical Equipment Provider" means a Durable Medical Equipment Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

EARLY ACQUIRED DISORDER.....means a disorder resulting from illness, trauma, injury, or some other event or condition suffered by a child prior to that child developing functional life skills such as, but not limited to, walking, talking or self-help skills. Early Acquired Disorder may include, but is not limited to, Autism or an Autism Spectrum Disorder and cerebral palsy.

ELIGIBLE CHARGE.....means (a) in the case of a Provider, other than a Professional Provider, which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to covered persons in the benefit program or is designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services for medical benefits are rendered by a Participating Provider, such Participating Provider's Claim Charge for Covered Services and (b) in the case of a Provider, other than a Professional Provider, which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to participants in the benefit program, or is not designated as a Participating Provider by any Blue Cross and/or Blue Shield Plan at the time Covered Services for medical benefits are rendered ("Non-Participating Provider"), the following amount (unless otherwise required by applicable law or arrangement with the Non-Participating Provider):

(i) the lesser of (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be approximately 150% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim; or

(ii) if there is no base Medicare reimbursement rate available for a particular Covered Service, or if the base Medicare reimbursement amount cannot otherwise be determined under subsection (i) above based upon the information submitted on the Claim, the lesser of (a) the Provider's Billed Charges and (b) an amount determined by the Claim Administrator to be 150% of the Maximum Allowance that would apply if the services were rendered by a Participating Professional Provider on the date of service; or

(iii) if the base Medicare reimbursement amount and the Eligible Charge cannot be determined under subsections (i) or (ii) above, based upon the information submitted on the Claim, then the amount will be 135% of the Provider's Billed Charges, provided, however, that the Claim Administrator may limit such amount to the lowest contracted rate that the Claim Administrator has with a Participating Provider for the same or similar services based upon the type of provider and the information submitted on the Claim, as of January 1 of the same year that the Covered Services are rendered to the covered person.

The Claim Administrator will utilize the same Claim processing rules, edits, or methodologies that it utilizes in processing Participating Provider Claims for processing Claims submitted by Non-Participating or Non-Administrator

Providers which may also alter the non-contracting Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The non-contracting Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Eligible Charge amount does not equate to the Non-Participating Provider's Claim Charge, you will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance, and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

ELIGIBLE PERSON.....means an employee of the Employer who meets the eligibility requirements for this health and/or dental coverage, as described in the ELIGIBILITY SECTION of this benefit booklet.

EMERGENCY ACCIDENT CARE.....means the initial Outpatient treatment of accidental injuries including related Diagnostic Services. The initial Outpatient treatment does not include surgical procedures, including but not limited to, stitching, gluing, and casting.

EMERGENCY MEDICAL CARE.....means services provided for the initial Outpatient treatment, including related Diagnostic Services, of a medical condition displaying itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

Examples of symptoms that may indicate the presence of an emergency medical condition include, but are not limited to, difficulty breathing, severe chest pains, convulsions, or persistent severe abdominal pains.

EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION.....means an admission for the treatment of Mental Illness or Substance Use Disorders as a result of the sudden and unexpected onset of a Mental Illness or Substance Use Disorders condition such that a prudent

layperson, who possesses an average knowledge of health and medicine, could reasonably expect that in the absence of immediate medical treatment would likely result in serious and permanent medical consequences to oneself or others.

EMPLOYER.....means the company with which you are employed.

ENROLLMENT DATE.....means the first day of coverage under your Employer's health plan or, if your Employer has a waiting period prior to the effective date of your coverage, the first day of the waiting period (typically, the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL or EXPERIMENTAL/INVESTIGATIONAL SERVICES AND SUPPLIES.....means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as Standard Medical Treatment for the condition being treated or, if any of such items required federal or other governmental agency approval, such approval was not granted at the time services were provided. Approval by a federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. As used herein, medical treatment includes medical, surgical, mental health treatment, Substance Use Disorder Treatment, or dental treatment.

Standard Medical Treatment means the services or supplies that are in general use in the medical community in the United States, and:

- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Claim Administrator shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-fixed programs in making its determination.

Although a Physician or Professional Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort. The Claim Administrator still may determine such services or supplies to be Experimental/Investigational with this definition. Treatment provided as part of a clinic trial or research study is Experimental/Investigational.

Approval by a government or regulatory agency will be taken into consideration in assessing Experimental/Investigational status of a drug, device, biological product, supply and equipment for medical treatment or procedure but will not be determinative.

FAMILY COVERAGE.....means coverage for you and your eligible dependents under the Health Care Plan.

HABILITATIVE SERVICES.....means Occupational Therapy, Physical Therapy, Speech Therapy, and other health care services that help an eligible person keep, learn, or improve skills and functioning for daily living, as prescribed by a Physician pursuant to a treatment plan. Examples include therapy for a child who isn't walking or talking at the expected age and includes therapy to enhance the ability of a child to function with a Congenital, Genetic, or Early Acquired Disorder. These services may include Physical Therapy and Occupational Therapy, speech-language pathology, and other services for an eligible person with disabilities in a variety of Inpatient and/or Outpatient settings, with coverage as described in this benefit booklet.

HOME INFUSION THERAPY PROVIDER.....means a duly licensed home infusion therapy provider, when operating within the scope of such license.

A "Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Home Infusion Therapy Provider" means a Home Infusion Therapy Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

HOSPICE CARE PROGRAM PROVIDER.....means an organization duly licensed to provide Hospice Care Program Service, when operating within the scope of such license.

A "Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

A "Non-Participating Hospice Care Program Provider" means a Hospice Care Program Provider that either: (i) does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield to provide services to participants in this benefits program, or; (ii) a Hospice Care Program Provider which has not been designated by a Blue Cross and/or Blue Shield Plan as a Participating Provider Option program.

HOSPICE CARE PROGRAM SERVICE.....means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special hospice care unit.

HOSPITAL.....means a facility which is a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by registered nurses and which is either accredited by the Joint Commission on Accreditation of Hospitals or certified by the Social Security Administration as eligible for participation under Title XVIII, Health Insurance for the Aged and Disabled.

An "Administrator Hospital" means a Hospital which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Hospital" means a Hospital that does not meet the definition of an Administrator Hospital.

A "Participating Hospital" means an Administrator Hospital that has an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide Hospital services to participants in the Participating Provider Option program.

A "Non-Participating Hospital" means an Administrator Hospital that does not meet the definition of a Participating Hospital.

IATROGENIC INFERTILITY.....means an impairment of fertility by Surgery, radiation, Chemotherapy, or other medical treatment affecting reproductive organs or processes.

INDIVIDUAL COVERAGE.....means coverage under the Health Care Plan for yourself but not your spouse and/or dependents.

INFERTILITY.....means the inability to conceive a child after one year of unprotected sexual intercourse or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy.

INFUSION THERAPY.....means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy, in most cases, requires health care professional services for the safe and effective administration of the medication.

INPATIENT.....means that you are a registered bed patient and are treated as such in a health care facility.

INTENSIVE OUTPATIENT PROGRAM.....means a freestanding or Hospital-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat Mental Illness or Substance Use Disorder or specializes in the treatment of co-occurring Mental Illness and Substance Use Disorder. Requirements: the Claims Administrator requires that any Mental Illness and/or Substance Use Disorder Intensive Outpatient Program must be licensed in the state where it is located, or accredited by a national organization that is recognized by the Claims Administrator, as set forth in the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Intensive Outpatient Program services may be available with less intensity if you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions. If you are recovering from severe and/or chronic Mental Illness and/or Substance Use Disorder conditions, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery plans and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services.

Intensive Outpatient Programs may be used as an initial point of entry into care, as a step up from routine Outpatient services, or as a step down from acute Inpatient, residential care or a Partial Hospitalization Treatment Program.

LIFE-THREATENING DISEASE OR CONDITION.....means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LONG TERM CARE SERVICES.....means those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self-care because of a chronic illness, injury, or condition.

MAINTENANCE CARE.....means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.

MAINTENANCE OCCUPATIONAL THERAPY, MAINTENANCE PHYSICAL THERAPY, and/or MAINTENANCE SPEECH THERAPY.....means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

MARRIAGE AND FAMILY THERAPIST ("LMFT").....means a duly licensed marriage and family therapist operating within the scope of their license.

A "Participating Marriage and Family Therapist" means a Marriage and Family Therapist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Marriage and Family Therapist" means a Marriage and Family Therapist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

MATERNITY SERVICE.....means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MAXIMUM ALLOWANCE.....means (a) the amount which Participating Professional Providers have agreed to accept as payment in full for a particular Covered Service, or the reimbursement amount set by the Claim Administrator, or the Host Blue Plan for Providers designated as Participating Professional Providers for a particular Covered Service. All benefit payments for Covered Services rendered by a Participating Professional Provider will be based on the Schedule of Maximum Allowances which such Provider has agreed to accept as payment in full (b) for Non-Participating Professional Providers, the Maximum Allowance will be the lesser of (unless otherwise required by applicable law or arrangement with Non-Participating Providers):

(i) the Provider's Billed Charges, or;

(ii) the Claim Administrator's non-contracting Maximum Allowance. Except as otherwise provided in this section, the non-contracting Maximum Allowance is developed from base Medicare reimbursements and represents approximately 150% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim. Notwithstanding the preceding sentence, (1) the non-contracting Maximum Allowance for Coordinated Home Care Program Covered Services will be 50% of the Non-Participating Professional Providers Billed Charges for such Covered Services, (2) the non-contracting Maximum Allowance for Ambulance Transportation services provided by Providers (other than Providers that bill through a Participating Provider, which use "Eligible Charge") will be such provider's Billed Charge, as described in the definition of Ambulance Transportation Eligible Charge, and (3) the non-contracting Maximum Allowance for other unsolicited Providers will be the same as the Maximum Allowance described in (a) above.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined based on the information submitted on the Claim, the Maximum Allowance for Non-Participating Professional Providers will be 100% of the Claim Administrator's rate for such Covered Services according to its current Schedule of Maximum Allowances. If there is no rate according to the Schedule of Maximum Allowances, then the Maximum Allowance will be 25% of Claim Charges.

The Claim Administrator will utilize the same Claim processing rules, edits, or methodologies that it utilizes in processing Participating Professional Provider Claims for processing Claims submitted by Non-Participating Professional Providers which may also alter the non-contracting Maximum Allowance for a particular Covered Service. In the event the Claim Administrator does not have any Claim edits, rules or methodologies, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing such Claims. The non-contracting Maximum Allowance will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments. In the event the non-contracting Maximum Allowance amount does not equate to the Non-Participating Professional Provider's Claim Charge, you will be responsible for the difference between such amount and the Claim Charge, along with any applicable Copayment, Coinsurance, and deductible amount(s).

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within one hundred and ninety (190) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

MEDICAL CARE.....means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

MEDICALLY NECESSARY/MEDICAL NECESSITY.....means that a specific medical, health care, supply or Hospital service is required for the treatment or management of a medical symptom or condition, and that the service, supply, or care provided is the most efficient and economical service which can safely be provided.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary, does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies. Please refer to the *Exclusions – What Is Not Covered* section of this booklet for additional information.

The Claim Administrator will make the initial decision whether hospitalization or other health care services or supplies were not Medically Necessary. In most instances this initial decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE

RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED. In making decisions of whether the hospitalization or other health care service(s) or supply(ies) are not Medically Necessary, and therefore not eligible for payment under the terms of this Plan, the Claim Administrator will take into account the information submitted to the Claim Administrator by your Provider(s), including any consultations with such Providers(s).

Hospitalization or other health care is not Medically Necessary when, applying the definition of Medical Necessary to the circumstances surrounding the hospitalization or other health care, it is determined that the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's condition.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's initial decision, your benefit program provides for an appeal of that decision. You must exercise your right to this appeal as a precondition to the taking of any further action against the Claim Administrator, either at law or in equity. To initiate your appeal, you must give the Claim Administrator written notice of your intention to do so as described in the *Claim Filing and Appeals Procedures* section of this booklet.

Below are some examples, not an exhaustive list, of hospitalization or other health care services and supplies that are not Medically Necessary:

1. Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
2. Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
3. Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
4. Hospitalization or admission to a Skilled Nursing Facility or Residential Treatment Center, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
5. The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

MEDICARE.....means the program established by Title XVIII of the Social Security Act (42 U.S.C. §1395 et seq.).

MEDICARE APPROVED or MEDICARE PARTICIPATING.....means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare program.

MEDICARE SECONDARY PAYER or MSP.....means those provisions of the Social Security Act set forth in 42 U.S.C. §1395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible employees, their spouses and, in some cases, dependent children.

MENTAL ILLNESS.....means a condition or disorder that involves a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

NAPRAPATH.....means a duly licensed Naprapath operating within the scope of such license.

A "Participating Naprapath" means a Naprapath who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Naprapath" means a Naprapath who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

NON-ADMINISTRATOR HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-ADMINISTRATOR PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-EMERGENCY FIXED-WING AMBULANCE TRANSPORTATION .....means Ambulance Transportation on a fixed-wing airplane from a Hospital emergency department, other health care facility or Inpatient setting to an equivalent or higher level of acuity facility when transportation is not needed due to an emergency situation. Non-Emergency Fixed-Wing Ambulance Transportation may be considered Medically Necessary when you require acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Non-Emergency Fixed-Wing Ambulance Transportation provided primarily for the convenience of you, your family/caregivers or Physician, or the transferring facility, is not considered Medically Necessary and is not covered under this Health Care Plan.

NON-PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

NON-PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

NON-PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

OCCUPATIONAL THERAPIST.....means a duly licensed occupational therapist operating within the scope of their license.

OCCUPATIONAL THERAPY.....means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

OPTOMETRIST.....means a duly licensed optometrist operating within the scope of their license.

A "Participating Optometrist" means an Optometrist who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Optometrist" means an Optometrist who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ORTHOTIC PROVIDER.....means a duly licensed orthotic provider operating within the scope of their license.

A "Participating Orthotic Provider" means an Orthotic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Orthotic Provider" means an Orthotic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

OUTPATIENT.....means that you are receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

PARTIAL HOSPITALIZATION TREATMENT PROGRAM.....means a Claim Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Mental Illness or Substance Use Disorder Treatment in which patients spend days or nights. This behavioral healthcare is typically 5 to 8 hours per day, 5 days per week (not less than 20 hours of treatment services per week). The program is staffed similarly to the day shift of an inpatient unit, i.e., medically supervised by a Physician and nurse. The program shall ensure a psychiatrist sees the patient

face to face at least once a week and is otherwise available, in person or by telephone, to provide assistance and direction to the program as needed. Participants at this level of care do not require 24-hour supervision and are not considered a resident at the program. Requirements: The Claim Administrator requires that any Mental Illness and/or Substance Use Disorder Partial Hospitalization Treatment Program must be licensed in the state where it is located or accredited by a national organization that is recognized by the Claim Administrator as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

PARTICIPATING HOSPITAL.....SEE DEFINITION OF HOSPITAL.

PARTICIPATING PRESCRIPTION DRUG PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER.....SEE DEFINITION OF PROVIDER.

PARTICIPATING PROVIDER OPTION.....means a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

PHARMACY.....means a state and federally licensed establishment that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescriptions to the general public by a pharmacist licensed to dispense such drugs and devices under laws of the state in which they practice.

PHYSICAL THERAPIST.....means a duly licensed physical therapist operating within the scope of their license.

PHYSICAL THERAPY.....means the treatment of a disease, injury, or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

PHYSICIAN.....means a physician duly licensed to practice medicine in all of its branches operating within the scope of their license.

PHYSICIAN ASSISTANT.....means a duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist or Podiatrist and billing under such Provider operating within the scope of their license.

PODIATRIST.....means a duly licensed podiatrist operating within the scope of their license.

PRIOR AUTHORIZATION.....means a requirement that you must obtain authorization from the Claim Administrator before you receive certain types of Covered Services designated by the Claim Administrator.

PRIOR AUTHORIZATION or EMERGENCY MENTAL ILLNESS OR SUBSTANCE USE DISORDER ADMISSION REVIEW.....means a submission of a request to the Behavioral Health Unit for a determination of Medically Necessary care under this benefit booklet.

PRIVATE DUTY NURSING SERVICE.....means Skilled Nursing Service provided on a one-to-one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care Service.

PROFESSIONAL PROVIDER.....SEE DEFINITION OF PROVIDER.

PROSTHETIC PROVIDER.....means a duly licensed prosthetic provider operating within the scope of their license.

A "Participating Prosthetic Provider" means a Prosthetic Provider who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Prosthetic Provider" means a Prosthetic Provider who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

PROVIDER.....means any health care facility (for example, a Hospital or Skilled Nursing Facility) or person (for example, a Physician or Dentist) or entity duly licensed to render Covered Services to you and operating within the scope of such license.

An "Administrator Provider" means a Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Provider" means a Provider that does not meet the definition of Administrator Provider unless otherwise specified in the definition of a particular Provider.

A "Participating Provider" means an Administrator Hospital or Professional Provider which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide

services to participants in the Participating Provider Option program or an Administrator facility which has been designated by the Claim Administrator as a Participating Provider.

A "Non-Participating Provider" means an Administrator Hospital or Professional Provider which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to participants in the Participating Provider Option program or a facility which has not been designated by the Claim Administrator as a Participating Provider.

A "Professional Provider" means a Physician, Dentist, Podiatrist, Psychologist, Chiropractor, Optometrist, or any Provider designated by the Claim Administrator or another Blue Cross and/or Blue Shield Plan.

A "Participating Prescription Drug Provider" means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty drug Pharmacy which has entered into an agreement to provide pharmaceutical services to participants in the benefit program. A retail Participating Pharmacy may or may not be a select Participating Pharmacy as that term is used in the Vaccinations obtained through Participating Pharmacies section.

A "Non-Participating Prescription Drug Provider" means a Pharmacy, including but not limited to, an independent retail Pharmacy, chain of retail Pharmacies, home delivery Pharmacy or specialty drug Pharmacy which (i) has not entered into a written agreement with the Claim Administrator or (ii) has not entered into a written agreement with an entity chosen by the Claim Administrator to administer its prescription drug program, for such Pharmacy to provide pharmaceutical services at the time Covered Services to participants in the benefit program at the time Covered Services are rendered.

PROVIDER INCENTIVE.....means an additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed upon procedural and/or outcome measures for a particular population of participants.

PSYCHOLOGIST.....means a Registered Clinical Psychologist operating within the scope of such license.

Registered Clinical Psychologist means a Clinical Psychologist who is registered with the Illinois Department of Financial and Professional Regulation pursuant to the Illinois "Psychologists Registration Act" or, in a state where statutory licensure exists, the Clinical Psychologist must hold a valid credential for such practice or, if practicing in a state where statutory licensure does not exist, such person must meet the qualifications specified in the definition of a Clinical Psychologist.

Clinical Psychologist means a psychologist who specializes in the evaluation and treatment of Mental Illness and who meets the following qualifications:

has a doctoral degree from a regionally accredited University, College or Professional School; and has two years of supervised experience in health services of which at least one year is post-doctoral and one year is in an organized health services program; or

is a Registered Clinical Psychologist with a graduate degree from a regionally accredited University or College; and has not less than six years as a psychologist with at least two years of supervised experience in health services.

QUALIFIED ABA PROVIDER.....means a Provider operating within the scope of their license registration or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

(i) Master's level, independently licensed Clinician, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, for services treating Autism Spectrum Disorder (ASD) symptoms, with or without applied behavior analysis (ABA) service techniques; or

(ii) Master's level Clinician whose professional credential is recognized and accepted by an appropriate agency of the United States (i.e., Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D) to supervise and provide treatment planning, with ABA service techniques; or

(iii) Health Care Practitioner who is certified as a provider under the TRICARE military health system, if requesting to provide ABA services; or

(iv) Master's level Clinician with a specific professional credential or certification recognized by the state in which the clinician is located; or

1. Developmental Therapist with Certified Early Intervention Specialist credential or CEIS; or
2. If the Doctor or Medicine (MD) prescribes ABA, writes a MD order for services to be provided by a specific person.

For the para-professional/line therapist:

(i) Two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCABA) for the para-professional/therapist; or

(ii) A bachelor level or high school graduate having obtained a GED, OR a staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist; or

(iii) A person who is "certified as a provider under TRICARE military health system," if requesting to provide ABA services.

RECOMMENDED CLINICAL REVIEW.....means an optional voluntary review of Provider's recommended medical procedure, treatment, or test, which does not require Prior Authorization, to make sure it meets approved Claim Administrator medical policy guidelines and Medical Necessity requirements.

REGISTERED DIETICIAN.....means a duly licensed clinical professional counselor operating within the scope of their license.

REGISTERED SURGICAL ASSISTANT.....means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified or registered nurse first assistant operating within the scope of their certification.

A "Participating Registered Surgical Assistant" means a Registered Surgical Assistant who has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Registered Surgical Assistant" means a Registered Surgical Assistant who does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

RENAL DIALYSIS TREATMENT.....means one unit of service including the equipment, supplies and administrative service which are customarily considered as necessary to perform the dialysis process.

RESCISSION.....means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums. A "Rescission" does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates.

RESIDENTIAL TREATMENT CENTER.....means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure medically necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National

Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served. As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center: half-way houses, supervised living, group homes, wilderness programs, boarding houses or other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities. To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

RESPITE CARE SERVICE.....means those services provided at home or in a facility to temporarily relieve the family or other caregivers (non-professional personnel) that usually provide or are able to provide such services to you.

RETAIL HEALTH CLINIC.....means a health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by Certified Nurse Practitioners.

A "Participating Retail Health Clinic" means a Retail Health Clinic which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

A "Non-Participating Retail Health Clinic" means a Retail Health Clinic which does not have a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered.

ROUTINE PATIENT COSTS.....means the cost for all items and services consistent with the coverage provided under this benefit booklet that is typically covered for you if you are not enrolled in a clinical trial. Routine Patient Costs do not include:

(i) The investigational item, device, or service, itself;

(ii) Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

(iii) A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SKILLED NURSING FACILITY.....means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the

appropriate governmental authority to provide such services and operating within the scope of such licenses.

An "Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Skilled Nursing Facility" means a Skilled Nursing Facility which does not have an agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan but has been certified in accordance with guidelines established by Medicare.

An "Uncertified Skilled Nursing Facility" means a Skilled Nursing Facility which does not meet the definition of an Administrator Skilled Nursing Facility and has not been certified in accordance with the guidelines established by Medicare.

SKILLED NURSING SERVICE.....means those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

SPEECH THERAPIST.....means a duly licensed speech therapist operating within the scope of their license.

SPEECH THERAPY.....means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

STANDARD FERTILITY PRESERVATION SERVICES.....means procedure based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society for Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

SUBSTANCE USE DISORDER.....means a condition or disorder that falls under any of the substance use disorder diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

SUBSTANCE USE DISORDER TREATMENT.....means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or

Substance Use Disorder Treatment Facility which may include, but is not limited to, Acute Treatment Services and Clinical Stabilization Services. It does not include programs consisting primarily of counseling by individuals other than a Behavioral Health Practitioner, court ordered evaluations, programs which are primarily for diagnostic evaluations, mental disabilities or learning disabilities, care in lieu of detention or correctional placement or family retreats.

SUBSTANCE USE DISORDER TREATMENT FACILITY.....means a facility (other than a Hospital) whose primary function is the treatment of Substance Use Disorder and is licensed by the appropriate state and local authority to provide such service, when operating within the scope of such license. It does not include half-way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

An "Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility which has a written agreement with the Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide services to you at the time services are rendered to you.

A "Non-Administrator Substance Use Disorder Treatment Facility" means a Substance Use Disorder Treatment Facility that does not meet the definition of an Administrator Substance Use Disorder Treatment Facility.

SURGERY.....means the performance of any medically recognized, non-Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by the Claim Administrator.

TELEHEALTH AND TELEMEDICINE SERVICES.....means a health care service delivered by a health care professional licensed, certified, or registered to practice in Illinois and acting within the scope of their license, certification, or entitlement to a patient at a different physical location than the health care professional using telecommunications or information technology.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS.....means jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jawbone and skull and the complex of muscles, nerves, and other tissues relating to that joint.

TOBACCO USER.....means a person who is permitted under state and federal law to legally use Tobacco, with Tobacco use (other than religious or ceremonial use of Tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call the number on the back of your Identification Card or visit our website at *www.bcbsil.com*.

TOTALLY DISABLED.....means with respect to an Eligible Person, an inability by reason of illness, injury or physical condition to perform the material duties of any occupation for which the Eligible Person is or becomes qualified by reason of experience, education or training or with respect to a covered person other than an Eligible Person, the inability by reason of illness, injury or physical condition to engage in the normal activities of a person of the same age and sex who is in good health.

TRANSPLANT LODGING ELIGIBLE EXPENSE.....means the amount of $50 per person per day reimbursed for lodging expenses related to a covered transplant.

VALUE BASED PROGRAM.....means an out-come based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

VIRTUAL PROVIDER.....means a licensed Provider who has a written agreement with the Claim Administrator to provide diagnosis and treatment of injuries and illnesses through either i) interactive audio communication (via telephone or other similar technology) or ii) interactive audio/video examination and communication (via online portal, mobile application, or similar technology) to you at the time Covered Services are rendered, operating within the scope of such license.

VIRTUAL VISIT.....means a service provided for the diagnosis or treatment of non-emergency medical illnesses or injuries as described in the VIRTUAL VISITS provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

VITAMIN D TESTING....means vitamin D blood testing that measures the level of vitamin D in a person's blood.

ELIGIBILITY SECTION

Please refer to BMO Plan Documents.

UTILIZATION MANAGEMENT AND REVIEW

The Claim Administrator has established the Utilization Management and Review Program to assist you in determining the course of treatment that will maximize your benefits under this Health Care Plan. Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on the Claim Administrator's Medical Policy and, site or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Please refer to the definition of Medically Necessary under the *Definitions* section of this booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

The Utilization Management and Review Program requires a review of the following Covered Services **before** maximum benefits for such services are available:

- Inpatient Hospital services
- Skilled Nursing Facility services
- Services received in a Coordinated Home Care Program
- Private Duty Nursing Services
- Certain Outpatient procedures

PRIOR AUTHORIZATION

Prior Authorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Services designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled "THE BLUECARD PROGRAM."

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Identification Card.

Please read the provisions below very carefully. The provisions of this section do not apply to the treatment of Mental Illness and Substance Use Disorder Treatment. The provisions for the treatment of Mental Illness and Substance Use Disorder Treatment are specified in the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet.

PREADMISSION REVIEW

- **Inpatient Hospital Preadmission Review**

  Preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  Whenever a non-emergency or non-maternity Inpatient Hospital admission is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the Hospital admission.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination, with a follow-up notification letter sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review**

  Emergency admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In the event of an emergency admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days or as soon as reasonably possible after the admission has occurred.

- **Pregnancy/Maternity Admission Review**

  Pregnancy/Maternity admission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan.

  In the event of a maternity admission, you or someone who calls on your behalf must notify the Claim Administrator no later than two business days after the admission has occurred.

  Even though you are not required to call the Claim Administrator prior to your maternity admission, if you call the medical pre-notification number as soon as you find out you are pregnant, the Claim Administrator will provide you information on support programs to assist you during pregnancy.

- **Skilled Nursing Facility Preadmission Review**

  Skilled Nursing Facility preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever an admission to a Skilled Nursing Facility is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Coordinated Home Care Program Preadmission Review**

  Coordinated Home Care Program preadmission review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Whenever an admission to a Coordinated Home Care Program is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to the scheduling of the admission.

- **Private Duty Nursing Service Review**

  Private Duty Nursing Service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever Private Duty Nursing Service is recommended by your Physician, you must call the Claim Administrator's medical pre-notification number. This call must be made at least one business day prior to receiving services.

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

Outpatient Service Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Whenever the following Outpatient procedure(s)/services(s), are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Coordinated Home Care Program services
- Home hemodialysis
- Home Infusion Therapy
- Home Hospice
- Home Health
- Private Duty Nursing
- Transplant Evaluations and Transplants
- Cardiology Lipid Apheresis

Ears, Nose and Throat (ENT):

- Bone Conduction Hearing Aids
- Cochlear Implant
- Nasal and Sinus Surgery

Gastroenterology (Stomach):

- Gastric Electrical Stimulation (GES)

Neurology:

- Deep Brain Stimulation
- Sacral Nerve Neuromodulation/Stimulation

Pain Management:

- Occipital Nerve Stimulation

Specialty Pharmacy:

- Specialty Pharmacy Medications covered by Medical Benefits including Infusion Site of Care, Medical Oncology & Supportive Care and Provider Administered Drug Therapies.

Surgical Procedures:

- Outpatient Surgery Jaw
- Outpatient Breast
- Surgical Deactivation of Headache Trigger Sites

Wound Care:

- Hyperbaric Oxygen (HBO2) Therapy-Systemic

Non-Emergency Fixed-Wing Ambulance Transportation:

Non-Emergency Fixed-Wing Ambulance Transportation - Please refer to the definition of "Non-Emergency Fixed-Wing Ambulance Transportation" under the DEFINITIONS section of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

Whenever the following Outpatient services(s), received by a Non-Participating Provider, are recommended by your Physician, in order to receive maximum benefits under this Health Care Plan, you must call the Claim Administrator's medical pre-notification number. This call must be made at least two business days prior to receiving these services:

- Dialysis
- Elective Surgery

If an Inpatient Emergency Hospital admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Claim Administrator.

The Claim Administrator will send a letter to you, your Physician and the Hospital or facility with a determination of your Prior Authorization review no later than fifteen (15) calendar days after the Claim Administrator receives the request for Prior Authorization review. However, in some instances depending on the timing of the request for review, these letters will not be received prior to your scheduled date of service or procedure.

For specific details about the Prior Authorization requirements for any of the above referenced Outpatient services, please call the customer service toll-free telephone number on the back of your Identification Card. The Claim Administrator reserves the right to no longer require Prior Authorization during your benefit period for any or all of the listed services. Updates to the list of services requiring Prior Authorization may be confirmed by calling the customer service number.

RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of medical necessity for coverage determinations that may occur prior to services rendered, during care, or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. The Claim Administrator will review the request to determine if it meets approved Claim Administrator medical policy and, site, or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsil.com/find-care/where-you-go-matters/utilization-management.com for the Required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review.

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under this Plan. Please coordinate with your Provider to submit a written request for a Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by the plan. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the member may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from the member's health care Provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other

supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or Post-Service Claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms member eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. Post-Service Medical Necessity Review does not guarantee payment of benefits by the plan, for instance a member may become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Post-Service Medical Necessity Review process may require additional documentation from the member's health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

CASE MANAGEMENT

Case management is a collaborative process that assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost-effective interventions.

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost-effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Health Care Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Health Care Plan.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

Upon completion of the Inpatient or emergency admission review, the Claim Administrator will send a letter to you, your Physician, Provider of services, Behavioral Health Practitioner and/or the Hospital or facility with a determination on the approved length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will not be extended. Additional notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the Plan for continued services. If you, your Provider, or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an Ongoing Course of Treatment, the Plan will make a determination on the request/appeal as soon as possible but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services. For further details regarding Medically Necessary care and other exclusions from coverage, see the EXCLUSIONS—WHAT IS NOT COVERED section in this benefit booklet.

The Claim Administrator does not determine your course of treatment or whether you receive particular health care services. Decisions regarding the course of treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Health Care Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Claim Administrator's Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Health Care Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary, however, the Health Care Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the benefit provision in the benefit booklet.

UTILIZATION REVIEW PROCEDURE

The following information is required when you contact the Claim Administrator:

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital where the admission has been scheduled and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator:

1. will review the information provided and seek additional information, as necessary.
2. will issue a determination that the services are either Medically Necessary or are not Medically Necessary.

3. will provide notification of the determination.

APPEAL PROCEDURE

If you, your Physician, Provider of health services, or Behavioral Health Practitioner disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your Identification Card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician, Provider of health services, or Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Medical Director
Blue Cross and Blue Shield of Illinois
P. O. Box A3957
Chicago, Illinois 60601

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO NOTIFY

The final decision regarding your course of treatment is solely your responsibility and the Claim Administrator will not interfere with your relationship with any Provider. However, the Claim Administrator has established the Utilization Management and Review Program for the specific purpose of assisting you in determining the course of treatment which will maximize your benefits provided under this benefit booklet.

For In–Network benefits your Participating Provider is required to obtain Prior Authorization. There is no penalty to you for failure to notify the Claim Administrator.

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Management and Review Program do not apply to you if you are Medicare eligible and have secondary coverage provided under the Health Care Plan.

CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

The Claim Administrator's Behavioral Health Unit has been established to assist in the administration of Mental Illness and Substance Use Disorder Treatment benefits, including Prior Authorization review, Emergency Mental Illness or Substance Use Disorder Admission Review and length of stay/service review for your Inpatient Hospital admissions and/or Outpatient services for the treatment of Mental Illness and Substance Use Disorders.

Failure to contact the Behavioral Health Unit or to comply with the determinations of the Behavioral Health Unit, as described in this section, may result in a reduction of benefits. The Behavioral Health Unit may be reached twenty-four (24) hours a day, 7 days a week at the toll-free telephone number 1-800-851-7498. Please read the provisions below very carefully.

Prior Authorization is a requirement that you must obtain authorization from the Claim Administrator before you receive a certain type of Covered Services designated by the Claim Administrator in order to be eligible for maximum benefits.

For Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on the Claim Administrator's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of the Claim Administrator's service area, see the section of this benefit booklet entitled "THE BLUECARD PROGRAM."

Failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator, as described in this section, may result in a reduction in benefits. These reductions in benefits are in addition to the applicable Copayments, Coinsurance, Deductibles, and out-of-pocket expense limit amounts. Providers may bill you for any reduction in payment, as described in this section, resulting from failure to contact the Claim Administrator or to comply with the determinations of the Claim Administrator. We encourage you to call ahead. The pre-notification toll-free telephone number is on your Identification Card.

CONTACTING BEHAVIORAL HEALTH

You, your Physician, Provider of services, or your authorized representative may contact the Claim Administrator for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of your Identification Card and follow the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same behavioral health line is answered by clinicians available for Inpatient

acute reviews only. Requests for residential or Partial Hospitalization are reviewed only during regular business hours.

PRIOR AUTHORIZATION REVIEW

- **Inpatient Hospital Prior Authorization Review**

  Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  To receive maximum benefits under this Health Care Plan, you must obtain Prior Authorization for your nonemergency Inpatient Hospital admission for the treatment of Mental Illness or Substance Use Disorder by calling the Behavioral Health Unit. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Residential Treatment Center Prior Authorization Review**

  Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  Whenever an admission to a Residential Treatment Center for the treatment of Mental Illness or Substance Use Disorder is recommended by your Physician, you must, in order to receive maximum benefits under this Health Care Plan, call the Behavioral Health Unit. This call must be made at least one day prior to scheduling of the admission. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the Inpatient Hospital admission.

- **Emergency Mental Illness or Substance Use Disorder Admission Review**

  Emergency Mental Illness or Substance Use Disorder Admission Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you or someone who calls on your behalf must notify the Behavioral Health Unit no later than two business days or as soon as reasonably possible

after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred.

If the call is made any later than the specified time period, you may not be eligible for maximum benefits. Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section.

- **Partial Hospitalization Treatment Program Review**

  Partial Hospitalization Treatment Program review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  In order to receive maximum benefits under this Health Care Plan, you must notify the Behavioral Health Unit no later than 48 hours after the admission for the treatment of Mental Illness or Substance Use Disorder has occurred. Providers may call for you, when required, but it is your responsibility to ensure these requirements are satisfied, as described in this section. The Behavioral Health Unit will obtain information regarding the service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

  If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after a service(s), in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

- **Length of Stay/Service Review**

  Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan.

  Upon completion of the Prior Authorization or Emergency Mental Illness or Substance Use Disorder Review, the Behavioral Health Unit will send you a letter confirming that you or your representative called the Behavioral Health Unit. A letter assigning a length of service or length of stay will be sent to your Behavioral Health Practitioner and/or the Hospital.

  An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary as determined by the Behavioral Health Unit. In the event that the extension is determined not to be Medically Necessary, the length of stay/service will not be extended, and the case will be referred to a Behavioral Health Unit Physician for review.

OUTPATIENT SERVICE PRIOR AUTHORIZATION REVIEW

- **Outpatient Service Prior Authorization Review**

  Outpatient Service Prior Authorization review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Health Care Plan. The Claim Administrator recommends you confirm with your Provider if Prior Authorization has been obtained.

  In order to receive maximum benefits under this Health Care Plan for Outpatient services for the treatment of Mental Illness or Substance Use Disorder, you must, except as otherwise provided, obtain Prior Authorization for the following Outpatient service(s) by calling the Behavioral Health Unit:

  - Psychological testing
  - Neuropsychological testing
  - Electroconvulsive therapy
  - Intensive Outpatient Programs
  - Repetitive Transcranial Magnetic Stimulation
  - Applied Behavior Analysis (ABA) Therapies. (Please see coverage details as described in the Autism Spectrum Disorder(s) provision under the SPECIAL CONDITIONS AND PAYMENTS section of this benefit booklet.

  Providers may obtain Prior Authorization for you, when required, but it is your responsibility to ensure Prior Authorization requirements are satisfied, as described in this section. This call must be made at least one day prior to the scheduling of the planned Outpatient services(s). The Behavioral Health Unit will obtain information regarding the Outpatient service(s) and may discuss proposed treatment with your Behavioral Health Practitioner.

  If an Inpatient Emergency Mental Illness or Substance Use Disorder Admission occurs after an Outpatient service, in order to receive maximum benefits under this Health Care Plan, an additional call must be made to the Behavioral Health Unit for an Emergency Mental Illness or Substance Use Disorder Admission Review.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient Hospital admission, Outpatient service, or other health care services or supplies are not Medically Necessary, as such term is defined in this benefit booklet, will be determined by the Behavioral Health Unit. If the Behavioral Health Unit concurs that the Inpatient Hospital admission, Outpatient service, or other health care service or supply does not meet the criteria for Medically Necessary care, benefit for some days, services or the entire hospitalization will be denied. Your Behavioral Health Practitioner and in the case of an Inpatient Hospital admissions, the Hospital

will be advised by telephone of this determinations, with a follow-up notification letter sent to you, your Behavioral Health Practitioner, and the Hospital, and will specify the dates, services or supplies that are not considered Medically Necessary. The Behavioral Health Unit will issue these notification letters promptly. However, in some instances, these letters will not be received prior to your scheduled date of admission or service. For further details regarding Medically Necessary care and other exclusions described in this benefit booklet, see the provision entitled, "EXCLUSIONS—WHAT IS NOT COVERED."

The Behavioral Health Unit does not determine your course of treatment or whether you receive particular health care services. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between you and your Behavioral Health Practitioner. The Behavioral Health Unit's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization, Outpatient service or other health care service is Medically Necessary under the Health Care Plan.

In the event that the Behavioral Health Unit determines that all or any portion of an Inpatient Hospital admission, Outpatient service, or other health care service or supply is not Medically Necessary, the Claim Administrator will not be responsible for any related Hospital or other health care service or supply charge incurred.

Remember that your Health Care Plan does not cover the cost of hospitalization or any health care services and supplies that are not Medically Necessary. The fact that your Behavioral Health Practitioner or another health care Provider may prescribe, order, recommend or approve an Inpatient Hospital admission, Outpatient service or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Behavioral Health Practitioner prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the Claim Administrator will not pay for the hospitalization, services or supplies if the Behavioral Health Unit decides they were not Medically Necessary.

BEHAVIORAL HEALTH UNIT PROCEDURE

When you contact the Behavioral Health Unit to obtain Prior Authorization for your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review you should be prepared to provide the following information:

1. the name of the attending and/or admitting Behavioral Health Practitioner;
2. the name of the Hospital or facility where the admission and/or service has been scheduled, when applicable;
3. the scheduled admission and/or service date; and

4. a preliminary diagnosis or reason for the admission and/or service.

When you contact the Behavioral Health Unit to obtain Prior Authorization for your Inpatient Hospital admission, Outpatient service, and/or other service/supply, provide notification of your Emergency Mental Illness or Substance Use Disorder Admission, or request a length of stay/service review, the Behavioral Health Unit:

1. will review the medical information provided and follow-up with the Behavioral Health Practitioner;
2. upon request, will advise you of Participating Providers in the area who may be able to provide the admission and/or services that are the subject of the Prior Authorization Review;
3. may determine that the admission and/or services to be rendered are not Medically Necessary.

APPEAL PROCEDURE

Expedited Appeal

If you or your Behavioral Health Practitioner disagrees with the determinations of the Behavioral Health Unit prior to or while receiving services, you or the Behavioral Health Practitioner may appeal that determination by contacting the Behavioral Health Unit and requesting an expedited appeal. The Behavioral Health Unit Physician will review your case and determine whether the service was Medically Necessary. You and/or your Behavioral Health Practitioner will be notified of the Behavioral Health Unit Physician's determination within twenty-four (24) hours or no later than the last authorized day. If you or your Behavioral Health Practitioner still disagree with the Behavioral Health Unit Physician, you may request an appeal in writing as outlined below.

Written Appeal

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after Claim processing has taken place or upon receipt of the notification letter from the Behavioral Health Unit, you may appeal that decision by having your Behavioral Health Practitioner call the contact person indicated in the notification letter or by submitting a written request to:

Blue Cross and Blue Shield of Illinois
Appeals Coordinator
Blue Cross and Blue Shield BH Unit
P. O. Box 660240
Dallas, Texas 75266-0240
Fax Number: 1-877-361-7656

You must exercise the right to this appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity.

Once you have requested this review, you may submit additional information and comments on your Claim to the Claim Administrator as long as you do so within 30 days of the date you asked for a review. Also, during this 30-day period, you may review any relevant documents held by the Claim Administrator if you request an appointment in writing.

Within 30 days of receiving your request for review, the Claim Administrator will send you its decision on the Claim. In unusual situations, an additional 15 days may be needed for the review, and you will be notified of this during the first 30-day period.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

FAILURE TO OBTAIN PRIOR AUTHORIZATION OR NOTIFY

For In-Network benefits your Participating Provider is required to obtain Prior Authorization. For Non-Network Benefits you must obtain Prior Authorization from the Claims Administrator as soon as is reasonably possible. If you fail to obtain Prior Authorization from the Claims Administrator as required, Benefits will be subject to a $400 reduction.

The final decision regarding your course of treatment is solely your responsibility and the Behavioral Health Unit will not interfere with your relationship with any Behavioral Health Practitioner. However, the Behavioral Health Unit has been established for the specific purpose of assisting you in maximizing your benefits as described in this benefit booklet.

Should you fail to obtain Prior Authorization or notify the Behavioral Health Unit as required in the Prior Authorization Review provision of this section, you will then be responsible for the first $ of the Hospital charges for an eligible Hospital stay in addition to any deductibles, Copayments and/or Coinsurance applicable to this benefit booklet. This amount shall not be eligible for later consideration as an unreimbursed expense under any Benefit Section of this benefit booklet nor can it be applied to your out-of-pocket expense limit, if applicable to this benefit booklet.

For Outpatient behavioral health services, there is no penalty to you for failure to notify the Claim Administrator. For Substance Use Disorder Treatment, there is no penalty to you for failure to notify the Claim Administrator for Inpatient Hospital admissions, Residential Treatment Centers and Partial Hospitalization Treatment Programs.

MEDICARE ELIGIBLE MEMBERS

The provisions of the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT section of this benefit booklet do not apply to you if you are Medicare Eligible and have secondary coverage provided under the Health Care Plan.

CASE MANAGEMENT

You may call the Behavioral Health Unit at the number shown on your Identification Card to access a case manager. They may answer questions

about your behavioral condition, help you understand what to expect when you are discharged from a behavioral health facility to your home or to another care facility and help coordinate special care you may need. The behavioral health case management program is designed to help those with mental health and/or substance use concerns manage the unique challenges of those conditions. A case manager may reach out to you via phone or letter to offer case management assistance.

THE PARTICIPATING PROVIDER OPTION

Your Employer has chosen the Claim Administrator's "Participating Provider Option" for the administration of your Hospital and Physician benefits. The Participating Provider Option is a program of health care benefits designed to provide you with economic incentives for using designated Providers of health care services.

As a participant in the Participating Provider Option a directory of Participating Providers is available to you. You can visit the Blue Cross and Blue Shield of Illinois website at *www.bcbsil.com* for a list of Participating Providers. While there may be changes in the directory from time to time, selection of Participating Providers by the Claim Administrator will continue to be based upon the range of services, geographic location, and cost-effectiveness of care. Notice of changes in the network will be provided to your Employer annually, or as required, to allow you to make selection within the network. However, you are urged to check with your Provider before undergoing treatment to make certain of its participation status. Although you can go to the Hospital or Professional Provider of your choice, benefits under the Participating Provider Option will be greater when you use the services of a Participating Provider.

Before reading the description of your benefits, you should understand the terms "Benefit Period" and "Deductible" as defined below.

YOUR BENEFIT PERIOD

Your benefit period is a period of one year which begins on January 1st of each year. When you first enroll under this coverage, your first benefit period begins on your Coverage Date, and ends on the first December 31st following that date.

YOUR DEDUCTIBLE

Each benefit period you must satisfy a $750 deductible for Covered Services rendered by Participating Provider(s) and a separate $1,500 deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s). In other words, after you have claims for Covered Services for more than the deductible amount in a benefit period, your benefits will begin. This deductible will be referred to as the program deductible.

FAMILY DEDUCTIBLE

If you have Family Coverage and your family has reached the program deductible amount of $1,500 for Covered Services rendered by Participating Provider(s) and a separate $3,000 program deductible for Covered Services rendered by Non-Participating Provider(s) or Non-Administrator Provider(s), it will not be necessary for anyone else in your family to meet the program deductible in that benefit period. That is, for the remainder of that benefit period only, no other family member(s) is required to meet the program deductible before receiving benefits. A family member may not apply more

than the individual program deductible amount toward the family program deductible.

In any case, should two or more members of your family ever receive Covered Services as a result of injuries received in the same accident, only one program deductible will be applied against those Covered Services.

BLUE DISTINCTION® AND BLUE DISTINCTION SPECIALTY CARE PROGRAM

Blue Distinction® ("Blue Distinction") is a national designation awarded by Blue Cross and Blue Shield Plans to health care Providers. The Blue Distinction Specialty Care program includes two levels of designation: Blue Distinction Centers (BDC) and Blue Distinction Centers+ (BDC+). The Blue Distinction Specialty Care program focuses on BDC and BDC+ providers that excel in providing safe, effective treatment for specialty care needs.

BLUE DISTINCTION CENTERS

The Blue Distinction designation uses nationally consistent criteria to designate high-performing providers based on objective, evidence-based selection criteria. The Blue Distinction Specialty Care program's purpose is to assist you in finding BDC and BDC+ providers that have met overall quality measures for patient safety and outcomes, fewer medical complications, lower readmission rates, and higher survival rates in the administration of specialty care.

Blue Distinction Centers provide care in the following specialty care areas:

- Cardiac Care
- Cellular Immunotherapy (CAR-T)
- Fertility Care*
- Substance Use Treatment and Recovery
- Gene Therapy
- Spine Surgery
- Bariatric Surgery
- Knee and Hip Replacement Surgery
- Maternity Care
- Transplants (Stem cell/bone marrow, solid organ (heart, liver, lung, kidney) and combination solid organ (heart/lung, liver/kidney, pancreas/kidney)

* BDC and BDC+ Fertility Care programs are currently supported by plans with Fertility Care programs at the professional level.

BDC and BDC+ Benefit Differential

Your plan offers lower out-of-pocket costs when you receive treatment at a BDC or BDC+ Provider for certain services related to Transplants services. You may choose to receive treatment at a non-BDC and/or non-BDC+ provider; however, your out-of-pocket costs will be higher. Please refer to your Benefit Highlights section to review the payment levels for procedures performed at a BDC or a BDC+ designated Provider, and procedures performed at other facilities. Blue Distinction benefit levels apply to Blue Distinction facility benefits only, except for Fertility, which offers Professional Provider services.

For additional information regarding Blue Distinction Centers for specialty care, please contact a customer service representative at the toll-free telephone number shown on your Identification Card or visit the following website: www.bcbs.com/blue-distinction-center/facility .

HOSPITAL BENEFIT SECTION

Expenses for Hospital care are usually the biggest of all health care costs. Your Hospital benefits will help ease the financial burden of these expensive services. This section of your benefit booklet tells you what Hospital services are covered and how much will be paid for each of these services.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

In addition, the benefits described in this section will be provided only when you receive services on or after your Coverage Date and they are rendered upon the direction or under the direct care of your Physician. Such services must be Medically Necessary and regularly included in the Provider's charges.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

INPATIENT CARE

The following are Covered Services when you receive them as an Inpatient in a Hospital.

Inpatient Covered Services

1. Bed, board, and general nursing care when you are in:
   - — a semi-private room
   - — a private room
   - — an intensive care unit
2. Ancillary services (such as operating rooms, drugs, surgical dressings, and lab work)

Preadmission Testing

Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery.

These tests are considered part of your Inpatient Hospital surgical stay.

Partial Hospitalization Treatment

Benefits are available for this program only if it is an Administrator Program. No benefits will be provided for services rendered in a Partial Hospitalization Treatment Program which has not been approved by the Claim Administrator.

Coordinated Home Care

Benefits will be provided for services under a Coordinated Home Care Program.

You are entitled to benefits for 120 visits in a Coordinated Home Care Program per benefit period.

BENEFIT PAYMENT FOR INPATIENT HOSPITAL COVERED SERVICES

Participating Provider

When you receive Inpatient Covered Services from a Participating Provider or in an Administrator Program of a Participating Provider benefits will be provided at 80% of the Eligible Charge after you have met your program deductible, unless otherwise specified in this benefit booklet. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Participating Provider

When you receive Inpatient Covered Services from a Non-Participating Provider or in an Administrator Program of a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge, after you have met your program deductible. If you are in a private room, benefits will be limited by the Hospital's rate for its most common type of room with two or more beds.

Non-Administrator Provider

When you receive Inpatient Covered Services from a Non-Administrator Provider, benefits will be provided at the same benefit payment level which would have been paid had such services been received from a Non-Participating Provider.

OUTPATIENT HOSPITAL CARE

The following are Covered Services when you receive them from a Hospital as an Outpatient.

Outpatient Hospital Covered Services

1. Surgery and any related Diagnostic Service received on the same day as the Surgery. In addition, benefits for Covered Services received for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.
2. Radiation Therapy Treatments
3. Chemotherapy
4. Electroconvulsive Therapy
5. Renal Dialysis Treatments—if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility
6. Diagnostic Service—when you are an Outpatient, and these services are related to Surgery or Medical Care
7. Urgent Care

8. Emergency Accident Care
9. Emergency Medical Care
10. Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis
11. Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

BENEFIT PAYMENT FOR OUTPATIENT HOSPITAL COVERED SERVICES

Participating Provider

Benefits will be provided at 80% of the Eligible Charge after you have met your program deductible when you receive Outpatient Hospital Covered Services from a Participating Provider.

Benefits for urgent care from a Participating Provider will be provided at 100% of the Hospital's Eligible Charge, subject to a Copayment of $150 per visit Your program deductible will not apply.

Non-Participating Provider

When you receive Outpatient Hospital Covered Services from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge after you have met your program deductible.

Benefits for urgent care from a Non-Participating Provider will be provided at 60% of the Hospital's Eligible Charge after you have met your program deductible.

Non-Administrator Provider

When you receive Outpatient Hospital Covered Services from a Non-Administrator Provider, benefits will be provided at the same payment level which would have been paid had such services been received from a Non-Participating Provider.

Emergency Care

Benefits for Emergency Accident Care will be provided at 100% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Accident Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

Benefits for Emergency Accident Care will not be subject to the program deductible.

Benefits for Emergency Medical Care will be provided at 100% of the Eligible Charge when you receive Covered Services that meet the definition of Emergency Medical Care from either a Participating, Non-Participating or Non-Administrator Provider in a Hospital emergency department.

Benefits for Emergency Medical Care will not be subject to the program deductible.

Each time you receive Covered Services in an emergency room, you will be responsible for a Copayment of $300. If you are admitted to the Hospital as an Inpatient immediately following emergency treatment, the emergency room Copayment will be waived.

However, Covered Services received for Emergency Accident Care and Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your program deductible. The emergency room Copayment will not apply.

If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your Claim.

WHEN SERVICES ARE NOT AVAILABLE FROM A PARTICIPATING PROVIDER (HOSPITAL)

If you must receive Hospital Covered Services which the Claim Administrator has reasonably determined are unavailable from a Participating Provider, benefits for the Covered Services you receive from a Non-Participating Provider will be provided at the payment level described for a Participating Provider.

PHYSICIAN BENEFIT SECTION

This section of your benefit booklet tells you what services are covered and how much will be paid when you receive care from a Physician or other specified Professional Provider.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For benefits to be available under this Benefit Section, services must be Medically Necessary, and you must receive such services on or after your Coverage Date.

Remember, whenever the term "you" or "your" is used, we also mean all eligible family members who are covered under Family Coverage.

Certain services are covered pursuant to the Claim Administrator's medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by the Claim Administrator when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the benefit Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsil.com, or call customer service at the number listed on the back of your Identification Card.

COVERED SERVICES

Surgery

Benefits are available for Surgery performed by a Physician, Dentist or Podiatrist. However, for services performed by a Dentist or Podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them, and which would be payable under this Health Care Plan had they been performed by a Physician. Benefits for oral Surgery are limited to the following services:

1. surgical removal of complete bony impacted teeth;
2. excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth;
3. surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth and;

4. excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands, or ducts; reduction of dislocation of, or excision of, the temporomandibular joints.

The following services are also part of your surgical benefits:

1. Anesthesia Services—if administered at the same time as a covered surgical procedure in a Hospital or Ambulatory Surgical Facility or by a Physician other than the operating surgeon or by a Certified Registered Nurse Anesthetist. However, benefits will be provided for anesthesia services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility.

   In addition, benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a Hospital or Ambulatory Surgical Facility if (a) a child is age 6 and under, (b) you have a chronic disability, or (c) you have a medical condition requiring hospitalization or general anesthesia for dental care.

   Benefits will be provided for anesthesia administered in connection with dental care treatment rendered in a dental office, oral surgeon's office, Hospital or Ambulatory Surgical Facility if you are under age 19 and have been diagnosed with an Autism Spectrum Disorder or a developmental disability.

   For purposes of this provision only, the following definitions shall apply:

   Autism Spectrum Disorder means.....a pervasive developmental disorder described by the American Psychiatric Association or the World Health Organization diagnostic manuals as an autistic disorder, atypical autism, Asperger Syndrome, Rett Syndrome, childhood disintegrative disorder, or pervasive developmental disorder not otherwise specified; or a special education classification for autism or other disabilities related to autism.

   Developmental disability means.....a disability that is attributable to an intellectual disability or a related condition, if the related condition meets all of the following conditions:

   - It is attributable to cerebral palsy, epilepsy, or any other condition, other than a Mental Illness, found to be closely related to an intellectual disability because that condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and requires treatment or services similar to those required for those individuals; for purposes of this definition, autism is considered a related condition;
   - It manifested before the age of 22;
   - It is likely to continue indefinitely; and

- It results in substantial functional limitations in 3 or more of the following areas of major life activity: i) self-care, ii) language, iii) learning, iv) mobility, v) self-direction, and vi) the capacity for independent living.

2. Assist at Surgery—when performed by a Physician, Dentist or Podiatrist who assists the operating surgeon in performing covered Surgery in a Hospital or Ambulatory Surgical Facility. In addition, benefits will be provided for assist at Surgery when performed by a Registered Surgical Assistant or an Advanced Practice Nurse. Benefits will also be provided for assist at Surgery performed by a Physician Assistant under the direct supervision of a Physician, Dentist or Podiatrist.
3. Sterilization Procedures (even if they are voluntary).
4. Gender reassignment—benefits for Covered Services for gender reassignment Surgery, including related services and supplies, will be provided the same as any other condition.

A1C Testing

This plan provides benefits for A1C testing for prediabetes, type I diabetes, and type II diabetes mellitus.

Biomarker Testing

This plan provides benefits for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition, including Medically Necessary home saliva cancer screenings, once every twenty-four (24) months, if you are at high risk or showing symptoms of the disease being tested for.

Biomarker Testing means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes single-analyte tests, multiplex panel tests and whole genome sequencing.

Blood Glucose Monitors for Treatment of Diabetes

This plan provides benefits for Medically Necessary blood glucose monitors (including non-invasive monitors and monitors for the blind) if a Physician has provided a written order.

Comprehensive Cancer Testing

This plan provides benefits for Medically Necessary Comprehensive Cancer Testing, including, but not limited to, whole-exome genome testing, whole-genome sequencing, RNA sequencing, tumor mutation burden, and targeted cancer gene panels.

Pancreatic Cancer Screening

This plan provides benefits for Medically Necessary pancreatic cancer screenings.

Vitamin D Testing

This plan provides benefits for Vitamin D Testing in accordance with vitamin D deficiency risk factors identified by the United States Centers for Disease Control and Prevention.

Medical Care

Benefits are available for Medical Care visits when:

1. you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Use Disorder Treatment Facility or a Residential Treatment Center or
2. you are a patient in a Partial Hospitalization Treatment Program or Coordinated Home Care Program or
3. you visit your Physician's office, or your Physician comes to your home.

Consultations

Your coverage includes benefits for consultations. The consultation must be requested by your Physician and consist of another Physician's advice in the diagnosis or treatment of a condition which requires special skill or knowledge. Benefits are not available for any consultation done because of Hospital regulations or by a Physician who also renders Surgery or Maternity Service during the same admission.

Diabetes Self-Management Training and Education

Benefits will be provided for Outpatient self-management training, education, and medical nutrition therapy. Benefits will also be provided for education programs that allow you to maintain a hemoglobin A1C level within the ranges identified in nationally recognized standards of care. Benefits will be provided if these services are rendered by a Physician, or duly certified, registered, or licensed health care professionals with expertise in diabetes management, operating within the scope of their license. Benefits for such health care professionals will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet. Benefits for Physicians will be provided at the Benefit Payment for Physician Services described later in this benefit section.

Benefits are also available for regular foot care examinations by a Physician or Podiatrist.

Diagnostic Service—Benefits will be provided for those services related to covered Surgery or Medical Care.

Emergency Accident Care

Emergency Medical Care

Electroconvulsive Therapy

Allergy Injections and Allergy Testing

Chemotherapy

Occupational Therapy

Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Occupational Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Physical Therapy

Benefits will be provided for Physical Therapy when rendered by a licensed professional Physical Therapist; provided, however, when the therapy is beyond the scope of the Physical Therapist's license, the Physical Therapist must be under the supervision of a Physician, and the therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Physical Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Chiropractic and Osteopathic Manipulation—Benefits will be provided for manipulation or adjustment of osseous or articular structures, commonly referred to as chiropractic and osteopathic manipulation, when performed by a person licensed to perform such procedures. Your benefits for chiropractic and osteopathic manipulation will be limited to a maximum of 20 visits per benefit period.

Naprapathy—Benefits will be provided for naprapathy when rendered by a Naprapath. Benefits for naprapathy will be limited to a maximum of 20 visits per benefit period.

Radiation Therapy Treatments

This plan provides benefits for Medically Necessary radiation therapy treatments.

Speech Therapy

Benefits will be provided for Speech Therapy when these services are rendered by a licensed Speech Therapist or Speech Therapist certified by the American Speech and Hearing Association. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission. Your benefits for Occupational Therapy, Speech Therapy and Physical Therapy are limited to a combined maximum of 60 visits per benefit period. Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Speech Therapy visits maximum indicated in the Benefit Highlights section of this benefit booklet.

Telehealth and Telemedicine Services

This plan provides benefits for Telehealth and Telemedicine Services as defined under the BENEFIT HIGHLIGHTS and DEFINITIONS section of this booklet.

Clinical Breast Examinations—Benefits will be provided for clinical breast examinations when performed by a Physician, Advanced Practice Nurse or a Physician Assistant working under the direct supervision of a Physician.

Diagnostic Colonoscopies

Benefits will be provided for diagnostic colonoscopies, when determined to be Medically Necessary by a Physician, Advanced Practice Nurse, or Physician Assistant.

Ovarian Cancer Screening

Benefits will be provided for annual ovarian cancer screening using CA-125 serum tumor marker testing, transvaginal ultrasound, and pelvic examination.

Pap Smear Test

Benefits will be provided for an annual routine cervical smear or pap smear test.

Prostate Cancer Screening

Benefits will be provided for an annual routine prostate cancer screening.

Routine Liver Screening

Benefits will be provided at no charge for routine liver screenings, including liver ultrasounds and alpha-fetoprotein blood tests, for individuals who are at high risk for liver disease, every six months.

Bone Mass Measurement and Osteoporosis—Benefits will be provided for bone mass measurement and the diagnosis and treatment of osteoporosis.

Experimental/Investigational Treatment—Benefits will be provided for routine patient care in conjunction with experimental/investigational treatments when medically appropriate and you have cancer or a terminal

condition that according to the diagnosis of your Physician is considered life threatening, if a) you are a qualified individual participating in an Approved Clinical Trial program; and b) if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with an Approved Clinical Trial program. You and/or your Physician are encouraged to call customer service at the toll-free number on your Identification Card in advance to obtain information about whether a particular clinical trial is qualified.

Approved Clinical Trials—Benefits for Covered Services for Routine Patient Costs are provided in connection with a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Acupuncture—Benefits will be provided for acupuncture when rendered by a licensed acupuncturist. Benefits for acupuncture will be limited to 20 visits per benefit period.

Durable Medical Equipment—Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), compression sleeves to prevent or mitigate lymphedema, bone screws, bolts, nails, plates, and any other internal and permanent devices. Benefits will also be provided for the rental (but not to exceed the total cost of equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose.

Amino Acid-Based Elemental Formulas—Benefits will be provided for amino acid-based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short-bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary. If you purchase the formula at a Pharmacy, benefits will be provided at the Benefit Payment for Other Covered Services described in the OTHER COVERED SERVICES section of this benefit booklet.

Orthotic Devices

Benefits will be provided for a supportive device for the body or a part of the body, head, neck, or extremities, including but not limited to, leg, back, arm and neck braces. In addition, benefits will be provided for adjustments, repairs, or replacement of the device because of a change in your physical condition, as Medically Necessary.

Outpatient Contraceptive Services

Benefits will be provided for prescription contraceptive devices, injections, implants, and Outpatient contraceptive services. Outpatient contraceptive services means consultations, examinations, procedures, and medical services provided on an Outpatient basis and related to the use of contraceptive

methods (including natural family planning) to prevent an unintended pregnancy.

Benefits for prescription contraceptive devices and implants will not be subject to a calendar year maximum.

Prosthetic Appliances

Benefits will be provided for prosthetic devices, special appliances, and surgical implants when:

1. they are required to replace all or part of an organ or tissue of the human body, or
2. they are required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repair and replacements of covered prosthetic devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the treatment of Temporomandibular Joint Dysfunction and Related Disorders, subject to specific limitations applicable to Temporomandibular Joint Dysfunction and Related Disorders, and replacement of cataract lenses when a prescription change is not required).

Routine Pediatric Hearing Examination—Benefits will be provided for routine pediatric hearing examinations.

Pulmonary Rehabilitation Therapy—Benefits will be provided for outpatient cardiac/pulmonary rehabilitation programs provided within six months of a cardiac incident and outpatient pulmonary rehabilitation services.

Reconstructive Services

This plan provides benefits for Medically Necessary reconstructive services to restore physical appearance due to trauma.

Gender assignment surgery and gender reassignment surgery with related services

BENEFIT PAYMENT FOR PHYSICIAN SERVICES

The benefits provided by the Claim Administrator and the expenses that are your responsibility for your Covered Services will depend on whether you receive services from a Participating or Non-Participating Professional Provider.

Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Participating Provider or from a Dentist, benefits will be provided at 80% of the Maximum Allowance after you have met your program deductible, unless otherwise specified in this benefit booklet.

Although Dentists are not Participating Providers they will be treated as such for purposes of benefit payment made under this benefit booklet and may bill you for the difference between the Claim Administrator's benefit payment and the Provider's charge to you.

When you receive Covered Services (except for those services specified below) in a Participating Provider's office (other than a specialist's office), benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of $25 per visit. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

When you receive Covered Services (except for those services specified below) in a Participating Provider specialist's office, benefits for Covered Services, including all related Covered Services received on the same day, are subject to a Copayment of $40 per visit. A specialist is a Professional Provider who is **not** a Physician in general practice, family practice, internal medicine, obstetrics, gynecology, or pediatrics. Benefits will then be provided at 100% of the Maximum Allowance. Your program deductible will not apply.

The following Covered Services are not subject to the office visit Copayment, and benefits will be provided at the general medical/surgical payment level:

- Surgery
- Occupational Therapy
- Physical Therapy
- Speech Therapy

When you receive Outpatient Occupational Therapy, Outpatient Physical Therapy, or Outpatient Speech Therapy from a Participating Provider, benefits will be provided at 100% of the Maximum Allowance.

Benefits for Outpatient Occupational Therapy, Outpatient Physical Therapy, or Outpatient Speech Therapy from a Participating Provider will be subject to your program deductible.

Benefits for chiropractic and osteopathic manipulation will be provided at 100% of the Maximum Allowance, subject to a Copayment of $25 per visit, when Covered Services are received from a Participating Provider.

Benefits for chiropractic and osteopathic manipulation from a Participating Provider will not be subject to the program deductible.

Benefits for Acupunture will be provided at 100% of the Maximum Allowance, subject to a Copayment of $25 per visit, when Covered Services are received from a Participating Provider.

Benefits for Acupunture from a Participating Provider will not be subject to the program deductible.

Non-Participating Provider

When you receive any of the Covered Services described in this Physician Benefit Section from a Non-Participating Provider, benefits will be provided

at 60% of the Maximum Allowance after you have met your program deductible.

Emergency Care

Benefits for Emergency Accident Care will be provided at 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible. Benefits for surgical procedures, such as stitching, gluing and casting are not provided at the Emergency Accident Care payment level. Such services will be provided at the benefit payment level for Surgery described in this benefit booklet.

When you receive Covered Services for Emergency Accident Care in a Provider's office, benefits for office visits are subject to a Copayment of $25 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

Benefits for Emergency Medical Care will be provided at 80% of the Maximum Allowance when rendered by either a Participating or Non-Participating Provider after you have met your program deductible.

When you receive Covered Services for Emergency Medical Care in a Provider's office, benefits for office visits are subject to a Copayment of $25 per visit. Benefits for office visits will be provided at 100% of the Maximum Allowance.

However, Covered Services for Emergency Accident Care and Emergency Medical Care resulting from a criminal sexual assault or abuse will be paid at 100% of the Maximum Allowance whether or not you have met your program deductible. The office visit Copayment will not apply.

If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Accident Care or Emergency Medical Care, you may call the Claim Administrator at the number on the back of your Identification Card. Please review the HOW TO FILE A CLAIM AND APPEALS PROCEDURES section of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your Claim.

Participating and Non-Participating Professional Providers are:

- Acupuncturists
- Audiologists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Dentists*
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Naprapaths
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Other Professional Providers
- Physical Therapists
- Physicians
- Podiatrists
- Psychologists
- Prosthetic Providers
- Registered Surgical Assistants
- Registered Dieticians
- Retail Health Clinics
- Speech Therapists

* Dentists are Non-Participating Providers and will be treated as such for purposes of benefit payment made under this benefit booklet. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

Participating Providers have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit payment and the Maximum Allowance for the Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider, or the Claim Administrator.

OTHER COVERED SERVICES

OTHER COVERED SERVICES

This section of your benefit booklet describes "Other Covered Services" and the benefits that will be provided for them.

- The processing, transporting, storing, handling and administration of blood and blood components.
- Private Duty Nursing Service—Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. No benefits will be provided when a nurse ordinarily resides in your home or is a member of your immediate family. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Your benefits for Private Duty Nursing Service are limited to a maximum of 60 visits per month.
- Ambulance Transportation—Benefits will not be provided for long distance trips or for use of an ambulance because it is more convenient than other transportation.
- Dental accident care—Dental services rendered by a Dentist or Physician which are required as the result of an accidental injury.
- Oxygen and its administration.
- Medical and surgical dressings, supplies, casts, and splints.
- Wigs—Benefits will be provided for wigs (also known as cranial prostheses) when your hair loss is due to Chemotherapy, radiation therapy or alopecia. Benefits for wigs will be limited to a lifetime maximum of $500.

BENEFIT PAYMENT FOR OTHER COVERED SERVICES

After you have met your program deductible, benefits will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance for any of the Covered Services described in this section.

Benefits for ambulance transportation (local ground or air transportation to the nearest appropriately equipped facility) will be provided at 80% of the Eligible Charge or 80% of the Maximum Allowance after you have met your program deductible. For ambulance, if not related to a true emergency, the charges should be paid at 60% of Eligible Charge or 60% of the Maximum Allowance after you have met your program deductible.

Notwithstanding anything else described herein, Providers of ambulance services will be paid based on the amount that represents the billed charges from the majority of the ambulance Providers in the Chicago Metro area as submitted to the Claim Administrator. Benefits for Ambulance Transportation will be paid at the highest level available under this benefit program. However, you will be responsible for any charges in excess of this amount.

When you receive Other Covered Services from a Participating or Non-Participating Provider, benefits for Other Covered Services will be provided at the payment levels previously described in this benefit booklet for Hospital and Physician Covered Services.

Participating and Non-Participating Professional Providers are:

- Acupuncturists
- Audiologists
- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Chiropractors
- Clinical Social Workers
- Clinical Professional Counselors
- Clinical Laboratories
- Dentists*
- Durable Medical Equipment Providers
- Home Infusion Therapy Providers
- Marriage and Family Therapists
- Naprapaths
- Occupational Therapists
- Optometrists
- Orthotic Providers
- Other Professional Providers
- Physical Therapists
- Physicians
- Podiatrists
- Psychologists
- Prosthetic Providers
- Registered Surgical Assistants
- Registered Dieticians
- Retail Health Clinics
- Speech Therapists

* Dentists are Non-Participating Providers and will be treated as such for purposes of benefit payment made under this benefit booklet. They may bill you for the difference between the Blue Cross and Blue Shield benefit payment and the Provider's charge to you.

Participating Providers have signed an Agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Such Participating Providers have agreed not to bill you for Covered Services amounts in excess of the Maximum Allowance. Therefore, you will be responsible only for the difference between the Claim Administrator's benefit

payment and the Maximum Allowance for the Covered Service — that is, your program deductible, Copayment and Coinsurance amounts.

Non-Participating Providers have not signed an agreement with the Claim Administrator to accept the Maximum Allowance as payment in full. Therefore, you are responsible to these Providers for the difference between the Claim Administrator's benefit payment and such Provider's charge to you.

Should you wish to know the Maximum Allowance for a particular procedure or whether a particular Provider is a Participating Provider, contact your Employer, your Professional Provider, or the Claim Administrator.

SPECIAL CONDITIONS AND PAYMENTS

There are some special things that you should know about your benefits should you receive any of the following types of treatments:

HUMAN ORGAN TRANSPLANTS

Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular-skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

— If both the donor and recipient have coverage each will have their benefits paid by their own program.

— If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this benefit booklet will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

— If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this benefit booklet will be provided for you. However, no benefits will be provided for the recipient.

Benefits will be provided for:

— Inpatient and Outpatient Covered Services related to the transplant Surgery.

— the evaluation, preparation, and delivery of the donor organ.

— the removal of the organ from the donor.

— the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants will be provided as follows:

— **Whenever a heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas, or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.**

— If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a dependent child under the limiting age of this benefit booklet, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For benefits to be available, your place of residency must be more than 100 miles from the Hospital where the transplant will be performed.

— The maximum amount that will be provided for lodging is $50 per person per day with a maximum of $100 per day if more than one person.

— In addition to the other exclusions of this benefit booklet, benefits will not be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this provision.
- Meals.

CARDIAC REHABILITATION SERVICES

Your benefits for cardiac rehabilitation services are the same as your benefits for any other condition. Benefits will be provided for cardiac rehabilitation services only in Claim Administrator approved programs. Benefits are available if you have a history of any of the following: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

BENEFIT VALUE ADVISOR

The Benefit Value Advisor (BVA) program has been established to assist you in maximizing your benefits under this benefit booklet. Benefit Value Advisors are trained customer service representatives who assist you by comparing cost and providing information on Participating Providers for certain types of health care services. A BVA helps you navigate your benefits.

In addition to calling the BVA, you may also have other call requirements. A call to the BVA does not satisfy any other call requirements you may have.

PREVENTIVE CARE SERVICES

In addition to the benefits otherwise provided for in this benefit booklet, (and notwithstanding anything in your benefit booklet to the contrary), the following preventive care services will be considered Covered Services and

will not be subject to any deductible, Coinsurance, Copayment or dollar maximum (to be implemented in quantities and within the time period allowed under applicable law or regulatory guidance) when such services are received from a Participating Provider or Participating Pharmacy that is contracted for such service:

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 ("USPSTF");
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;
4. with respect to women, such additional preventive care, and screenings, not described in item 1. above, as provided for in comprehensive guidelines supported by the HRSA; and
5. Preventive Drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.

A copay waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the member.

For purposes of this Preventive Care Services benefit provision, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The preventive care services described in items 1. through 5. above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Claim Administrator's website at *www.bcbsil.com* or contact customer service at the toll-free number on your Identification Card.

If a recommendation or guideline for a particular preventive health service does not specify the frequency, method, treatment or setting in which it must

be provided, the Claim Administrator may use reasonable medical management techniques, including but not limited to, those related to setting and medical appropriateness to determine coverage.

If a covered preventive health service is provided during an office visit and is billed separately from the office visit, you may be responsible for the Copayment or Coinsurance for the office visit only. If an office visit and the preventive health service are billed together and the primary purpose of the visit was not the preventive health service, you may be responsible for the Copayment or Coinsurance for the office visit including the preventive health service.

Preventive Care Services for Adults (or others as specified):

1. Abdominal aortic aneurysm screening for men ages 65 to 75 who have ever smoked
2. Unhealthy alcohol and drug use screening and counseling
3. Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions
4. Aspirin use for prevention of cardiovascular disease for certain ages
5. Blood pressure screening
6. Cholesterol screening for adults of certain ages or at higher risk
7. Colorectal cancer screening for adults over age 45
8. Depression screening
9. Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease
10. HIV screening for all adults at higher risk
11. HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition including baseline and monitoring services
12. The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
    - Haemophilus influenzae type b (Hib)
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster (Shingles)
    - Human papillomavirus
    - Influenza (Flu shot or flu mist)
    - Measles, Mumps, Rubella
    - Meningococcal

- MPOX
- Pneumococcal
- RSV
- Tetanus, Diphtheria, Pertussis
- Varicella
- COVID-19

13. Obesity screening and counseling
14. Sexually transmitted infections (STI) counseling
15. Tobacco use screening and cessation interventions for tobacco users
16. Syphilis screening for adults at higher risk
17. Exercise interventions to prevent falls in adults aged 65 years and older who are at increased risk for falls
18. Hepatitis C virus (HCV) screening of infection in adults aged 19 to 79 years
19. Hepatitis B virus screening for persons at high risk for infection
20. Counseling children, adolescents and young adults who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
21. Lung cancer screening in adults 50 and older who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years
22. Screening for high blood pressure in adults aged 18 years or older
23. Screening for abnormal blood glucose and type II diabetes as part of cardiovascular risk assessment in adults who are overweight or obese
24. Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with: (a) no history of CVD, (b) 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking) and (c) a calculated 10-year CVD risk of 10% or greater
25. Tuberculin testing for adults 18 years or older who are at risk of tuberculosis
26. Whole body skin examination for lesions suspicious for skin cancer

Preventive Care Services for Women (including pregnant women or others as specified):

1. Bacteriuria urinary tract screening or other infection screening for pregnant women
2. Perinatal depression screening and counseling
3. BRCA counseling about genetic testing for women at higher risk

4. Breast cancer chemoprevention counseling for women at higher risk
5. Breastfeeding comprehensive lactation support and counseling from trained providers, as well as access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to one per benefit period.
6. Cervical cancer screening
7. Chlamydia infection screening for younger women and women at higher risk
8. Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
9. Domestic and interpersonal violence screening and counseling for all women
10. Daily supplements of .4 to .8 mg of folic acid supplements for women who may become pregnant
11. Diabetes screening after pregnancy
12. Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
13. Gonorrhea screening for all women
14. Hepatitis B screening for pregnant women at their first prenatal visit
15. HIV screening and counseling for women
16. Human papillomavirus (HPV) DNA test: high risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
17. Osteoporosis screening for women over age 65, and younger women with risk factors
18. Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
19. Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users
20. Screening for anxiety in adolescent and adult women, including those who are pregnant or postpartum, who have not recently been screened
21. Sexually transmitted infections (STI) counseling
22. Syphilis screening for all pregnant women or other women at increased risk
23. Well-woman visits to obtain recommended preventive services
24. Urinary incontinence screening
25. Breast cancer mammography screening, including breast tomosynthesis and, if determined to be Medically Necessary by a Physician, Advanced

Practice Nurse or a Physician Assistant, a screening MRI and comprehensive ultrasound

26. Intrauterine device (IUD) services related to follow up and management of side effects, counseling for continued adherence, and device removal
27. Aspirin use for pregnant women to prevent preeclampsia
28. Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy
29. Behavioral counseling to promote healthy weight gain during pregnancy
30. Behavioral counseling to maintain weight or limit weight gain to prevent obesity for women who are aged 40 or older

Preventive Care Services for Children (or others as specified):

1. Alcohol and drug use assessment for adolescents
2. Behavioral assessments for children of all ages
3. Blood pressure screenings for children of all ages
4. Cervical dysplasia screening for sexually active females
5. Congenital hypothyroidism screening for newborns
6. Critical congenital heart defect screening for newborns
7. Depression screening for adolescents
8. Development screening for children under age 3, and surveillance throughout childhood
9. Dyslipidemia screening for children ages 9-11 and 17-21
10. Bilirubin screening in newborns
11. Fluoride chemoprevention supplements for children without fluoride in their water source
12. Fluoride varnish to primary teeth of all infants and children starting at the age of primary tooth eruption
13. Gonorrhea preventive medication for the eyes of all newborns
14. Hearing screening for all newborns, children, and adolescents
15. Height, weight, and body mass index measurements
16. Hematocrit or hemoglobin screening
17. Hemoglobinopathies or sickle cell screening for all newborns
18. HIV screening for adolescents at higher risk
19. The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):
    - Hepatitis A
    - Hepatitis B

- Human papillomavirus
- Influenza (Flu shot or Flu mist)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Varicella
- Haemophilus influenzae type b
- Rotavirus
- RSV
- Inactivated Poliovirus
- Diphtheria, tetanus, and acellular pertussis
- COVID-19

20. Lead screening for children at risk for exposure
21. Medical history for all children throughout development
22. Obesity screening and counseling
23. Oral health risk assessment for younger children up to six years old
24. Phenylketonuria (PKU) screening for newborns
25. Sexually transmitted infections (STI) prevention and counseling for adolescents
26. Tuberculin testing for children at higher risk of tuberculosis
27. Vision screening for children and adolescents
28. Autism screening
29. Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
30. Newborn blood screening
31. Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision
32. Whole body skin examination for lesions suspicious for skin cancer

The FDA-approved contraceptive drugs and devices currently covered under this benefit provision are listed on the *Contraceptive Coverage List*. This list is available on the Claim Administrator's website at *www.bcbsil.com* and/or by contacting customer service at the toll-free number on your Identification Card. Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the *Contraceptive Coverage List*. You may, however, have coverage under other sections of this benefit booklet, subject to any applicable deductible, Coinsurance, Copayments and/or benefit maximums. The *Contraceptive Coverage List* and the preventive care services

covered under this benefit provision are subject to change as FDA guidelines, medical management and medical policies are modified.

Routine pediatric care, women's preventive care (such as contraceptives) and/or Outpatient periodic health examinations Covered Services not included above will be subject to the deductible, Coinsurance, Copayments and/or benefit maximums previously described in your benefit booklet, if applicable.

Preventive care services received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other routine Covered Services not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximums.

Benefits for vaccinations that are considered preventive care services will not be subject to any deductible, Coinsurance, Copayments and/or benefit maximum when such services are received from a Participating Provider or Participating Pharmacy.

Vaccinations that are received from a Non-Participating Provider, or a Non-Administrator Provider facility, or a Non-Participating Pharmacy or other vaccinations that are not provided for under this provision may be subject to the deductible, Coinsurance, Copayments and/or benefit maximum.

WELLNESS CARE

Benefits will be provided for Covered Services rendered to you, even though you are not ill. Benefits will be limited to the following services:

- Routine diagnostic medical procedures;
- Routine laboratory tests;
- Routine EKG;
- Routine x-ray;
- Routine ovarian cancer screening;
- Routine colorectal cancer screening x-ray;
- Routine digital rectal examinations and prostate tests.

Participating Provider

When you receive Covered Services for wellness care from a Participating Provider, benefits for wellness care will be provided at 100% of the Eligible Charge or 100% of the Maximum Allowance and will not be subject to the program deductible.

Non-Participating Provider

When you receive Covered Services for wellness care from a Non-Participating Provider, benefits will be provided at 60% of the Eligible Charge or 60% of the Maximum Allowance after you have met your program deductible.

SKILLED NURSING FACILITY CARE

The following are Covered Services when you receive them in a Skilled Nursing Facility:

1. Bed, board, and general nursing care.
2. Ancillary services (such as drugs and surgical dressings or supplies).

No benefits will be provided for admissions to a Skilled Nursing Facility which are for the convenience of the patient or Physician or because care in the home is not available or the home is unsuitable for such care.

Benefits for Covered Services rendered in an Administrator Skilled Nursing Facility will be provided at 80% of the Eligible Charge after you have met your program deductible.

Benefits for Covered Services rendered in a Non-Administrator Skilled Nursing Facility will be provided at 60% of the Eligible Charge once you have met your program deductible. Benefits will not be provided for Covered Services received in an Uncertified Skilled Nursing Facility.

You are entitled to benefits for 60 days of care in a Skilled Nursing Facility per benefit period.

AMBULATORY SURGICAL FACILITY

Benefits for all of the Covered Services previously described in this benefit booklet are available for Outpatient Surgery. In addition, benefits will be provided if these services are rendered by an Ambulatory Surgical Facility.

Benefits for services rendered by an Administrator Ambulatory Surgical Facility will be provided at 80% of the Eligible Charge. Benefits for services rendered by a Non-Administrator Ambulatory Surgical Facility will be provided at 60% of the Eligible Charge.

Benefits for Outpatient Surgery will be provided as stated above after you have met your program deductible.

AUTISM SPECTRUM DISORDER(S)

Your benefits for the diagnosis and treatment of Autism Spectrum Disorder(s) are the same as your benefits for any other condition. Treatment for Autism Spectrum Disorder(s) shall include the following care when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder (a) by a Physician or a Psychologist who has determined that such care is Medically Necessary, or (b) by a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s), including but not limited to, a health care professional who is eligible as a Qualified ABA Provider by state regulation and when such care is determined to be Medically Necessary and ordered by a Physician or a Psychologist:

- psychiatric care, including diagnostic services;
- psychological assessments and treatments;
- habilitative or rehabilitative treatments;

- therapeutic care, including behavioral Speech, Occupational and Physical Therapies that provide treatment in the following areas: a) self care and feeding, b) pragmatic, receptive and expressive language, c) cognitive functioning, d) applied behavior analysis (ABA), intervention and modification, e) motor planning and f) sensory processing.

Please review the Occupational Therapy, Physical Therapy and Speech Therapy provisions in this benefit booklet for more specific information about how visit maximums for Occupational Therapy, Physical Therapy and Speech Therapy apply to benefits for Autism Spectrum Disorder(s).

Note: Covered benefits for clinically appropriate Autism Spectrum Disorder services and Habilitative services will not be denied solely on the basis of where those services are provided.

HABILITATIVE SERVICES

Your benefits for Habilitative Services with Congenital, Genetic, or Early Acquired Disorder are the same as your benefits for any other condition if all of the following conditions are met:

- a physician has diagnosed the Congenital, Genetic, or Early Acquired Disorder; and
- treatment is administered by a licensed speech-language pathologist, Audiologist, Occupational Therapist, Physical Therapist, Physician, licensed nurse, Optometrist, licensed nutritionist, or Psychologist upon the referral of a Physician; and
- treatment must be Medically Necessary and therapeutic and not Investigational.

SUBSTANCE USE DISORDER TREATMENT

Benefits for all of the Covered Services described in this benefit booklet are available for Substance Use Disorder Treatment. In addition, benefits will be provided if these Covered Services are rendered by a Behavioral Health Practitioner in a Substance Use Disorder Treatment Facility. Inpatient benefits for these Covered Services will also be provided for Substance Use Disorder Treatment in a Residential Treatment Center. Substance Use Disorder Treatment Covered Services rendered in a program that does not have a written agreement with the Claim Administrator or in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

DETOXIFICATION

Covered Services received for detoxification are not subject to the Substance Use Disorder Treatment provisions specified above. Benefits for Covered Services received for detoxification will be provided under the HOSPITAL BENEFITS and PHYSICIAN BENEFITS section of this benefit booklet, the same as for any other condition.

MENTAL ILLNESS AND SUBSTANCE USE DISORDER SERVICES

Benefits for all of the Covered Services described in this benefit booklet are available for the diagnosis and/or treatment of a Mental Illness and/or Substance Use Disorder. Inpatient benefits for these Covered Services will also be provided for the diagnosis and/or treatment of Inpatient Mental Illness or Substance Use Disorder in a Residential Treatment Center. Treatment of a Mental Illness or Substance Use Disorder is eligible when rendered by a Behavioral Health Practitioner working within the scope of their license. Covered Services rendered in a Non-Administrator Provider facility will be paid at the Non-Participating Provider facility payment level.

BARIATRIC SURGERY

Benefits for Covered Services received for bariatric Surgery will be provided under the HOSPITAL BENEFIT and PHYSICIAN BENEFIT sections of this benefit booklet, the same as for any other condition. Benefit for Surgery for morbid obesity (including bariatric Surgery) are limited to a lifetime maximum of one.

MATERNITY SERVICE

Your benefits for Maternity Service are the same as your benefits for any other condition and are available whether you have Individual Coverage or Family Coverage. Benefits will also be provided for Covered Services rendered by a Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and Complications of Pregnancy. As part of your maternity benefits certain services rendered to your newborn infant are also covered, even if you have Individual Coverage. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. (If the newborn child needs treatment for an illness or injury, benefits will be available for that care only if you have Family Coverage. You may apply for Family Coverage within 31 days of date of the birth. Your Family Coverage will then be effective from the date of the birth).

Benefits will be provided for any hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for prescribing a length of stay less than 48 hours (or 96 hours). Such an earlier discharge may only be provided if there is coverage and availability of a post-discharge Physician office visit or an in-home visit to verify the condition of the infant in the first 48 hours after discharge.

Your coverage also includes benefits for elective abortions.

FERTILITY CARE

Benefits will be provided the same as your benefits for any other condition for Covered Services rendered in connection with the diagnosis and/or treatment of Infertility, or to promote fertility including, but not limited to, in-vitro fertilization, uterine embryo lavage, embryo transfer, artificial insemination, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, and low tubal ovum transfer and intracytoplasmic sperm injection.

Infertility means the inability to conceive a child after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after an individual is diagnosed with a condition affecting fertility or the inability to attain or maintain a viable pregnancy or sustain a successful pregnancy. The one year requirement will be waived if your Physician determines that a medical condition exists that makes conception impossible through unprotected sexual intercourse including, but not limited to, congenital absence of the uterus or ovaries, absence of the uterus or ovaries due to surgical removal due to a medical condition, or involuntary sterilization due to Chemotherapy or radiation treatments; or, efforts to conceive as a result of one year of medically based and supervised methods of conception, including artificial insemination, have failed and are not likely to lead to a successful pregnancy.

Unprotected sexual intercourse means sexual union between a male and female without the use of any process, device or method that prevents conception including, but not limited to, oral contraceptives, chemicals, physical or barrier contraceptives, natural abstinence or voluntary permanent surgical procedures and includes appropriate measures to ensure the health and safety of sexual partners.

Benefits for treatments that include oocyte retrievals will be provided only when you have been unable to attain or maintain a viable pregnancy or sustain a successful pregnancy through reasonable, less costly medically appropriate Infertility treatments; however, this requirement will be waived if you or your partner has a medical condition that renders such treatment useless. Benefits for treatments that include oocyte retrievals are limited to a lifetime maximum of four completed oocytes.

Benefits will also be provided for medical expenses of an oocyte or sperm donor for procedures used to retrieve oocytes or sperm and the subsequent procedure to transfer the oocytes or sperm to you. Associated donor medical expenses are also covered, including, but not limited to, physical examinations, laboratory screenings, psychological screenings and prescription drugs.

If an oocyte donor is used, then the completed oocyte retrieval performed on the donor shall count as one completed oocyte retrieval.

Special Limitations

Benefits will not be provided for the following:

1. Services or supplies rendered to a surrogate, except those costs for procedures to obtain eggs, sperm, or embryos from you will be covered if you choose to use a surrogate.
2. Expenses incurred for cryo-preservation or storage of sperm, eggs, or embryos, except for those procedures which use a cryo-preserved substance. Please note, that benefits may be provided for fertility preservation as set forth in the FERTILITY PRESERVATION SERVICES provision of this benefit booklet.
3. Non-medical costs of an egg or sperm donor.
4. Fertility treatments which are deemed Investigational, in writing, by the American Society for Reproductive Medicine or the American College of Obstetricians or Gynecologists.
5. Fertility treatment rendered to your dependents under age 18.

In addition to the above provisions, in-vitro fertilization, gamete intrafallopian tube transfer, zygote intrafallopian tube transfer, low tubal ovum transfer and intracytoplasmic sperm injection procedures must be performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in-vitro fertilization clinics or to the American Society for Reproductive Medicine minimal standards for programs of in-vitro fertilization.

FERTILITY PRESERVATION SERVICES

Benefits will be provided for Medically Necessary Standard Fertility Preservation Services when a necessary medical treatment may directly or indirectly cause Iatrogenic Infertility to you.

For purposes of this section, "may directly or indirectly cause" means the likely possibility that treatment will cause a side effect of Infertility, based upon current evidence-based standards of care established by the American Society for Reproductive Medicine, the American Society of Clinical Oncology, or other national medical associations that follow current evidence-based standards of care.

ROUTINE MAMMOGRAMS

Benefits will be provided for routine mammograms for all women. A routine mammogram is an x-ray or digital examination of the breast for the presence of breast cancer, even if no symptoms are present. Benefits for routine mammograms will be provided as follows:

— one baseline mammogram

— an annual mammogram

Benefits for routine mammograms will be provided for women who have a family history of breast cancer, prior personal history of breast cancer, positive

genetic testing or other risk factors at the age and intervals considered Medically Necessary by their Physician.

If a routine mammogram reveals heterogeneous or dense breast tissue, benefits will be provided for a comprehensive ultrasound screening and magnetic resonance imaging (MRI) screening of an entire breast or breasts, when determined to be Medically Necessary by your Physician.

DIAGNOSTIC MAMMOGRAMS

Benefits will be provided for Diagnostic Mammograms for women when determined to be Medically Necessary by a Physician, Advanced Practice Nurse, or Physician Assistant.

Participating Providers

Benefits for routine mammograms when received from a Participating Provider will be provided at 100% of the Eligible Charge or Maximum Allowance whether or not you have met your program deductible.

Non-Participating Providers

Benefits for routine mammogra,s when received from a Non–Participating Provider will be provided at 60% of the Eligible Charge or Maximum Allowance after you have met your program deductible.

Benefit Maximum

Benefits for routine mammograms will not be subject to any benefit period maximum or lifetime maximum.

TEMPOROMANDIBULAR JOINT DYSFUNCTION AND RELATED DISORDERS

Benefits for all Covered Services previously described under this benefit booklet are available for the diagnosis and treatment of Temporomandibular Joint Dysfunction and Related Disorders.

PORT-WINE STAIN TREATMENT

Benefits for all of the Covered Services previously described under this benefit booklet are available for the treatment to eliminate or provide maximum feasible treatment of nevus flammeus, also known as port-wine stains, including, but not limited to, port-wine stains caused by Sturge-Weber Syndrome. This benefit does not apply to Port-Wine Stain Treatment, solely for cosmetic reasons.

MASTECTOMY-RELATED SERVICES

Benefits for Covered Services related to mastectomies are the same as for any other condition. Mastectomy-related Covered Services include, but are not limited to:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Inpatient care following a mastectomy for the length of time determined by your attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow-up Physician office visit or in-home nurse visit within 48 hours after discharge;
4. Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas; and
5. The removal of breast implants when the removal of the implants is a Medically Necessary treatment for a sickness or injury. Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered. Cosmetic changes performed as reconstruction resulting from sickness or injury is not considered Cosmetic Surgery.

VIRTUAL VISITS

Benefits will be provided for Covered Services described in this benefit booklet for the diagnosis and treatment of non-emergency medical injuries or illnesses in situations when a Virtual Provider determines that such diagnosis and treatment can be conducted without an in-person primary care office visit, convenient care, urgent care or emergency room visit. Benefits for such Covered Services will only be provided if you receive them via consultation with a Virtual Provider who has a specific written agreement with the Claim Administrator to provide Virtual Visits to you at the time services are rendered. For more information about this benefit, you may visit the Claim Administrator's website at *www.bcbsil.com* or call customer service at the number on the back of your Identification Card.

Benefits for Covered Services you receive through a Virtual Visit from a Participating Virtual Provider are subject to the same office visit Copayment as indicated for Participating Providers as described under the BENEFIT PAYMENT FOR PHYSICIAN SERVICES provision in the PHYSICIAN BENEFIT SECTION of this benefit booklet.

Benefits will not be provided for services you receive through an interactive audio or interactive audio/video communication from a Provider who does not have a specific agreement with the Claim Administrator to provide Virtual Visits.

Note: Not all medical conditions can be appropriately treated through Virtual Visits. The Virtual Provider will identify any condition for which treatment by an in-person Provider is necessary.

PAYMENT PROVISIONS

Lifetime Maximum

Your benefits are not subject to a lifetime maximum. The total dollar amount that will be available in benefits for you is unlimited.

TRAVEL BENEFITS

You will be reimbursed for travel expenses for transportation and lodging that you incur for travel that is necessary to obtain any Covered Service rendered by a Participating Provider if there is no Participating Provider able to perform that service located within 100 miles of your home address (such benefits referred to herein as "Travel Benefits"). Coverage is available for you and up to one companion, or, if the person receiving the Covered Service is under age 18, up to two companions. Reimbursement for lodging is limited to $50 per night for you and an additional $50 per night for each permitted companion. To obtain reimbursement, you will need to submit a form, which includes receipts and supporting documentation of your expenses. Meals are not reimbursable. Travel Benefits are limited to a cap of $4,000 per occurrence. Reimbursement is subject to the services, travel, and reimbursement being in accordance with all applicable laws or regulations.

OUT-OF-POCKET EXPENSE LIMIT

There are separate Out-of-Pocket Expense Limits applicable to Covered Services received from Participating Providers and Non-Participating Providers.

For Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $3,000, any additional eligible Claims for Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for which you are responsible after benefits have been provided (except for any expenses incurred for Covered Services rendered by a Non-Participating or Non-Administrator Provider other than Emergency Accident Care, Emergency Medical Care, and Inpatient treatment during the period of time when your condition is serious)

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Participating Provider or a Non-Administrator Provider
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- Copayments resulting from noncompliance with the provisions of the UTILIZATION MANAGEMENT AND REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

If you have Family Coverage and your out-of-pocket expense as described above equals $6,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

For Non-Participating Providers

If, during one benefit period, your out-of-pocket expense (the amount remaining unpaid after benefits have been provided) equals $6,000, any additional eligible Claims for Non-Participating Providers (except for those Covered Services specifically excluded below) during that benefit period will be paid in full up to the Eligible Charge or Maximum Allowance.

This out-of-pocket expense limit may be reached by:

- the payments for Covered Services rendered by a Non-Participating Provider for which you are responsible after benefits have been provided

The following expenses for Covered Services cannot be applied to the out-of-pocket expense limit and will not be paid at 100% of the Eligible Charge or Maximum Allowance when your out-of-pocket expense limit is reached:

- charges that exceed the Eligible Charge or Maximum Allowance
- the Coinsurance resulting from Covered Services rendered by a Non-Administrator Hospital or other Non-Administrator Provider facility
- charges for Covered Services which have a separate dollar maximum specifically mentioned in this benefit booklet
- the urgent care Copayment
- the Hospital emergency room Copayment
- Copayments resulting from noncompliance with the provisions of the UTILIZATION MANAGEMENT AND REVIEW PROGRAM and/or the CLAIM ADMINISTRATOR'S BEHAVIORAL HEALTH UNIT

If you have Family Coverage and your expense as described above equals $12,000 during one benefit period, then, for the rest of the benefit period, all other family members will have benefits for Covered Services (except for those Covered Services specifically excluded above) provided at 100% of the Eligible Charge or Maximum Allowance. A member may not apply more than the individual out-of-pocket expense limit toward this amount.

EXTENSION OF BENEFITS IN CASE OF TERMINATION

If you are an Inpatient at the time your coverage under this plan is terminated, benefits will be provided for, and limited to, the Covered Services of this plan which are rendered by and regularly charged for by a Hospital, Skilled Nursing Facility, Substance Use Disorder Treatment Facility, Partial

Hospitalization Treatment Program, Residential Treatment Center or Coordinated Home Care Program. Benefits will be provided until you are discharged or until the end of your benefit period, whichever occurs first.

HOSPICE CARE PROGRAM

Your Hospital coverage also includes benefits for Hospice Care Program Service.

Benefits will be provided for the Hospice Care Program Service described below when these services are rendered to you by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less, as certified by your attending Physician, and you will no longer benefit from standard medical care or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

1. Coordinated Home Care;
2. Medical supplies and dressings;
3. Medication;
4. Nursing Services - Skilled and non-Skilled;
5. Occupational Therapy;
6. Pain management services;
7. Physical Therapy;
8. Physician visits;
9. Social and spiritual services;
10. Respite Care Service.

The following services are **not** covered under the Hospice Care Program:

1. Durable medical equipment;
2. Home delivered meals;
3. Homemaker services;
4. Traditional medical services provided for the direct care of the terminal illness, disease or condition;
5. Transportation, including, but not limited to, Ambulance Transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this benefit booklet.

Benefit Payment for Hospice Care Program Services

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same payment level as described for Inpatient Hospital Covered Services.

HEARING CARE PROGRAM

Your coverage includes benefits for hearing care when you receive such care from a Physician, Otologist, Audiologist or Hearing Aid Dealer.

The benefits of this section are subject to all of the terms and conditions described in this benefit booklet. Please refer to the DEFINITIONS, ELIGIBILITY and EXCLUSIONS sections of this benefit booklet for additional information regarding any limitations and/or special conditions pertaining to your benefits.

For hearing care benefits to be available, such care must be Medically Necessary and you must receive such care on or after your Coverage Date.

In addition to the Definitions of this benefit booklet, the following definitions are applicable to this Benefit Section:

AUDIOLOGIST.....means a duly licensed audiologist.

HEARING AID DEALER.....means a Provider licensed to make and provide hearing aids to you.

OTOLOGIST.....means a duly licensed otologist or otolaryngologist.

Benefit Period

Your hearing care benefit period beings on the first date a Covered Service is received after your Coverage Date and continues for a period of 24 consecutive months thereafter. Later benefit periods will begin on the first date a Covered Service is received following the expiration of your prior benefit period.

Covered Services

Benefits will be provided under this Benefit Section for the following:

Audiometric Examination
Hearing Aid Evaluation
Conformity Evaluation
Hearing Aids

Benefits will be limited to Covered Service(s) of each type listed above per benefit period.

Special Limitations

Benefits will not be provided for the following:

1. Audiometric examinations by an Audiologist when not ordered by your Physician within 6 months of such examination.
2. Medical or surgical treatment.
3. Drugs or other medications.
4. Replacement for lost or broken hearing aids, except if otherwise eligible under frequency limitations.

5. Hearing aids ordered while covered but delivered more than 60 days after termination.

Benefit Payment for Hearing Care

Benefits for hearing care Covered Services will be provided at 100% of the Usual and Customary Fee.

Benefits for hearing aids will be provided up to a lifetime maximum of $5,000.

For purpose of this Benefits Section only, the definition of Usual and Customary Fee shall read as follows:

> USUAL AND CUSTOMARY FEE.....means the fee as reasonably determined by the Claim Administrator, which is based on the fee which the Physician, Otologist, Audiologist or Hearing Aid Dealer who renders the particular service usually charges his patient or customers for the same service and the fee which is within the range of usual fees other Physicians, Otologists, Audiologists or Hearing Aid Dealers of similar training and experience in the same geographic are charge their patient or customers for the same service, under similar or comparable circumstances.

BENEFITS FOR MEDICARE ELIGIBLE COVERED PERSONS

This section describes the benefits which will be provided for Medicare Eligible covered persons who are not affected by MSP laws, unless otherwise specified in this benefit booklet (see provisions entitled ''Medicare Eligible covered persons'' in the ELIGIBILITY SECTION of this benefit booklet).

The benefits and provisions described throughout this benefit booklet apply to you, however, in determining the benefits to be paid for your Covered Services, consideration is given to the benefits available under Medicare.

The process used in determining benefits under the Health Care Plan is as follows:

1. determine what the payment for a Covered Service would be following the payment provisions of this coverage and
2. deduct from this resulting amount the amount paid or payable by Medicare. (If you are eligible for Medicare, the amount that is available from Medicare will be deducted whether or not you have enrolled and/or received payment from Medicare.) The difference, if any, is the amount that will be paid under the Health Care Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

EXCLUSIONS - WHAT IS NOT COVERED

Expenses for the following are not covered under your benefit program:

— **Hospitalization, services and supplies which are not Medically Necessary.**
No benefits will be provided for services which are not, in the reasonable judgment of the Claim Administrator, Medically Necessary. Medically Necessary means that a specific medical, health care or Hospital service is required, in the reasonable medical judgment of the Claim Administrator, for the treatment or management of a medical symptom or condition and that the service or care provided is the most efficient and economical service which can safely be provided.

Hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition.

Examples of hospitalization and other health care services and supplies that are not Medically Necessary include:

— Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.

— Hospital admissions primarily for diagnostic studies (x-ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

— Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.

— Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.

— Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

— The use of skilled or private duty nurses to assist in daily living activities, routine supportive care or to provide services for the convenience of the patient and/or their family members.

These are just some examples, not an exhaustive list, of hospitalizations or other services and supplies that are not Medically Necessary.

The Claim Administrator will make the decision whether hospitalization or other health care services or supplies were not Medically Necessary and therefore not eligible for payment under the terms of your health care plan. In most instances this decision is made by the Claim Administrator AFTER YOU HAVE BEEN HOSPITALIZED OR HAVE RECEIVED OTHER HEALTH CARE SERVICES OR SUPPLIES AND AFTER A CLAIM FOR PAYMENT HAS BEEN SUBMITTED.

The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Claim Administrator will pay the cost of the hospitalization, services, or supplies.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, your plan provides for an appeal of that decision.

Additional information about appeals procedures is set forth in the CLAIM FILING AND APPEALS PROCEDURES section of this benefit booklet.

REMEMBER, EVEN IF YOUR PHYSICIAN PRESCRIBES, ORDERS, RECOMMENDS, APPROVES OR VIEWS HOSPITALIZATION OR OTHER HEALTH CARE SERVICES AND SUPPLIES AS MEDICALLY NECESSARY, THE CLAIM ADMINISTRATOR WILL NOT PAY FOR THE HOSPITALIZATION, SERVICES AND SUPPLIES IF IT DECIDES THEY WERE NOT MEDICALLY NECESSARY.

— Services or supplies that are not specifically mentioned in this benefit booklet.

— Services or supplies for any illness or injury arising out of or in the course of employment for which benefits are available under any Workers' Compensation Law or other similar laws whether or not you make a claim for such compensation or receive such benefits. However, this exclusion shall not apply if you are a corporate officer of any domestic or foreign corporation and are employed by the corporation and elect to withdraw yourself from the operation of the Illinois Workers' Compensation Act according to the provisions of the Act.

— Services or supplies that are furnished to you by the local, state or federal government and for any services or supplies to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not that payment or benefits are received, except in the case of Medicare, except however, this exclusion shall not be applicable to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5-1 et seq. or 5/6-1 et seq.) or similar Legislation of any state, benefits provided

in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.

— Services and supplies for any illness or injury occurring on or after your Coverage Date as a result of war or an act of war.

— Services or supplies that were received prior to your Coverage Date or after the date that your coverage was terminated.

— Services or supplies from more than one Provider on the same day(s) to the extent benefits are duplicated.

— Services or supplies that do not meet accepted standards of medical and/or dental practice.

— Investigational Services and Supplies and all related services and supplies, except as may be provided under this benefit booklet for a) the cost of routine patient care associated with Investigational cancer treatment if you are a qualified individual participating in a qualified clinical cancer trial, if those services or supplies would otherwise be covered under this benefit booklet if not provided in connection with a qualified cancer trial program and b) applied behavior analysis used for the treatment of Autism Spectrum Disorder(s).

— Custodial Care Service.

— Long Term Care Service.

— Respite Care Service, except as specifically mentioned under the Hospice Care Program.

— Inpatient Private Duty Nursing Service.

— Routine physical examinations, unless otherwise specified in this benefit booklet.

— Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This does not include services or supplies provided for the treatment of an injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).

— Cosmetic Surgery and related services and supplies, except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases.

— Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.

— Charges for failure to keep a scheduled visit or charges for completion of a Claim form.

— Personal hygiene, comfort or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones.

— Special braces, splints, specialized equipment, appliances, ambulatory apparatus, battery implants, except as specifically mentioned in this benefit booklet.

— Services or supplies for intersegmental traction; all types of home traction devices and equipment; vertebral axial decompression sessions; surface EMGs; spinal manipulation under anesthesia; muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron; and balance testing through computerized dynamic posturography sensory organization test.

— Blood derivatives which are not classified as drugs in the official formularies.

— Eyeglasses, contact lenses or cataract lenses and the examination for prescribing or fitting of glasses or contact lenses or for determining the refractive state of the eye, except as specifically mentioned in this benefit booklet.

— Treatment of flat foot conditions and the prescription of supportive devices for such conditions and the treatment of subluxations of the foot.

— Routine foot care, except for persons diagnosed with diabetes.

— Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet rich plasma.

— Treatment of tissue damage or disease in any location with platelet-rich plasma.

— Immunizations, unless otherwise specified in this benefit booklet.

— Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this benefit booklet.

— Maintenance Care.

— Speech Therapy when rendered for the treatment of psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual disability, or mental disability, except as may be provided under this benefit booklet for Autism Spectrum Disorder(s).

— Habilitative Services that are solely educational in nature or otherwise paid under state or federal law for purely educational services.

— Hypnotism.

— Services and supplies to the extent benefits are duplicated because the spouse, parent and/or child are covered separately under this Health Care Plan.

— Diagnostic Service as part of routine physical examinations or check-ups, premarital examinations, determination of the refractive errors of the eyes, auditory problems, surveys, case finding, research studies, screening, or similar procedures and studies, or tests which are Investigational, unless otherwise specified in this benefit booklet.

— Procurement or use of prosthetic devices, special appliances and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of a disease or injury.

— Wigs (also referred to as cranial prostheses), unless otherwise specified in this benefit booklet.

— Services and supplies rendered or provided for human organ or tissue transplants other than those specifically named in this benefit booklet.

— Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

— Testing of blood for measurement of levels of: Lipoprotein a; small dense low density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected deposits in the walls of blood vessels; urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover; cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby(premature ruptured membranes); and allergen specific IgG measurement.

— Nutritional items such as infant formulas, weight-loss supplements, over-the-counter food substitutes, non-prescription vitamins, and herbal supplements, other than those specifically named in this benefit booklet.

— Reversals of sterilization.

— Appliances for Temporomandibular Joint Dysfunction.

— Any related services to a non-covered service. Related services are a) services in preparation for the non-covered service; b) services in connection with providing the non-covered service; c) hospitalization required to perform the non-covered service; or d) services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

— Self-Administered drugs dispensed by a Physician.

— Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses, and group homes, except for Covered Services provided by appropriate Providers as defined in this benefit booklet.

— This Plan does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds, or its resin. Cannabis with THC as an active ingredient may be called marijuana.

Any of the following applied behavioral analysis (ABA) related services:

— Services with a primary diagnosis that is not Autism Spectrum Disorder;

— Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of "Qualified ABA Provider" in the DEFINITIONS SECTION of this benefit booklet;

— Activities primarily of an educational nature;

— Shadow or companion services; or

— Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

COORDINATION OF BENEFITS SECTION

Coordination of Benefits (COB) applies when you have health care coverage through more than one group program. The purpose of COB is to ensure that you receive all of the coverage to which you are entitled but no more than the actual cost of the care received. In other words, the total payment from all of your coverages together will not add up to be more than the total charges that you have incurred. It is your obligation to notify the Claim Administrator of the existence of such other group coverages.

To coordinate benefits, it is necessary to determine what the payment responsibility is for each benefit program. This is done by following these rules:

1. The coverage under which the patient is the Eligible Person (rather than a dependent) is primary (that is, full benefits are paid under that program). The other coverage is secondary and only pays any remaining eligible charges.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this ''birthday'' type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.

   — However, when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a contract which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a contract which covers the child as a dependent of the parent without custody;

   — when the parents are divorced and the parent with custody of the child has remarried, the benefits of a contract which covers the child as a dependent of the parent with custody shall be determined before the benefits of a contract which covers that child as a dependent of the stepparent, and the benefits of a contract which covers that child as a dependent of the stepparent will be determined before the benefits of a contract which covers that child as a dependent of the parent without custody.

   Notwithstanding the items above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a contract which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other contract which covers the child as a

dependent child. It is the obligation of the person claiming benefits to notify the Claim Administrator, and upon its request to provide a copy, of such court decree.

3. If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group benefit program does not include a COB provision. In that case, the other group program is automatically primary.

The Claim Administrator has the right in administering these COB provisions to:

— pay any other organization an amount which it determines to be warranted if payments which should have been made by the Claim Administrator have been made by such other organization under any other group program.

— recover any overpayment which the Claim Administrator may have made to you, any Provider, insurance company, person, or other organization.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Please refer to BMO Plan Documents.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

Please refer to BMO Plan Documents.

HOW TO FILE A CLAIM AND APPEALS PROCEDURES

To obtain your benefits under this benefit program, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your Identification Card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed, and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases, the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from your Employee Benefits Department or from the Claim Administrator's office.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments to:

   Blue Cross and Blue Shield of Illinois
   P. O. Box 805107
   Chicago, Illinois 60680-4112

In any case, Claims should be filed no later than twelve months after the date a service is received. Claims not filed within twelve months from the date a service is received, will not be eligible for payment.

Should you have any questions about filing Claims, ask your Employee Benefits Department or call the Claim Administrator's office.

INTERNAL CLAIM DETERMINATIONS AND APPEALS PROCESS

INITIAL CLAIM DETERMINATIONS

When the Claim Administrator receives a properly submitted claim, the Claim Administrator will determine benefits in accordance with the Health Benefit Plan provisions. The Claim Administrator will receive and review claims for benefits and will process claims consistent with administrative practices and procedures established by your Plan. You, your valid assignee, your authorized representative, or Provider will be notified of the Claim Administrator's benefit decision.

(For information regarding assigning benefits, see "Payment of Claims and Assignment of Benefits" provisions in the GENERAL PROVISIONS section of this benefit booklet.)

If a Claim Is Denied or Not Paid in Full

If the claim for benefits is denied, you or your authorized representative shall be notified in writing of the following:

a. The reasons for determination;

b. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative, medical policy or protocol for the determination;

c. A description of additional information which may be necessary to perfect the Claim and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, treatment and determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

e. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

f. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);

g. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;

h. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;

i. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;

j. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the determination was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

k. In the case of a determination of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such Claims. An Urgent Care Clinical Claim decision may be provided orally, so long as written notice is furnished to the claimant within three days of oral notification.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator Headquarters at 1-800-538-8833. The Claim Administrator's offices are open from 8:45 a.m. to 4:45 p.m., Monday through Friday. Customer service hours and operations are subject to change without notice.

Blue Cross and Blue Shield of Illinois
P. O. Box 805107
Chicago, Illinois 60680-4112
1-800-538-8833 Toll-free phone

If you need assistance with the internal Claims and appeals or the external review processes that are described below, you may contact the health insurance consumer assistance office or ombudsman. You may contact the Illinois ombudsman program at 1-877-527-9431 or call the number on the back of your Identification Card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

INQUIRIES AND COMPLAINTS

An **"Inquiry"** is a general request for information regarding claims, benefits, or membership.

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to, the following:

- Claims
- Quality of care

When your Complaint relates to dissatisfaction with an Adverse Benefit Determination (or partial determination), then you have the right to a Claim review/appeal as described in the CLAIM APPEAL PROCEDURES.

To pursue an Inquiry or a Complaint, you may contact **customer service** at the number on the back of your Identification Card, or you may write to:

Blue Cross and Blue Shield of Illinois
300 East Randolph
Chicago, Illinois 60601

When you contact customer service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of

receipt by customer service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted. If an Inquiry or Complaint is not resolved to your satisfaction, you may appeal to the Claim Administrator.

An appeal is an oral or written request for review of an Adverse Benefit Determination (as defined below) or an adverse action by the Claim Administrator, its employees, or a Provider.

The following is the contact information for the Illinois Department of Insurance consumer assistance and ombudsman:

For Complaints and general Inquiries:

Illinois Department of Insurance
Office of Consumer Health Insurance
320 West Washington Street
Springfield, Illinois 62767
(877) 527-9431 Toll-free phone
(217) 558-2083 Fax number
Consumer_complaints@ins.state.il.us Email address
https://mc.insurance.illinois.gov/messagecenter.nsf

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are three types of Claims as defined below.

a. **Urgent Care Clinical Claim** is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

b. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

c. **Post-Service Claim** is notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	**24 hours****
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**48 hours after receiving notice**
The Claim Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**48 hours**
after receiving the completed Claim (if the initial Claim is incomplete), within:	**48 hours**

*You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call the Claim Administrator at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

**Notification may be oral unless the claimant requests written notification.

Pre-Service Claims

Type of Notice or Extension	Timing
If your Claim is filed improperly, the Claim Administrator must notify you within:	**5 days***
If your Claim is incomplete, the Claim Administrator must notify you within:	**15 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**
The Claim Administrator must notify you of the Claim determination (whether adverse or not):	
if the initial Claim is complete, within:	**15 days****
after receiving the completed Claim (if the initial Claim is incomplete), within:	**30 days**
If you require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

*Notification may be oral unless the claimant requests written notification.

**This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Post-Service Claims

Type of Notice or Extension	Timing
If your Claim is incomplete, the Claim Administrator must notify you within:	**30 days**
If you are notified that your Claim is incomplete, you must then provide completed Claim information to the Claim Administrator within:	**45 days after receiving notice**
The Claim Administrator must notify you of any adverse Claim determination:	
if the initial Claim is complete, within:	**30 days***
after receiving the completed Claim (if the initial Claim is incomplete), within:	**45 days**

*This period may be extended one time by the Claim Administrator for up to 15 days, provided that the Claim Administrator both (1) determines that such an extension is necessary due to matters beyond the control of the Claim Administrator and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Claim Administrator expects to render a decision.

Concurrent Care

For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

CLAIM APPEAL PROCEDURES - DEFINITIONS

An **"Adverse Benefit Determination"** means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, in response to a Claim, Pre-Service Claim or Urgent Care Clinical Claim, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator and the Claim Administrator reduces or terminates such treatment (other than by amendment or termination of the Group's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not include a termination of coverage for reasons related to non-payment of premium.

Urgent Care/Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but in no event more than 24 hours after submission of the appeal, of all the information needed to review the appeal. The Claim Administrator will render a decision on the appeal within 24 hours after it receives the requested information, but not more than 72 hours from the appeal request.

Standard or Non-Urgent Appeals

The Claim Administrator will send you a written decision for appeals that need medical review within 30 calendar days after we receive your appeal request, or if you are appealing before getting a service. All other appeals will be answered within 60 calendar days.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by the Claim Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on their own behalf. Under your health benefit plan, there is one level of internal appeal available to you. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your Identification Card. In urgent care situations, a doctor may act as your authorized representative without completing the form.

If you believe the Claim Administrator incorrectly denied all or part of your benefits, you may have your Claim reviewed. The Claim Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination.

- In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments, and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.
- The Illinois Department of Insurance (IDOI) offers consumer assistance. If your standard or expedited (urgent) external review request does not qualify for review by your plan or its representatives, you may file an appeal with the IDOI at the Springfield address below. Also, if you have questions about your rights, with to file a complaint or wish to take up your matter with the IDOI, you may use either address below:

  IDOI Consumer Division
  320 W. Washington St.
  Springfield, Illinois 62767
  1-217-782-4515

  or

  IDOI Consumer Division
  122 S. Michigan Ave., 19th Floor
  Chicago, Illinois 60603
  1-312-814-2420
  web: *http://insurance.Illinois.gov*

Your Right to Appeal
You may appeal if you think you have been denied benefits in error. For all levels of appeals and reviews described below, you may give a written explanation of why you think we should change our decision and you may give any documents you want to add to make your point. For appeals, you may also make a verbal statement about your case. Send a written appeal request to: The Claim Administrator Claim Review Section P.O. Box 2401 Chicago, Illinois 60690
To file an appeal or if you have questions, please call 800-538-8833 (TTY/TDD:711, send a fax to 888-235-2936, or send a secure email using our Message Center by logging into Blue Access for Members (BAM) at *bcbsil.com*

During your internal appeal(s), the Claim Administrator will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon, or generated by the Claim Administrator in connection with the appealed Claim, as well as any new or additional rationale for a determination at the internal appeals stage.

Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made to give you a reasonable opportunity to respond. The Claim Administrator may extend the time period described in this benefit booklet for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the Claim is based in whole or in part on a medical judgement, the appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors, but who were not involved in making the initial determination of your Claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator.

Timing of Non-Urgent Appeal Determinations

Upon receipt of a non-urgent concurrent pre-service or post-service appeal, the Claim Administrator will notify the party filing the appeal within five business days of all the information needed to review the appeal.

The Claim Administrator will render a decision of a non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 calendar days after receipt of all required information. We will send you a written decision for appeals that are related to health care services and not related to administrative matters or Complaints within 30 calendar days after receipt of any needed information, but no later than 30 calendar days of receipt of the request. All other appeals will be answered within 30 calendar days if you are appealing before getting a service or within 60 calendar days if you have already received the service.

If the appeal is related to administrative matters or Complaints, the Claim Administrator will render a decision of a pre-service or post-service appeal as soon as practical, but in no event more than 60 business days after receipt of all required information.

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal.

The written notice will include:

1. The reasons for the determination;
2. A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and a statement describing determination codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
4. An explanation of the Claim Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final determination on internal and external appeal;
5. An explanation that you and your Provider may file appeals separately and at the same time, and that deadlines for filing appeals or external review requests are not delayed by appeals made by your Provider UNLESS you have chosen your Provider to act for you as your authorized representative;
6. In certain situations, a statement in non-English language(s) that future notices of Claim determinations and certain other benefit information may be available in such non-English language(s);
7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claim Administrator;
8. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
9. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
11. A description of the standard that was used in denying the claim and a discussion of the decision;
12. When the notice is given upon the exhaustion of an appeal submitted by a health care Provider on their own behalf, the timeframes from the date of the adverse determination for the member to file an appeal or file an external review;
13. When the notice of final adverse determination is given upon the exhaustion of internal appeals by the member, a statement that all internal appeals have been exhausted and the member has 4 months from the date of the letter to file an external review;
14. A statement indicating whether the adverse determination relates to a MEMBER appeal (filed by the member or authorized representative who may be the health care Provider) or a PROVIDER appeal (pursuant to the

Provider contract) and shall explain timeframes from the date of the adverse determination for the member to appeal and to file an external review regardless of the status of a Provider appeal.

If the Claim Administrator's or your Employer's decision is to continue to deny or partially deny your Claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the determination and issue a final decision. Your external review rights are described in the **STANDARD EXTERNAL REVIEW** section below.

You may file a Complaint with the Illinois Department of Insurance. The Illinois Department of Insurance will notify the Claim Administrator of the Complaint. The Claim Administrator will have 21 days to respond to the Illinois Department of Insurance.

You must exercise the right to internal appeal as a precondition to taking any action against the Claim Administrator, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

Forum Selection

In the event of any dispute relating to or arising from this Plan, the jurisdiction and venue for the dispute is the United States District Court for the Northern District of Illinois. If, and only if, the United States District Court for the Northern District of Illinois lacks subject-matter jurisdiction over such dispute, the jurisdiction and venue for the dispute is the Circuit Court of Cook County, Illinois.

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO). The external review is at no charge to the member.

An "**Adverse Benefit Determination**" means a determination, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such determination, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claim Administrator or your Employer and the Claim Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination. A Rescission does not

include a termination of coverage for reasons related to non-payment of premium.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claim Administrator at the completion of the Claim Administrator's internal review/appeal process.

1. **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
2. **Preliminary review.** Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
    a. You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;
    b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination);
    c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the **EXHAUSTION** section below for additional information and exhaustion of the internal appeal process; and
    d. You or your authorized representative have provided all the information and forms required to process an external review.

    You will be notified within 1 business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).

3. **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally recognized accrediting organization. Moreover, the Claim Administrator will act against bias and to ensure independence. Accordingly, the Claim Administrator must contract within at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the determination of benefits.

   The IRO must provide the following:

   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.

   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

   c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

   d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit

Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:

   (1) Your medical records;

   (2) The attending health care professional's recommendation;

   (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;

   (4) The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;

   (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

   (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and

   (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

   (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care

provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous determination);

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

(6) A statement that judicial review may be available to you or your authorized representative; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

1. **Request for expedited external review.** Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health

or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in STANDARD EXTERNAL REVIEW section above.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the STANDARD EXTERNAL REVIEW section above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.

4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the STANDARD EXTERNAL REVIEW section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claim Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL PROVISIONS

1. CLAIM ADMINISTRATOR'S SEPARATE FINANCIAL ARRANGEMENTS WITH PROVIDERS AND OTHER ENTITIES

The Claim Administrator hereby informs you that it has contracts with certain Providers (''Administrator Providers'') in its service area to provide and pay for health care services to all persons entitled to health care benefits under health policies and contracts to which the Claim Administrator is a party, including all persons covered under the Health Care Plan. Under certain circumstances described in its contracts with Administrator Providers, the Claim Administrator may:

- receive substantial payments from Administrator Providers with respect to services rendered to you for which the Claim Administrator was obligated to pay the Administrator Provider, or
- pay Administrator Providers substantially less than their Claim Charges for services, by discount or otherwise, or
- receive from Administrator Providers other substantial allowances under the Claim Administrator's contracts with them.

In the case of Hospitals and other facilities, the calculation of any out-of-pocket maximums or any maximum amounts of benefits payable by the Claim Administrator as described in this benefit booklet and the calculation of all required deductible and Coinsurance amounts payable by you as described in this benefit booklet shall be based on the Eligible Charge or Provider's Claim Charge for Covered Services rendered to you, reduced by the Average Discount Percentage ("ADP") applicable to your Claim or Claims. Your Employer has been advised that the Claim Administrator may receive such payments, discounts and/or other allowances during the term of the agreement between your Employer and the Claim Administrator. Neither the Employer nor you are entitled to receive any portion of any such payments, discounts and/or other allowances in excess of the ADP.

To help you understand how the Claim Administrator's separate financial arrangements with Provider's work, please consider the following example:

a. Assume you go into the Hospital for one night and the normal, full amount the Hospital bills for Covered Services is $1,000. How is the $1,000 bill paid?

b. You personally will have to pay the deductible and Coinsurance amounts set out in your benefit booklet.

c. However, for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums, the Hospital's Eligible Charge would be reduced by the ADP applicable to your Claim. In our

example, if the applicable ADP were 30%, the $1,000 Hospital bill would be reduced by 30% to $700 for purposes of calculating your deductible and Coinsurance amounts, and whether you have reached any out-of-pocket or benefit maximums.

d. Assuming you have already satisfied your deductible, you will still have to pay the Coinsurance portion of the $1,000 Hospital bill after it has been reduced by the ADP. In our example, if your Coinsurance obligation is 20%, you personally will have to pay 20% of $700, or $140. You should note that your 20% Coinsurance is based on the full $1,000 Hospital bill, after it is reduced by the applicable ADP.

e. After considering the deductible and Coinsurance amounts, the Claim Administrator will satisfy its portion of the Hospital bill. In most cases, the Claim Administrator has a contract with Hospitals that allows it to pay less, and requires the Hospital to accept less, than the amount of money the Claim Administrator would be required to pay if it did not have a contract with the Hospital.

So, in the example we are using, since the full Hospital bill is $1,000, your deductible has already been satisfied, and your Coinsurance is $140, then the Claim Administrator has to satisfy the rest of the Hospital bill, or $860. Assuming the Claim Administrator has a contract with the Hospital, the Claim Administrator will usually be able to satisfy the $860 bill that remains after your Coinsurance and deductible, by paying less than $860 to the Hospital, often substantially less than $860. The Claim Administrator receives, and keeps for its own account, the difference between the $860 bill and whatever the Claim Administrator ultimately pays under its contracts with Administrator Providers, and neither you nor your Employer are entitled to any part of these savings.

The Claim Administrator or its subsidiaries or affiliates may also have ownership interests in or financial arrangements with certain Providers who provide Covered Services to covered persons and/or vendors or other third parties who provide services related to the Policy or provide services to certain Providers.

2. INTER-PLAN ARRANGEMENTS

I. Out-of-Area Services

Overview

The Claim Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever you access healthcare services outside the geographic area the Claim Administrator serves, the Claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Claim Administrator's service area, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("non-participating Providers") do not contract with the Host Blue. The Claim Administrator explains below how the Claim Administrator pays both kinds of Providers.

Inter-Plan Arrangements Eligibility - Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for all dental care benefits except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by the Claim Administrator to provide the specific service or services.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Claim Administrator will remain responsible for doing what we agreed in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

For Inpatient facility services received in a Hospital, the Host Blue's participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the participating Provider will be sanctioned based on the Host Blue's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction.

When you receive Covered Services outside the Claim Administrator's service area and the Claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services, or
- The negotiated price that the Host Blue makes available to the Claim Administrator.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Illinois. You show your Identification Card to the provider to let them know that you are covered by the Claim Administrator.

b. The provider has negotiated with the Host Blue a price of $80, even though the provider's standard charge for this service is $100. In this example, the provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Claim Administrator and indicates that the negotiated price for the covered service is $80. The Claim Administrator would then base the amount you must pay for the service - the amount applied to your deductible, if any, and your coinsurance percentage - on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a covered service.

PLEASE NOTE: The Coinsurance percentage in the above example is for illustration purposes only. The example assumes that you have met your deductible and that there are no copayments associated with the service rendered. Your deductible(s), Coinsurance and Copayment(s) are specified in this benefit booklet.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, also take into account adjustments to correct for over or underestimation of modifications of past pricing of Claims, as noted above. However, such adjustments will not affect the price the Claim Administrator has used for your claim because they will not be applied after a Claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, the Claim Administrator may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to the Claim Administrator by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the healthcare provider bills above the specific reference benefit limit for the given procedure. For a participating Provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a non-participating Provider, that amount will be the difference between the Provider's billed charge and the reference benefit limit.

Where a reference benefit limit is greater than either a negotiated price or a Provider's billed charge, you will incur no liability, other than any related patient cost sharing under this agreement.

C. Special Cases: Value Based Programs

BlueCard® Program

If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to the Claim Administrator through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If the Claim Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your Employer on your behalf, the Claim Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Claim Administrator will include any such surcharge, tax, or other fee as part of the Claim Charge passed on to you.

E. Non-Participating Healthcare Providers Outside The Claim Administrator's Service Area

a. Member Liability Calculation

(1) In General

When Covered Services are provided outside of the Claim Administrator's service area by non-participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

(2) Exceptions

In some exception cases, the Claim Administrator may, but is not required to, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not

available, then the Claim Administrator may make a payment based on the lesser of:

1. The amount calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area (and described in Section (a)(1) above); or
2. The following:
   a. For professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar services, adjusted for geographical differences where applicable, or
   b. For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have reportedly incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment the Claim Administrator will make for the Covered Services as set forth in this paragraph.

F. Blue Cross Blue Shield Global® Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and Professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin claims processing. However, if you paid in full at the time of

service, you must submit a Claim to receive reimbursement for Covered Services. **You must contact the Claim Administrator to obtain Prior Authorization for non-emergency Inpatient services.**

- **Outpatient Services**

  Outpatient Services are available for Emergency Care, Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for Covered Services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

  When you pay for Covered Services outside the BlueCard service area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the Claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from the Claim Administrator, the service center or online at www.bcbsglobalcore.com. If you need assistance with your Claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

Servicing Plans

In some instances, the Claim Administrator has entered into agreements with other Blue Cross and Blue Shield Plans ("Servicing Plans") to provide, on the Claim Administrator's behalf, Claim Payments, and certain administrative services for you. Under these agreements, the Claim Administrator will reimburse each Servicing Plan for all Claim Payments made on the Claim Administrator's behalf for you.

Certain Servicing Plans may have contracts similar to the contracts described above with certain Providers ("Servicing Plan Providers") in their service area. The Servicing Plan will process your claim in accordance with the Servicing Plan's applicable contract with the Servicing Plan Provider. Further, all amounts payable to the Servicing Plan by the Claim Administrator for Claim Payments made by the Servicing Plan and applicable service charges, and all benefit maximum amounts and any required deductible and Coinsurance amounts under this Health Care Plan will be calculated on the basis of the Servicing Plan Provider's Eligible Charge for Covered Services rendered to you or the cost agreed upon between the Servicing Plan and the Claim Administrator for Covered Services that the Servicing Plan passes to the Claim Administrator, whichever is lower.

Often, the agreed upon cost is a simple discount. Sometimes, however, the agreed upon cost may represent either an estimated discount or an average discount received or expected by the Servicing Plan based on separate financial arrangements with Servicing Plan Providers.

In other instances, laws in a small number of states dictate the basis upon which the Coinsurance is calculated. When Covered Services are rendered in those states, the Coinsurance amount will be calculated using the state's statutory method.

Claim Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The Claim Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claim Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claim Administrator's behalf, Claim Payments and certain administrative services for your prescription drug benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claim Administrator. In addition, the mail-order pharmacy and specialty pharmacy operate through an affiliate partially owned by Prime Therapeutics, LLC. Neither the Employer nor you are entitled to receive any portion of such rebates.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Claim Administrator but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufactures to cover the administrative costs of processing late payments). The Claim Administrator may also negotiate rebate contracts with pharmaceutical manufacturers. The Claim Administrator may receive such rebates from Prime or pharmaceutical manufacturers. You are not entitled to receive any portion of any such rebates.

3. PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

a. Under this Health Care Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from a Non-Administrator Provider. The Claim Administrator is specifically authorized by you to determine to whom any benefit payment should be made.

b. Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

c. A covered person's claim for benefits under this Health Care Plan is expressly non-assignable and non-transferable in whole or in part to any person or entity, including any Provider, at any time before or after Covered Services are rendered to a covered person. Coverage under this Health Care Plan is expressly non-assignable and non-transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a claim for benefits or coverage shall be null and void.

4. YOUR PROVIDER RELATIONSHIPS

a. The choice of a Provider is solely your choice and the Claim Administrator will not interfere with your relationship with any Provider.

b. The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. The Claim Administrator is not in any event liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and an Administrator Provider shall not be construed to mean that the Claim Administrator is providing professional service.

c. The use of an adjective such as Participating, Administrator, Preferred or approved in modifying a Provider shall in no way be construed as a recommendation, referral, or any other statement as to the ability or quality of such Provider. In addition, the omission, non-use or non-designation of Participating, Administrator, Preferred approved or any similar modifier or the use of a term such as Non-Administrator or Non-Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

d. Each Provider provides Covered Services only to you and does not interact with or provide any services to your Employer (other than as an individual covered person) or your Employer's ERISA Health Benefit Program.

5. NOTICES

Any information or notice which you furnish to the Claim Administrator under the Health Care Plan as described in this benefit booklet must be in writing and sent to the Claim Administrator at its offices at 300 East Randolph, Chicago, Illinois 60601 (unless another address has been stated in this benefit booklet for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Employer and if applicable, in the case of a Qualified Medical Child Support Order, to the designated

representative as it appears on the Claim Administrator's records. The Claim Administrator may also provide such notices electronically to the extent permitted by applicable law.

6. LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Health Care Plan as described in this benefit booklet, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this benefit booklet.

7. INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, other Blue Cross and Blue Shield Plan, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or injury for which a Claim or Claims for benefits are made under the Health Care Plan, (b) any medical history which might be pertinent to such illness, injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or programs or other entities providing insurance-type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or your Employer or group administrator information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

8. OVERPAYMENT

If your group's benefit plan or the Claim Administrator pays benefits for eligible expenses incurred by you or your dependents and it is found that the payment was more than it should have been, or it was made in error ("Overpayment"), your group's benefit plan or the Claim Administrator has the right to obtain a refund of the Overpayment amount from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Participating Providers or Non-Participating Providers.

If no refund is received, your group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a. Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different member; or

b. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Contracted Provider; or

c. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy, if the future benefit payment owed is to a Contracted Provider; or

d. Any future benefit payment, or other payment, made to any person or entity; or

e. Any future payment owed to one or more Contracted Providers.

Further, the Claim Administrator has the right to reduce your benefit plan's payment to a Contracted Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Contracted Provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

9. VALUE BASED DESIGN PROGRAMS

The Claim Administrator and your Employer has the right to offer medical management programs, quality improvement programs and health behavior wellness, incentive, maintenance, or improvement programs that allow for a reward, a contribution, a penalty, a differential in premiums or a differential in medical, prescription drug or equipment Copayments, Coinsurance or deductibles, or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by the Claim Administrator or an entity chosen by the Claim Administrator to administer such programs. In addition, discount, or incentive programs for various health and wellness-related, insurance-related, or other items and services may be available from time-to-time. Such programs may be discontinued with or without notice.

Contact your Employer for additional information regarding any value-based programs offered by your Employer.

REIMBURSEMENT PROVISION

If you or one of your covered dependents incur expenses for sickness or injury that occurred due to negligence of a third party and benefits are provided for Covered Services described in this benefit booklet, you agree:

a. the Claim Administrator has the rights to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of sickness or injury, in the amount of the total Eligible Charge or Provider's Claim Charge for Covered Services for which the Claim Administrator has provided benefits to you, reduced by any Average Discount Percentage ("ADP") applicable to your Claim or Claims.

b. the Claim Administrator is assigned the right to recover from the third party, or their insurer, to the extent of the benefits the Claim Administrator provided for that sickness or injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered dependents, or your legal representative, are or were able to obtain for the same expenses for which the Claim Administrator has provided benefits as a result of that sickness or injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability. (See provisions of this benefit booklet regarding "Claim Administrator's Separate Financial Arrangements with Providers.")

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the benefit booklet to which this Amendment is attached and becomes a part of the benefit booklet. Unless otherwise required by Federal or Illinois law, in the event of a conflict between the terms on this Amendment and the terms of the benefit booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any Member, including Subscriber and Dependents.

The benefit booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the benefit booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's Covered Services at the Participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be

extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the benefit booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the benefit booklet and this Amendment, those terms will apply only to their use in the benefit booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or a Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- Covered Services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:

    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of Illinois (BCBSIL) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSIL for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a physician or other health care provider who has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSIL setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your Participating Provider deductible and/or out-of-pocket expense limit, if any.

3. Prohibition of Balance Billing

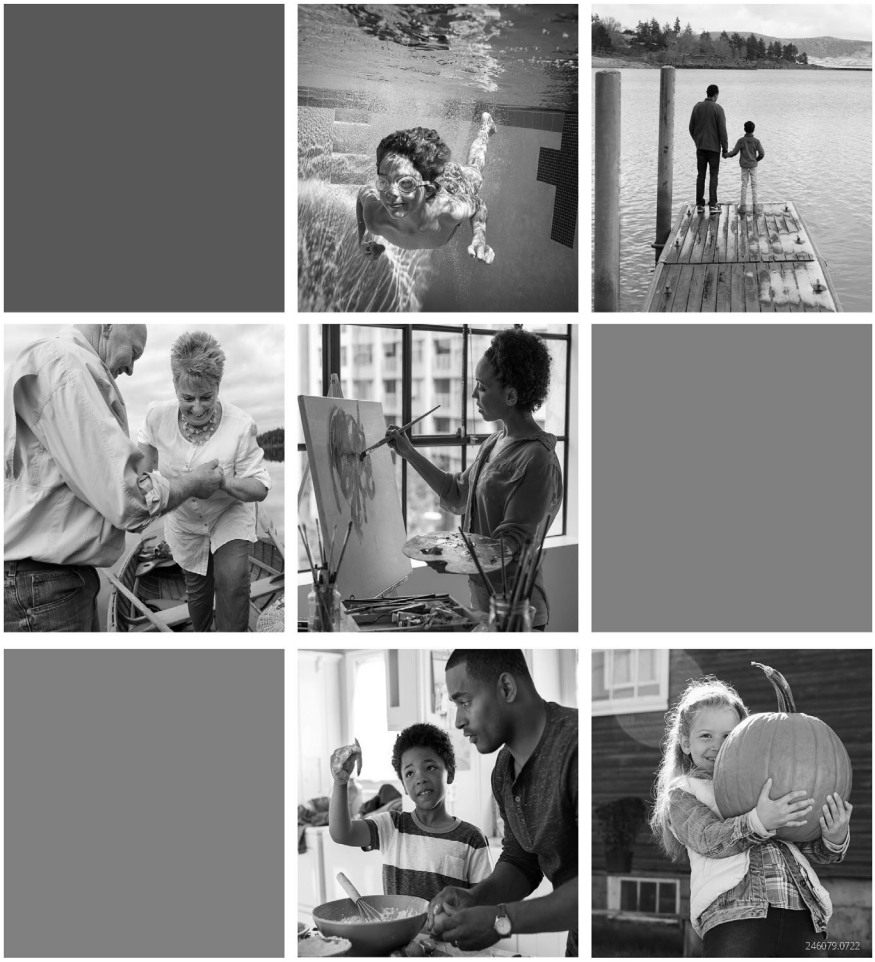
You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.



bcbsil.com

ASO–1

Effective Date: January 1, 2025

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Cross and Blue Shield of Illinois provides administrative services only and does not assume any financial risk or obligation with respect to claims.

BMO

Prescription Drug Coverage

Plan Details



EVERNORTH℠
HEALTH SERVICES
Express Scripts® Pharmacy Benefit Services

Quick Facts

Vendor	Express Scripts (Evernorth Health Services)

Overview

When you enroll in a BMO medical plan administered by Blue Cross Blue Shield of Illinois (BCBSIL), you automatically receive prescription drug coverage through Express Scripts, our pharmacy benefits manager. Express Scripts helps manage your prescriptions and your health. Here are a few highlights you can expect:

- **Easy**. Register online or download the Express Scripts mobile app to always have your info with you. Check coverage, compare prices, and see if generic medications are available.
- **Accessible**. Connect with pharmacists in the app, or online and by phone 24/7.
- **Personalized**. Select your communication preferences so you can control how you receive information.
- **Convenient**. Order refills, track shipments, compare prices and access your plan information online.

	Visit www.express-scripts.com First time visitors must register using their member ID or Social Security Number. You can manage your medication online when your coverage takes effect. Before then, you can set up your online account, including your preferred shipping address, preferences, and payment method(s) for home delivery orders. Have a question about Account management & preferences, prescription orders, prices & paying for medication past orders & records, getting medicine: nearby or delivered, prescription rules & coverage, common terms, or taking medicine log in and go to the **Help** menu and select **FAQs & Contact Us** for support!
	Visit your favorite app store to download the Express Scripts mobile app
	Text JOIN to 69717 for a link to Express Scripts registration page Automated text message will be sent to you. Message and data rates apply. Not a condition of purchase.

Prescription Drug Coverage: HDHP vs. PPO

Prescription drug benefits are subject to the annual deductible and out-of-pocket maximum in both HDHP and PPO medical plans, but how you pay for medications can differ. Understanding these variables can help you make informed decisions about your prescription drug spending and maximize your benefits.

There are also certain categories of prescriptions that are considered preventive and therefore not subject to the deductible and either covered at 100% by the Plan or immediately covered at applicable copayment or coinsurance. Your out-of-pocket cost for prescriptions will vary based on your health plan and:

- Where you fill your prescription (retail pharmacy or home delivery)
- What type of drug it is (generic, preferred brand-name, or non-preferred brand-name).

Prescription Category	Examples	Plan Coverage
Affordable Care Act (ACA) Preventive Drug List	Aspirin products, fluoride products, folic acid products, contraceptive methods, smoking cessation products, most vaccines, bowel preps and primary prevention of breast cancer	You pay $0*
	**Not all prescriptions for the listed medications are covered at 100% and are subject to change. Specific criteria, exclusions, and other rules or limitations may apply to all categories (i.e., quantity limit, age, gender).*	
Expanded Preventive Drug List	Maintenance medications to treat conditions such as high blood pressure, high cholesterol, diabetes, asthma and more	Deductible does not apply; you pay applicable copay or coinsurance based on the Plan's cost share structure
Non-Preventive Prescription Drugs	All other covered prescription Medications	After the deductible, you pay applicable copay or coinsurance based on the Plan's cost share structure

	HDHP	PPO
MEDICAL		
Annual Deductible (individual/family)	$1,750/$3,500 (includes *medical and prescription drugs*)	$750/$1,500 (includes *medical only)*
Deductible Type*	Aggregate	Embedded
Annual Out-of-Pocket Maximum (individual/family)	$3,425/$6,850 (includes deductible, copays and coinsurance for *medical and prescription drugs*)	$3,000/$6,000 (includes deductible, copays and coinsurance for *medical and prescription drugs*)
PRESCRIPTION DRUGS		
Annual Deductible (individual/family)	Combined with medical	$250/$500 (includes *prescription drugs only*)
Annual Out-of-Pocket Maximum	Combined with medical	
Generic	Retail: $10 copay | Mail order: $25 copay	
Formulary	30% coinsurance | Retail: $25 minimum; $100 maximum | Mail order: $62.50 minimum; $250 maximum	
Non-Formulary	40% coinsurance | Retail: $50 minimum; no maximum | Mail order: $125 minimum; no maximum	

***How the deductibles work**

The HDHP plan has an "aggregate deductible," which means: As a family, you have one family deductible and out-of-pocket maximum that applies to the entire family. If combined expenses for the family meet the family deductible, the deductible is met for the entire family, and the plan begins to pay coinsurance for the whole family. The plan works similarly for the out-of-pocket maximum.

The PPO plan has an "embedded deductible," which means: Each member of your family has an individual deductible and individual out-of-pocket maximum. If any one person in the family meets the individual deductible amount, the plan starts paying coinsurance for that person. If expenses for two or more family members reach the family deductible amount, the whole family has met the deductible, and the plan begins to pay coinsurance for the whole family. The plan works similarly for the out-of-pocket maximum.

What's Covered

Benefits are provided only if the drugs are prescribed by a physician, deemed medically necessary and considered eligible under the plan. Some covered medications may be excluded from coverage or be subject to Express Scripts' clinical programs, including but not limited to prior authorization, step therapy, quantity limits and refill too soon.

The Plan includes a list of preferred drugs (both generic and brand name) that are either more effective at treating a particular condition than other drugs in the same class of drugs, or as effective as and less costly than similar medications. Non-preferred drugs may also be covered under the prescription drug program, but at a higher cost-sharing tier. Collectively, these lists of drugs make up the Plan's Formulary.

Formularies can help you save money by alerting you to more affordable and clinically effective medications. Medications chosen for the formulary have gone through an extensive review process, guided by an independent panel of clinical experts that review quality and efficacy (they're known to work well, with minimal side effects), safety and cost-effectiveness. In addition, the Plan's Formulary is updated periodically and subject to change:

- a drug may be moved to a higher or lower cost-sharing Formulary tier;
- additional drugs may be excluded from the Formulary;
- a restriction may be added on coverage for a Formulary-covered drug (e.g. Prior Authorization);
- a Formulary-covered brand name drug may be replaced with a Formulary-covered generic drug.

To get the most up-to-date drug information go online to www.express-scripts.com/bmofinancialgroup or call Express Scripts Member Services at 1 - 877-795-2926.

Please be sure to check before the drug is purchased to make sure it is covered on the Formulary. Certain drugs even if covered on the Formulary will require prior authorization in advance of receiving the drug. Other Formulary covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as step-therapy. As with all aspects of the Formulary, these requirements may also change from time to time.

Drugs that are excluded from the formulary are not covered under the Plan unless approved in advance through a Formulary exception process managed by Express Scripts on the basis that the drug requested is:

- medically necessary and essential to the Covered Person's health and safety and/or,

- all Formulary drugs comparable to the excluded drug have been tried by the Covered Person.

If approved through that process, the applicable Formulary copayment or coinsurance would apply for the approved drug based on the Plan's cost share structure. Absent such approval, individuals selecting drugs excluded from the Formulary will be required to pay the full cost of the drug without any reimbursement under the Plan. If the Covered Person's Physician believes that an excluded drug meets the requirements described above, the Physician should take the necessary steps to initiate a Formulary exception review.

Important information about your prescription coverage

Specialty Drug Program through Accredo

Specialty medications are drugs that are used to treat complex conditions such as cancer, growth hormone deficiency, hemophilia, hepatitis C, immune deficiency, multiple sclerosis and rheumatoid arthritis. For these types of prescriptions, you are required to fill your prescriptions through the Express Scripts dedicated specialty pharmacy, Accredo Health Group, Inc. You may call Member Services at 1-877-795-2926 for information on how to order your specialty medications or to find out more information about Accredo.

Dispense As Written (DAW)

If you, or your doctor, request a brand-name medication when a generic equivalent is available, you will pay the generic copayment, plus the difference in cost between the brand and the generic. If you cannot take a generic equivalent due to medical necessity, your doctor may request a review and provide supporting documentation on why the brand is medically necessary. If approved by Express Scripts, you will pay the brand copayment.

Exclusive Smart90

Exclusive Smart90 requires you to fill 3–month supplies of long-term prescriptions at a Smart90 retailer (Walgreens or CVS) or through Express Scripts home delivery. Members can get two retail 30-day grace fills for maintenance medications before you must make the switch to a 90-day supply at a Smart90 network pharmacy.

Manufacturer Copay Assistance

Manufacturer copay assistance funds will NOT accumulate towards the deductible or max out-of-pocket amounts.

Evernorth EnGuide Pharmacy

Evernorth EnGuide Pharmacy is dedicated solely to dispensing, packaging, and shipping GLP-1 medications. Given the complexity of these medications, Evernorth EnGuide Pharmacy benefits from a staff of pharmacists specially trained in GLP-1s, giving a more focused level of care to patients and helping them get on the right dose long-term, while advising on any potential side effects.

For home delivery, you may previously have received your GLP-1 medications from Express Scripts® Pharmacy, our home delivery pharmacy, but as of June 15, 2025, you'll be receiving your GLP-1 medications through Evernorth EnGuide Pharmacy/CHD. You may also choose to fill at other in-network pharmacies.

Drug Specific Cap

Infertility medications are covered up to a lifetime pharmacy benefit maximum of $40,000. Once this limit is reached, no additional infertility medication expenses will be reimbursed under the plan.

Over-the-counter (OTC) NARCAN® Nasal Spray (naloxone)

Naloxone is a life-saving medication that can reverse an overdose from opioids, including heroin, fentanyl and prescription opioid medications. NARCAN is not effective for overdoses of non-opioids, such as methamphetamine. Naloxone is safe and will not harm someone if you give it to them when they are not overdosing on an opioid.

Why is NARCAN important?

NARCAN is used in emergency situations to reverse the effects of opioids and allow a person to breathe properly. Anyone can carry naloxone to help respond to an overdose. Individuals who are concerned about the risk of an opioid overdose, including people who use prescription or illicit opioids, their family members, friends and caregivers, and concerned members of the public, should consider having naloxone on hand. This allows them to administer naloxone if they witness someone experiencing an overdose.

Additional help

- To learn how to administer NARCAN, visit: https://www.ama-assn.org/delivering-care/nation-s-overdose-epidemic/how-administer-naloxone

- **Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline** 800.662.4357

Pharmacy Program Descriptions

Formulary Overview: Express Scripts formulary options help decrease prescription drug expenses. To ensure the clinical appropriateness of their formularies, Express Scripts physicians and pharmacists carefully evaluate pharmaceuticals and prepare recommendations for the National Pharmacy & Therapeutics (P&T) Committee, which reviews and approves Express Scripts formularies.

Drug Quantity Management (DQM) makes sure that members are getting the right amount of medication and that it is prescribed in the most efficient way. For example, the doctor may say, “take two 20mg pills each morning.” If that medication is also available in 40mg pills, Express Scripts will contact the doctor about prescribing one 40mg pill a day instead of two 20mg pills. In addition, if the doctor writes the original prescription for 30 pills (a 15-day supply), the new prescription for 30 pills will last a full month — and the members will have just one copayment, not two.

DQM also makes sure that a member’s prescriptions do not exceed the amount of medication that the Plan covers. If the prescription is for too large a quantity, the pharmacist can fill the prescription for the amount that the Plan covers or contact the doctor to discuss other options, such as increasing the strength or getting a prior authorization for the quantity originally prescribed.

Prior Authorization monitors both cost and safety. If a pharmacist tells a member that a prescription requires prior authorization, Express Scripts will need to communicate with the doctor to be sure that the medicine is right and will verify that the Plan covers the drug. This is like when a healthcare plan authorizes a medical procedure in advance.

When a prescription requires prior authorization, the doctor can call Express Scripts or prescribe a different medicine that is covered by the Plan. Only doctors can give Express Scripts the information needed to determine if the drug may be covered. Express Scripts answers its prior authorization phone lines 24/7, and a determination can be made right away. If the medicine is covered, the member will pay the normal copay. If the medication is not covered but the member wants to take it, the member will pay the full price of the medicine.

Step Therapy is a program for people who take prescription medicine regularly to treat long-term conditions, such as arthritis, asthma or high blood pressure. It lets members get the treatment they need affordably.

- First-line medicines are the first step. First-line medicines are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. Step therapy suggests that a patient try these medicines first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.

- Second-line drugs are the second and third steps. Second-line drugs typically are brand-name drugs. They are best suited for the few patients who do not respond to first-line medicines. Second-line drugs are the most expensive options.

The first time a member tries to fill a prescription that is not for a first-line medicine, the pharmacist should explain that step therapy asks the member to try a first-line medicine before a second-line drug. Only the doctor can change the current prescription to a first-line medicine covered by the Plan.

To get a first-line medicine that the Plan covers, a member should ask the pharmacist to call the doctor and ask for a new prescription. If it is easier, the member can also call the doctor to ask for a new prescription. Also, the pharmacist should explain to the member that there's an option to choose a second-line alternative to the first-line medicine. However, because the Plan will not cover second-line drugs until after the member and the doctor have considered a first-line medicine to treat the condition, the member will pay full price for that second-line drug.

For information on Formulary medications, Drug Quantity Management, Prior Authorization or Step Therapy programs contact Express Scripts at 1-877-795-2926. To inquire about specific medications, search medications directly by logging into your account at www.express-scripts.com, or if you are not yet a member, visit the pre-member site at www.express-scripts.com/bmofinancialgroup.

Retail Pharmacy Network

Express Scripts has many participating retail pharmacies across the country where you can purchase smaller quantities of prescriptions to be used for 30 days or less. For example, if your doctor prescribes short-term antibiotics, or you need to quickly get your initial supply of a maintenance drug, just go to a participating retail network pharmacy and present your Express Scripts prescription ID card or digital ID card and pay the applicable copayment or coinsurance.

For a list of participating network pharmacies, visit www.express-scripts.com, or call Member Services at 1-877-795-2926.

If you do not present your prescription drug ID card at the time of your purchase at the retail pharmacy, or if you purchase your prescription from a non-participating pharmacy, you will have to submit the claim yourself to Express Scripts. The amount that you will be reimbursed for using a non-participating pharmacy will be based upon the cost of the drug if you had used a participating network pharmacy. You will be responsible for the amount above the discounted in-network pharmacy rate plus the required copayment/coinsurance. The reimbursement claim is generally responded to within 10 business days.

Log into your account at www.express-scripts.com. Once logged in, on the Benefits tab, simply click on Forms, and then click on the link to start a claim to request reimbursement. You can download and print the Prescription Drug Reimbursement Form and mail it to the address found on the form, or you can also request a blank claim for to be mailed to you. If you are a first-time visitor, take a moment to register. Please remember to have your member ID number and recent prescription number available. If you do not have a recent prescription number, you may still register; just remember to add a prescription number later so that you can fully manage your prescription benefit online.

Home Delivery

Home delivery, also referred to as mail order, is designed for longer-term medication (any medicine you must take for three or more months to control symptoms or to prevent complications from a condition) of up to 90 days. Examples of conditions that might require long-term medicine include high blood pressure, high cholesterol, diabetes, arthritis, heart conditions, and long-term pain. When you need longer-term prescriptions, using home delivery saves you both time and money. Benefits of delivery from Express Scripts includes:

- Up to a 3-month supply of your long-term medicine with each refill
- Medicine shipped to your door
- Online order tracking
- Easy online payments through the extended payment program let you spread out the cost over 3 months
- Access to an Express Scripts pharmacist any time of the day or night

Extended payment program (EPP)
This lets you pay for your delivery prescriptions in three monthly payments (installments), instead of paying the full amount all at once. Each monthly payment is automatically processed using your preferred payment method. **Example**: You order a prescription that costs $90, and your preferred payment method is a credit card. Under the EPP, you would make 3 monthly payments as follows:

- First payment: As soon as your prescription ships, we'll charge your card $30.
- Second payment: 30 days after your prescription ships, we'll charge your card another $30.
- Third payment: 60 days after your prescription ships, we'll charge your card the final payment of $30. EPP does not cover expedited shipping costs. If you select expedited shipping for your order, the total shipping cost will be billed with your first payment.

Medical necessity appeals: Express Scripts performs appeal services internally or facilitates the performance of appeal services through a contracted, independent, third-

party utilization management company. Appeal cases are handled by reviewing available information as well as clinical guidelines and current clinical literature to determine if drug coverage is permitted under the plan's pharmacy benefit coverage rules. The review considers plan rules based on Food and Drug Administration (FDA)-approved prescribing and safety information, as well as relevant clinical guidelines.

WHAT'S NOT COVERED UNDER PRESCRIPTION DRUGS

The Prescription Drug Program does not cover:

- acts of war: injury or illness caused or contributed to international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared;
- allergy serums;
- any charge for the administration of prescription products;
- all illegal medications or supplies, even if prescribed by a duly licensed medical professional;
- any medication, prescription or non-prescription which is taken or administered at the place where it is dispensed;
- any medication which is meant to be taken by or administered in whole or in part while the covered person is treated at a hospital, physician's office or extended care facility, but is instead self-administered or administered elsewhere, unless expressly designated by the pharmacy benefits administrator;
- charges that are in access of the contracted amount;
- claims received later than 12 months from the date of service;
- compound prescriptions unless approved by this plan;
- compounded prescriptions delivered through home delivery, except for specialty prescriptions through a specialty pharmacy;
- cosmetic drugs
- difference in cost between a generic product and brand product when the medical professional has not specified a brand product or has not indicated that the brand product is necessary;
- duplicate services and charges or inappropriate billing;
- glucoWatch products;
- hair growth stimulants and products indicated only for cosmetic use;
- injectable contraceptives;
- nutritional supplements;
- ostomy supplies
- over-the-counter contraceptives;
- over-the-counter products, unless specifically provided under this plan;
- non-specialty implantable medications;
- non-systemic prescription contraceptives (i.e. diaphragm, cervical caps, etc.);

- prescription medications which are administered or dispensed as take home drugs as part of treatment while in the hospital or at a medical facility and that requires a physician's prescription;
- prescription products that are not dispensed by a licensed pharmacist or medical professional;
- prescription products dispensed in a foreign country if you traveled solely for the purpose of reimporting prescription drugs into the United States and/or you used other means to ship or bring prescription products from a foreign country into the United States;
- prescription products that may be received without charge under local, state or federal programs, including worker's compensation;
- prescription products that require Prior Authorization or any other clinical process in which the prescription was denied or was needed and not requested;
- prescriptions and prescription refills which exceed the Plan's quantity limits;
- prescriptions or supplies rendered before coverage begins under this Plan or after coverage ends;
- refilling a prescription more than the number specified on the prescription or any refill dispensed after one year from the order of the medical professional;
- replacement prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.

If your requested medication or supply is not covered, in whole or in part, you still have the right to purchase that product, however the entire cost of the product will be your responsibility.

CLAIMING BENEFITS FOR PRESCRIPTION DRUGS LIMITATION OF ACTION

You cannot bring any legal action against BMO Financial Corp. or the pharmacy benefits administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against BMO Financial Corp. or the pharmacy benefits administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against BMO Financial Corp. or the pharmacy benefits administrator. You cannot bring any legal action against BMO Financial Corp. or the pharmacy benefits administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring legal action against BMO Financial Corp. or the pharmacy benefits administrator you must do so within three years of the

date you are notified of the final decision on your appeal or lose any rights to bring such action against BMO Financial Corp. or the pharmacy benefits administrator.

MANDATORY VENUE

Any lawsuit to challenge a final claim determination or to address any other dispute arising out of or relating to the Plan must be brought to federal court in Cook County, Illinois. The federal courts governing Cook County, Illinois, along with the United States Supreme Court, have exclusive jurisdiction over all disputes arising out of or in any way relating to this Plan.

CLAIM DENIALS AND APPEALS

In the event you receive an adverse benefit determination following a request for coverage of a prescription benefit claims, you have the right to appeal the adverse benefit determination in writing within 180 days of receipt of notice of the initial coverage decision. An appeal may be initiated by you or your authorized representative (such as your physician). To initiate an appeal for coverage, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied, the diagnosis code and treatment codes to which the prescription relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

A decision regarding your appeal will be sent to you within 15 days of receipt of your written request. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes and any additional information needed to perfect your claim. You have the right to receive, upon request and at no charge, the information used to review your appeal.

If you are not satisfied with the decision made on appeal, you may request in writing, within 90 days of receipt of notice of the decision, a second-level appeal. A second level appeal may be initiated by you or your authorized representative (such as your physician). To initiate a second level appeal, provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been denied the diagnosis code and treatment codes to which the prescription relates (and the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

You have the right to review your file and present evidence and testimony as part of your appeal, and the right to a full and fair impartial review of your claim. A decision regarding your request will be sent to you in writing within 15 days of receipt of your written request for an appeal. The notice will include information to identify the claim involved, the specific reasons for the decision, new or additional evidence, if any considered by the plan in relation to your appeal, the plan provisions on which the decision is based, a description of applicable internal and external review processes and contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes. You have the right to receive, upon request and at no charge, the information used to review your second level appeal. If new information is received and considered or relied upon in the review of your second level appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding.

If your second level appeal is denied and you are not satisfied with the decision of the second level appeal or your adverse benefit determination notice or final adverse benefit determination notice does not contain all the information required under ERISA, you also have the right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA).

You also may have the right to obtain an independent external review. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination. External reviews are not available for decisions relating to eligibility.

In the case of a claim for coverage involving urgent care, you will be notified of the benefit determination within 24 hours of receipt of the claim. An urgent care claim is any claim for treatment with respect to which the application of the time periods for making non -urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed. If the claim does not contain sufficient information to determine whether, or to what extent, benefits are covered, you will be notified within 24 hours after receiving receipt of your claim of the information necessary to complete the claim. You will then have 48 hours to provide the information and will be notified of the decision within 24 hours of receiving the information. If you don't provide the needed information within the 48-hour period, your claim will be deemed denied.

You have the right to request an urgent appeal of an adverse benefit determination (including a deemed denial) if you request coverage of a claim that is urgent. Urgent appeal requests may be oral or written. You or your physician may call 1-800-864-1135 or send a written request to:

Attn: Urgent Appeals Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

In the case of an urgent appeal for coverage involving urgent care, you will be notified of the benefit determination within 72 hours of receipt of the claim. This coverage decision is final and binding. You have the right to receive, upon request and at no charge, the information used to review your appeal. If new information is received and considered or relied upon in the review of your appeal, such information will be provided to you together with an opportunity to respond prior to issuance to any final adverse determination of this appeal. The decision made on your second level appeal is final and binding. You also have the right to bring a civil action under section 502(a) of Employee Retirement Income Security Act of 1974 (ERISA) if your appeal is denied or your adverse benefit determination notice, or final adverse benefit determination notice does not contain all the information required under ERISA. You also have the right to obtain an independent external review. In situations where the timeframe for completion of an internal review would seriously jeopardize your life or health or your ability to regain maximum function you could have the right to immediately request an expedited external review, prior to exhausting the internal appeal process, provided you simultaneously file your request for an internal appeal of the adverse benefit determination. Details about the process to initiate an external review will be described in any notice of an adverse benefit determination.

If your claim is denied, you will receive a written notice within 30 days of receipt of the claim, if all the information needed is provided with the claim. You will be notified within this 30-day period if additional information is needed to process the claim and a one-time extension not longer than 15 days may be requested and your claim pending until all information is received. Once you are notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame and the claim is denied, you will be notified of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be deemed denied.

If you are not satisfied with the decision regarding your benefit coverage or your claim is deemed denied, you have the right to appeal this decision in writing within 180 days of receipt of notice of the initial decision. To initiate an appeal for coverage, you or your authorized representative (such as your physician), must provide in writing your name, member ID, phone number, the prescription drug for which benefit coverage has been reduced or denied, the diagnosis code and treatment codes to which the prescription

relates (together with the corresponding explanation for those codes) and any additional information that may be relevant to your appeal. This information should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

KAISER PERMANENTE®

2025 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we made to your *Group Agreement* for the 2025 plan year. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), *Benefit Summary*, and any applicable notices, riders, and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*, or changes that may occur throughout the remainder of the plan year as a result of federal or state mandates.

Other plan-specific or product-specific benefit changes, including changes to deductible, copayment, or coinsurance amounts, may apply to your plan. Please refer to the 2025 renewal proposal and/or confirmation for your group and the 2025 Oregon and Washington Plan Changes document for information about these types of changes.

This Summary of Changes and Clarifications supplements the information contained in your *Group Agreement*. In the event of conflict between this summary and the *Group Agreement*, the *Group Agreement* shall control. Unless another date is listed, the changes described in this summary are effective when your *Group Agreement* renews in 2025. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and Clarifications that Apply to Medical Plans

These changes apply to Kaiser Permanente's commercial (non-Medicare) group plans. Changes to our Senior Advantage plans may be found at the end of this summary.

Benefit Changes

- **Kaiser Permanente at Home in HDHP Plans**. The Kaiser Permanente at Home benefit has been removed from High Deductible plans.

Benefit Clarifications

- **Bariatric Surgery Services.** For groups that cover Bariatric Surgery, the "Bariatric Surgery Services" section of the *Benefit Summary* was updated to include a row for "Outpatient surgery visit." This change is also reflected in the "Bariatric Surgery Services" section of the *EOC*.
- **Cochlear Implants**. We added a "Cochlear implant surgery visit" row under the "Outpatient Services" section of the *Benefit Summary* to indicate the cost share for this service is only subject to the Deductible in High-Deductible plans. Additionally, we removed mention of cochlear implants from the "Benefits for Inpatient Hospital Services" section of the *EOC* as this service is performed as an outpatient procedure.
- **Eye Exam Clarifying Language**. In the "Benefits for Outpatient Services" section of the *EOC*, the eye exam bullet was altered to clarify that refraction exams are included in covered eye exams.
- **Hearing Aids Age Limit Language**. We made minor revisions in the "Hearing Aids and Other Hearing Devices" section of the *EOC* and *Benefit Summary* to clarify that Services covered under the section are available to all Members under the Dependent Limiting Age. One such revision included changing the section title from "Hearing Aids and Other Hearing Devices for Dependents" to "Hearing Aids and Other Hearing Devices."

- **Rehabilitative Therapy Services**. We removed the rehabilitative therapy Services bullet from the "Benefits for Outpatient Services" and "Benefits for Inpatient Hospital Services" sections of the *EOC* to reduce redundancy, as more information about these Services can be found in the "Rehabilitative Therapy Services" section.
- **Substance Use Disorder Prescriptions**. In accordance with OR House Bill 4002, we made minor edits in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* and in the "Outpatient Prescription Drug Rider" to clarify the early refill and prior authorization requirements around Substance Use Disorder medications.

Other Changes or Clarifications

- **Added Choice Network Name Change**. The term "Select," which was used to describe the facility, pharmacy, physician, or provider that contracts directly with Kaiser Permanente in the Added Choice® product documents, was changed to "KP Select".
- **Allowances.** We added clarification in the Added Choice® and PPO Plus *Benefit Summaries* that any applicable day limits are also combined for benefits received from all provider types unless otherwise indicated in the *EOC*.
- ***Benefit Summary* Introductory Paragraph Edit**. In the Traditional, Deductible, and High-Deductible *Benefit Summary* introductory paragraphs, we removed the sentence referencing exclusions, limitations, and reductions, as this information is redundant and already provided in the *EOC*.
- **External Review.** We revised the "External Review" section of the *EOC* to reflect that in certain circumstances, the external review process no longer requires a signed waiver prior to review.
- **Gender Inclusivity.** Throughout the *EOC* we have made minor updates to remove some gendered language.
- **Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance.** In the *EOC*, the Third Party Administrator and address for filing claims or legal action against another party or insurer has changed from "Equian, LLC" to "The Phia Group, LLC."
- **Member Register URL.** The URL in the sections of the *EOC* that direct members where to register was updated from **kp.org** to **kp.org/register** for a more direct link to register.
- **Post-Service Claims - Services Already Received Revisions.** We made minor revisions in the "Post-Service Claims - Services Already Received" section of the *EOC* to make it clear that information in this section also applies to pharmacy claims.
- **Primary Care Provider Paneling**. In accordance with 2022 Oregon Senate Bill 1529 and 2024 Oregon House Bill 4010, we have made several changes to the *EOC* including:
    - Adding a definition of "Primary Care Provider" to the "Definitions" section;
    - Revising the "Your Primary Care Provider" section to include information on the Primary Care Provider (PCP) paneling process and create standardized language between product types; and
    - In the PPO Plus plan, adding the "Your Primary Care Provider" section to the *EOC* to match the other products.
- **Provider Title Change.** In accordance with Oregon House Bill 4010, we have revised our *EOC* to update the term "Physician Assistant" to "Physician Associate."
- **Removal of the "Women's Health Care Services" Section.** We removed the "Women's Health Care Services" section in the *EOC* to reduce redundancy, as the information in that section is addressed in

other "Benefits" sections. This does not apply to the PPO Plus or Dual Choice *EOC*, as the "Women's Health Care Services" section was not present in those products.

Changes and Clarifications that Apply to Medical Benefit Riders

Other Changes or Clarifications

- **Hearing Aids Age Limit Language**. We made minor revisions in the "Hearing Aid Rider" to clarify that Services covered under the Rider are available to Members who are the Dependent Limiting Age and older. Members under the Dependent Limiting Age are covered as described under the "Hearing Aids and Other Hearing Devices" section of the *EOC*.
- **URL Changes for Dual Choice Riders.** The existing product specific URL page (**kp.org/dualchoice/nw**) was changed in the Dual Choice "Pediatric Vision Hardware and Optical Services Rider" and "Hearing Aid Rider" to the more general **kp.org/choiceproducts/nw** landing page to improve members' navigation experience at **kp.org**, and match the information members will see on their ID cards and other member materials.

Changes and Clarifications that Apply to Dental Plans

Benefit Changes

- **Nightguard Frequency Limitation**. We added a nightguard frequency limitation of one every five years.
- **Prior Authorization Revisions**. In the PPO Dental *EOC,* we made minor language modifications in the "Prior Authorization" section to improve readability and minimize redundant language found in other sections.

Benefit Clarifications

- **Full Mouth Gross Debridement Limitation**. In the "Exclusions and Limitations" section of the Traditional Dental plan *EOC* we added a limitation for full mouth gross debridement of once every 36 months.

Other Changes or Clarifications

- **Deductible Definition**. We removed redundant language from the "Deductible" definition in the PPO Dental *EOC*.
- **Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance.** In the *EOC*, the Third Party Administrator and address for filing claims or legal action against another party or insurer has changed from "Equian, LLC" to "The Phia Group, LLC."
- **Least Costly Treatment Alternative**. We altered the least costly treatment language in the "Benefits" section of the Traditional Dental *EOC* for improved readability and to reduce redundancy.
- **Member Register URL.** In the Traditional Dental *EOC*, the URL in the sections of the *EOC* that direct members where to register was updated from **kp.org/dental/nw** to **kp.org/register** for a more direct registration link.
- **Post-Service Claims Address**. In the "Post-Service Claims – Services Already Received" and "Post-service Claim" sections of the Traditional Dental *EOC*, we updated the address where Members can send dental claims for services they received from Non-Participating Providers without a referral.

- **Provider Definition Changes**. We made edits to the "Non-Participating Provider," "Participating Dentist," and "Participating Provider" definitions in the *EOC* for added clarity and alignment across products.

Changes and Clarifications that Apply to Senior Advantage Plans

Benefit Changes or Clarifications

- **Primary Care Provider Paneling.** We updated *EOC* language in Chapter 3, Section 2.1, to show that Members will be required to choose one of our available network providers to be their primary care provider (PCP). If a member does not choose a PCP, a PCP or primary care team will be assigned to the member, and the member will be notified. Members can change their assigned PCP at any time.
- **Fitness Benefit.** We updated the *Medical Benefits Chart* to show that the Silver&Fit® fitness program has been replaced with the One Pass™ fitness program, which includes access to in-network gyms, online fitness classes and resources, home fitness kits, and an online brain health program.
- **"Drug List" Change.** For groups with Part D coverage, we updated *EOC* language in Chapter 5, Section 6.2, and definitions in Chapter 12 related to biological products and biosimilars. As part of changes to our "Drug List," starting in 2025, original biological products can be immediately replaced with certain biosimilars. This means, for instance, if a member is taking an original biological product that is being replaced by a biosimilar, the member may not get notice of the change 30 days before we make it or get a month's supply of the original biological product at a network pharmacy. If the member is taking the original biological product at the time we make the change, the member will still get information on the specific change we made, but it may arrive after we make the change.
- **Part D Out-of-Pocket Costs.** For groups with Part D coverage, we updated Chapter 6, Sections 1.3, 5.5, and 6 of the *EOC* to show that the amount of out-of-pocket costs that a member must pay for Part D prescription drugs before moving from the Initial Coverage Stage to the Catastrophic Coverage Stage has been reduced from $8,000 to $2,000.
- **Prescription Payment Option.** For groups with Part D coverage, we added language to the *EOC* in Chapter 1, Section 4.5, and Chapter 2, Section 7, about the Medicare Prescription Payment Plan, a new payment option that works with your current drug coverage and can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Plan
Group Agreement

Group Name: Bmo Financial Corp.

Group Number: 3992-004, 006

Term of *Agreement*

1/1/2025 through 12/31/2025

Anniversary date

January 1



Jeffrey A. Collins
President, Kaiser Foundation Health Plan
and Hospitals of the Northwest

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KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

This *Group Agreement* (*Agreement*), including the attached *Evidence of Coverage* (*EOC)* incorporated herein by reference, and any amendments, constitutes the contract between Kaiser Foundation Health Plan of the Northwest (Company) and **Bmo Financial Corp.** (Group). In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document for terms you should know.

To be eligible under this *Agreement*, the Group must meet the underwriting requirements set forth in Company's Rate Assumptions and Requirements document.

PREMIUM

Group will pay to Company, for each Subscriber and their Dependents, the Premium amount(s) specified for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date to which Company and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Premium Due Date").

When this *Agreement* terminates, if Group does not have another agreement with Company, then the due date for all Premium amounts will be the earlier of: (1) the last Premium Due Date, or (2) the termination date of this *Agreement*.

Monthly Premium Amounts

Group will pay Company the following Premium amount(s) each month for each Subscriber and their Dependents. Only Members for whom Company has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Company has received appropriate payment.

Subscriber only: $481.12

Subscriber and Spouse: $1058.46

Subscriber, Spouse, and child(ren): $2001.46

Subscriber and child(ren): $938.18

Medicare as Secondary Payer

Members who are eligible and enrolled in Medicare Part A or B and for whom Medicare is secondary payer are subject to the same Premium amounts (shown above) and receive the same benefits as Members who are not eligible for Medicare. Members who are eligible and enrolled in Medicare Parts A and B as secondary payer and who meet applicable eligibility requirements may also enroll in a Kaiser Permanente Senior Advantage Plan. These Members receive the coverages described in both the non-Medicare Plan and the Senior Advantage Plan, and the Premium amounts for these Members are the Premium amounts for the non-Medicare Plan (shown above).

Medicare as Primary Payer

Premium amounts are based on the assumption that Company or its designee will receive Medicare payments for Medicare-covered Services provided to certain types of Members. For each Member to whom this "Medicare as Primary Payer" section applies, Group must pay the applicable Premium shown above in this

"Monthly Premium Amounts" section if the Member is for any reason not enrolled through Group in Kaiser Permanente Senior Advantage (including inability to enroll because they do not meet the Senior Advantage Plan's eligibility requirements or Group does not offer a Senior Advantage Plan).

Those Members eligible for Medicare based on disability, end stage renal disease (ESRD), domestic partner status, or who are Medicare eligible and enrolled in COBRA will be charged the Premium amount for the non-Medicare Plan (shown above).

Members to whom this "Medicare as Primary Payer" section applies. This "Medicare as Primary Payer" section applies to Members who meet all of the following requirements:

- They are age 65 or over.
- They are eligible for Medicare Parts A and B as primary payer (i.e., retirees).

TERM OF *AGREEMENT*, ACCEPTANCE OF *AGREEMENT*, AND RENEWAL

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective for the term shown on the cover page.

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement*, if Group pays Company any amount toward Premium.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Company account manager. Company might not respond to any changes or comments that Group may submit. Group may not construe Company's lack of response to any submitted changes or comments to imply acceptance. Company will issue a new *agreement* or amendment if Company and Group agree on any changes.

Renewal

This *Agreement* is guaranteed renewable but does not automatically renew. If Group complies with all of the terms of this *Agreement,* Company will offer to renew this *Agreement,* upon not less than 30 days prior written notice to Group, either by sending Group a new group *agreement* to become effective immediately after termination of this *Agreement,* or by extending the term of this *Agreement* pursuant to "Amendments Effective on Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended group *agreement* will include a new term of *agreement* and other changes. If Group does not renew this *Agreement*, Group must give Company written notice as described under "Termination on Notice" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

Upon not less than 30 days prior written notice to Group, Company may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on the anniversary date of any year (see cover page for anniversary date).

Amendment due to Tax or Other Charges

If during the term of this *Agreement* a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Company, Medical Group, or Kaiser Foundation Hospitals or upon any activity of any of them, then upon 31 days prior written notice, Company may increase Group's Premium to include Group's share of the new or increased tax or charge.

Other Amendments

Company may amend this *Agreement* at any time by giving written notice to Group, in order to: (a) address any law or regulatory requirement; (b) reduce or expand the Company Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed in this "Termination of *Agreement*" section. All rights to benefits under this *Agreement* end at 11:59 p.m. PT on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of *the EOC*.

If this *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination not later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

If Company fails to give notice as required, this *Agreement* shall continue in effect from the date notice should have been given until the date the Group receives the notice. Company will waive the Premium for the period for which coverage is continued and the time period within which Member may exercise any right to continuation shall commence on the date that Group receives the notice. Company will properly notify Members of their right to continuation of coverage under federal and state law.

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Company not less than 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement*, including Premium, for the period through the termination date.

Termination due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Company written notice of nonacceptance at least 15 days before the effective date of the amendment in which case this *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

When Group fails to pay Premium on or before the Premium Due Date, Group shall have a period of at least 31 days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Premium Due Date. If Group fails to pay all Premiums owed (including those owed for the Grace Period) on or before the last day of the Grace Period, then Company may, at its option and in lieu of any other remedy, terminate this Agreement without further extension or consideration.

Company will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least 10 days prior to the effective date of termination. Group shall continue to be liable for all Premiums due through the date of termination.

This Agreement will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums. If Company receives full payment of Premiums on or before the last day of the Grace Period, this Agreement will remain in effect according to its terms and conditions.

If Premiums are paid after the Grace Period ends, Company may charge interest on the overdue Premiums. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be 6 percent per year or the maximum amount permitted by applicable law, whichever is less.

Termination for Fraud

Company may terminate this *Agreement* by giving at least 30 days prior written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Company or is aware that incorrect or incomplete material information has been provided to Company on enrollment or other Company forms.

Termination for Violation of Contribution or Participation Requirements

Company may terminate this *Agreement* upon 31 days prior written notice to Group, if Group fails to comply with Company's contribution or participation requirements (including those listed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Company may terminate a particular product or all products offered in the group market as permitted by law.

Company may terminate this *Agreement* if it ceases to write new business in the group market in Oregon or in a specific service area within Oregon, or elects not to renew all of its group Plans in Oregon or in a specific service area within Oregon, or both cease offering and cease renewing all products in Oregon or a specific service area in Oregon, if Company fails to reach an agreement with health care providers. To discontinue all products, Company must: (a) notify the Director of the Department of Consumer and Business Services and all Groups; and (b) not cancel coverage for 180 days after the date of notice to the Director and Groups.

Company may terminate this *Agreement* if it elects not to offer or renew, or offer and renew, this type of Plan in Oregon or within a specific service area within Oregon. Except as provided below regarding failure to reach agreement with providers, in order to discontinue a product, Company must: (a) cease to offer and/or cease to renew this Plan for all groups; (b) offer (in writing) to each group covered by this Plan, enrollment in any other Plan offered by Company in the group market, not less than 90 days prior to discontinuance; and (c) act uniformly without regard to claims experience of affected groups or the health status of any current or prospective Member.

Company may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Company to discontinue coverage upon finding that continuation of coverage (a) would not be in the best interests of the Members; or (b) would impair Company's ability to meet its contractual obligations.

Company may terminate this *Agreement* by providing not less than 90 days prior written notice if there are no Members covered under this *Agreement*.

Company may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Company must: (a) cease to offer and cease to renew this Plan for all groups within the service area; and (b) not less than 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue offering the Plan(s) and offer all other group Plans available in that service area.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Company consents in writing.

Group must:

- Meet all underwriting requirements set forth in Company's Rate Assumptions and Requirements document.
- With respect to all persons entitled to coverage under Group's Plan(s), offer enrollment in Company's Plan to all such persons on conditions no less favorable than those for any other Plan available through Group.
- Permit Company to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

Company may adopt policies, procedures, rules, and interpretations to promote efficient administration of this *Agreement*.

Assignment

Company may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Company's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Company and Group.

Attorney Fees and Costs

If Company or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable costs of collection, including attorneys' fees, by the other party.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with Oregon law and any provision that is required to be in this *Agreement* by state or federal law shall bind Group and Company regardless of whether that provision is set forth in this *Agreement*.

Grandfathered Health Plan Coverage

For any coverage identified in an *EOC* as a "grandfathered health plan" under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Company if this coverage does not meet (or no longer meets) the requirements for grandfathered status. This includes, but is not limited to, any change in its contribution rate to the cost of any grandfathered health plan(s) during the contract year. Group represents that, for any coverage identified as a grandfathered health plan in the applicable *EOC*, Group has not decreased its contribution rate more than five percent for any rate tier in that plan when compared to the contribution rate in effect on March 23, 2010, for the same plan. Company will rely on Group's representation when issuing and/or continuing grandfathered health plan coverage.

Nonduplication Agreement

Company agrees to undertake performance of the following regulatory requirements, and Group may rely on Company's performance in order to satisfy its obligation to perform the same activities with respect to the coverages issued to Group by Company:

- Preparation and publication of machine-readable files on a public website for in-network rates and billed charges and Allowed Amounts for out-of-network providers in the required form and manner as set forth in applicable regulations and any sub-regulatory guidance;

- Provision of an internet, self-service tool as well as paper reports and telephone assistance to provide personalized estimates of cost sharing for 500 shoppable services beginning on January 1, 2023, and for all covered services as of January 1, 2024, as set forth in applicable regulations and any sub-regulatory guidance;
- Annual reporting of prescription drug and health care costs reporting required to be furnished in accordance with applicable regulations and any sub-regulatory guidance;
- Publication of a consumer notice regarding federal and, when applicable, any state legal requirements related to balance billing by non-participating providers in accordance with applicable regulations and any sub-regulatory guidance;
- Annual reporting of data related to the provision and cost of air ambulance services for 2022 and 2023 in the required form and manner as set forth in applicable regulations and any sub-regulatory guidance; and
- Annual submission of a Gag Clause Prohibition Compliance Attestation in the required form and manner as set forth in applicable regulations, if any, and sub-regulatory guidance.

No Waiver

Company's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision or impair Company's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below, except that Company or Group may change its address for notices by giving written notice to the other. Notices are deemed given when delivered in person, sent via email, or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Company to Group will be sent to:

Group Contact	Shannon Sarcia-Carlson
Group Name	Bmo Financial Corp.
Group Address	395 N Executive Dr
Group Address	
Group Address	Brookfield, WI 53005
Producer Contact	Beth Grellner
Producer Name	Willis Towers Watson US LLC (Los Angeles)
Producer Address	Lockbox 28852
Producer Address	
Producer Address	New York, NY 10087

Note: When Company sends Group a new (or renewed) group *agreement*, Company will enclose a summary that discusses the changes Company has made to this *Agreement*. Groups that want information about changes before receiving the new group *agreement* may request advance information from Group's Company account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Company may send the advance information to the third party rather than to Group (unless Group requests a copy also).

Notices from Group to Company regarding billing and enrollment must be sent to:

Kaiser Foundation Health Plan of the Northwest
P.O. Box 23127
San Diego, CA 92193
Or emailed to: **csc-den-roc-group@kp.org**

Notices from Group to Company regarding Premium payments must be sent to:

Kaiser Foundation Health Plan of the Northwest
PO Box 34178
Seattle, WA 98124

Notices from Group to Company regarding termination of this *Agreement* must be sent to the Group's account manager at:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Other Group Coverages that Cover Essential Health Benefits (EHBs)

Essential Health Benefits means benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. Essential Health Benefits must be equal to the scope of benefits provided under a typical employer plan, except that they must include at least the following: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

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

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

Premium Rebates

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

Reporting Membership Changes and Retroactivity

Company's billing statement to Group explains how to report membership changes. Group's Kaiser Permanente account manager can also provide Group with this information. Group must report membership changes (including sending Company-approved membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership changes is the calendar month when Company's San Diego Service Center receives Group's notification of the change plus the previous two months unless Company agrees otherwise in writing.

Representation Regarding Waiting Periods

Pursuant to section 2708 of the Public Health Service Act (PHSA) and 45 CFR 147.116(b), Group hereby represents that Group does not impose a waiting period exceeding 90 days on its employees who meet

Group's substantive eligibility requirements. (A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, including completion of Group's reasonable and bona fide employment-based orientation period that does not exceed one month, if any.)

In addition, Group represents that eligibility data provided by the Group to Company will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in 45 CFR 147.116.

Social Security and Tax Identification Numbers

Within 60 days after Company sends Group a written request, Group will send Company a list of all Members covered under this *Agreement,* along with the following:

- The Member's Social Security number.
- The tax identification number of the employer of the Subscriber in the Member's Family.
- Any other information that Company is required by law to collect.

Summaries of Benefits and Coverage

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

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Plan
Group Agreement

Group Name: Bmo Financial Corp.

Group Number: 3992-007-010

Term of *Agreement*

1/1/2025 through 12/31/2025

Anniversary date

January 1



Jeffrey A. Collins
President, Kaiser Foundation Health Plan
and Hospitals of the Northwest

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KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

This *Group Agreement* (*Agreement*), including the attached *Evidence of Coverage* (*EOC)* incorporated herein by reference, and any amendments, constitutes the contract between Kaiser Foundation Health Plan of the Northwest (Company) and **Bmo Financial Corp.** (Group). In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document for terms you should know.

To be eligible under this *Agreement*, the Group must meet the underwriting requirements set forth in Company's Rate Assumptions and Requirements document.

PREMIUM

Group will pay to Company, for each Subscriber and their Dependents, the Premium amount(s) specified for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date to which Company and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Premium Due Date").

When this *Agreement* terminates, if Group does not have another agreement with Company, then the due date for all Premium amounts will be the earlier of: (1) the last Premium Due Date, or (2) the termination date of this *Agreement*.

Monthly Premium Amounts

Group will pay Company the following Premium amount(s) each month for each Subscriber and their Dependents. Only Members for whom Company has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Company has received appropriate payment.

Subscriber only: $826.17

Subscriber and Spouse: $1817.54

Subscriber, Spouse, and child(ren): $3436.87

Subscriber and child(ren): $1611.03

Medicare as Secondary Payer

Members who are eligible and enrolled in Medicare Part A or B and for whom Medicare is secondary payer are subject to the same Premium amounts (shown above) and receive the same benefits as Members who are not eligible for Medicare. Members who are eligible and enrolled in Medicare Parts A and B as secondary payer and who meet applicable eligibility requirements may also enroll in a Kaiser Permanente Senior Advantage Plan. These Members receive the coverages described in both the non-Medicare Plan and the Senior Advantage Plan, and the Premium amounts for these Members are the Premium amounts for the non-Medicare Plan (shown above).

Medicare as Primary Payer

Premium amounts are based on the assumption that Company or its designee will receive Medicare payments for Medicare-covered Services provided to certain types of Members. For each Member to whom this "Medicare as Primary Payer" section applies, Group must pay the applicable Premium shown above in this

"Monthly Premium Amounts" section if the Member is for any reason not enrolled through Group in Kaiser Permanente Senior Advantage (including inability to enroll because they do not meet the Senior Advantage Plan's eligibility requirements or Group does not offer a Senior Advantage Plan).

Those Members eligible for Medicare based on disability, end stage renal disease (ESRD), domestic partner status, or who are Medicare eligible and enrolled in COBRA will be charged the Premium amount for the non-Medicare Plan (shown above).

Members to whom this "Medicare as Primary Payer" section applies. This "Medicare as Primary Payer" section applies to Members who meet all of the following requirements:

- They are age 65 or over.
- They are eligible for Medicare Parts A and B as primary payer (i.e., retirees).

TERM OF *AGREEMENT*, ACCEPTANCE OF *AGREEMENT*, AND RENEWAL

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective for the term shown on the cover page.

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement*, if Group pays Company any amount toward Premium.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Company account manager. Company might not respond to any changes or comments that Group may submit. Group may not construe Company's lack of response to any submitted changes or comments to imply acceptance. Company will issue a new *agreement* or amendment if Company and Group agree on any changes.

Renewal

This *Agreement* is guaranteed renewable but does not automatically renew. If Group complies with all of the terms of this *Agreement,* Company will offer to renew this *Agreement,* upon not less than 30 days prior written notice to Group, either by sending Group a new group *agreement* to become effective immediately after termination of this *Agreement,* or by extending the term of this *Agreement* pursuant to "Amendments Effective on Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended group *agreement* will include a new term of *agreement* and other changes. If Group does not renew this *Agreement*, Group must give Company written notice as described under "Termination on Notice" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

Upon not less than 30 days prior written notice to Group, Company may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on the anniversary date of any year (see cover page for anniversary date).

Amendment due to Tax or Other Charges

If during the term of this *Agreement* a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Company, Medical Group, or Kaiser Foundation Hospitals or upon any activity of any of them, then upon 31 days prior written notice, Company may increase Group's Premium to include Group's share of the new or increased tax or charge.

Other Amendments

Company may amend this *Agreement* at any time by giving written notice to Group, in order to: (a) address any law or regulatory requirement; (b) reduce or expand the Company Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed in this "Termination of *Agreement*" section. All rights to benefits under this *Agreement* end at 11:59 p.m. PT on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of *the EOC*.

If this *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination not later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

If Company fails to give notice as required, this *Agreement* shall continue in effect from the date notice should have been given until the date the Group receives the notice. Company will waive the Premium for the period for which coverage is continued and the time period within which Member may exercise any right to continuation shall commence on the date that Group receives the notice. Company will properly notify Members of their right to continuation of coverage under federal and state law.

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Company not less than 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement*, including Premium, for the period through the termination date.

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All amendments are deemed accepted by Group unless Group gives Company written notice of nonacceptance at least 15 days before the effective date of the amendment in which case this *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

When Group fails to pay Premium on or before the Premium Due Date, Group shall have a period of at least 31 days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Premium Due Date. If Group fails to pay all Premiums owed (including those owed for the Grace Period) on or before the last day of the Grace Period, then Company may, at its option and in lieu of any other remedy, terminate this Agreement without further extension or consideration.

Company will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least 10 days prior to the effective date of termination. Group shall continue to be liable for all Premiums due through the date of termination.

This Agreement will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums. If Company receives full payment of Premiums on or before the last day of the Grace Period, this Agreement will remain in effect according to its terms and conditions.

If Premiums are paid after the Grace Period ends, Company may charge interest on the overdue Premiums. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be 6 percent per year or the maximum amount permitted by applicable law, whichever is less.

Termination for Fraud

Company may terminate this *Agreement* by giving at least 30 days prior written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Company or is aware that incorrect or incomplete material information has been provided to Company on enrollment or other Company forms.

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Company may terminate this *Agreement* upon 31 days prior written notice to Group, if Group fails to comply with Company's contribution or participation requirements (including those listed in the "Contribution and Participation Requirements" section).

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Company may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Company to discontinue coverage upon finding that continuation of coverage (a) would not be in the best interests of the Members; or (b) would impair Company's ability to meet its contractual obligations.

Company may terminate this *Agreement* by providing not less than 90 days prior written notice if there are no Members covered under this *Agreement*.

Company may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Company must: (a) cease to offer and cease to renew this Plan for all groups within the service area; and (b) not less than 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue offering the Plan(s) and offer all other group Plans available in that service area.

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Except as preempted by federal law, this *Agreement* will be governed in accord with Oregon law and any provision that is required to be in this *Agreement* by state or federal law shall bind Group and Company regardless of whether that provision is set forth in this *Agreement*.

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Company agrees to undertake performance of the following regulatory requirements, and Group may rely on Company's performance in order to satisfy its obligation to perform the same activities with respect to the coverages issued to Group by Company:

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- Annual submission of a Gag Clause Prohibition Compliance Attestation in the required form and manner as set forth in applicable regulations, if any, and sub-regulatory guidance.

No Waiver

Company's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision or impair Company's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below, except that Company or Group may change its address for notices by giving written notice to the other. Notices are deemed given when delivered in person, sent via email, or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Company to Group will be sent to:

Group Contact	Shannon Sarcia-Carlson
Group Name	Bmo Financial Corp.
Group Address	395 N Executive Dr
Group Address	
Group Address	Brookfield, WI 53005
Producer Contact	Beth Grellner
Producer Name	Willis Towers Watson US LLC (Los Angeles)
Producer Address	Lockbox 28852
Producer Address	
Producer Address	New York, NY 10087

Note: When Company sends Group a new (or renewed) group *agreement*, Company will enclose a summary that discusses the changes Company has made to this *Agreement*. Groups that want information about changes before receiving the new group *agreement* may request advance information from Group's Company account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Company may send the advance information to the third party rather than to Group (unless Group requests a copy also).

Notices from Group to Company regarding billing and enrollment must be sent to:

Kaiser Foundation Health Plan of the Northwest
P.O. Box 23127
San Diego, CA 92193
Or emailed to: **csc-den-roc-group@kp.org**

Notices from Group to Company regarding Premium payments must be sent to:

Kaiser Foundation Health Plan of the Northwest
PO Box 34178
Seattle, WA 98124

Notices from Group to Company regarding termination of this *Agreement* must be sent to the Group's account manager at:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Other Group Coverages that Cover Essential Health Benefits (EHBs)

Essential Health Benefits means benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. Essential Health Benefits must be equal to the scope of benefits provided under a typical employer plan, except that they must include at least the following: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

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

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

Premium Rebates

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

Reporting Membership Changes and Retroactivity

Company's billing statement to Group explains how to report membership changes. Group's Kaiser Permanente account manager can also provide Group with this information. Group must report membership changes (including sending Company-approved membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership changes is the calendar month when Company's San Diego Service Center receives Group's notification of the change plus the previous two months unless Company agrees otherwise in writing.

Representation Regarding Waiting Periods

Pursuant to section 2708 of the Public Health Service Act (PHSA) and 45 CFR 147.116(b), Group hereby represents that Group does not impose a waiting period exceeding 90 days on its employees who meet

Group's substantive eligibility requirements. (A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, including completion of Group's reasonable and bona fide employment-based orientation period that does not exceed one month, if any.)

In addition, Group represents that eligibility data provided by the Group to Company will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in 45 CFR 147.116.

Social Security and Tax Identification Numbers

Within 60 days after Company sends Group a written request, Group will send Company a list of all Members covered under this *Agreement,* along with the following:

- The Member's Social Security number.
- The tax identification number of the employer of the Subscriber in the Member's Family.
- Any other information that Company is required by law to collect.

Summaries of Benefits and Coverage

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

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group
High Deductible Health Plan
Evidence of Coverage

Group Name: Bmo Financial Corp.

Group Number: 3992-004, 006-010

This *Evidence of Coverage* is effective 1/1/2025 through 12/31/2025.

Printed: Monday, January 13, 2025

Member Services

Monday through Friday (except holidays)
8 a.m. to 6 p.m. PT

All areas.....1-800-813-2000

TTY

All areas..... 711

Language interpretation services

All areas.....1-800-324-8010

kp.org

HIGH DEDUCTIBLE HEALTH PLAN BENEFIT SUMMARY

This "Benefit Summary," which is part of the *Evidence of Coverage (EOC)*, is a summary of answers to the most frequently asked questions about benefits. This summary does not fully describe benefits, limitations, or exclusions. To see complete explanations of what is covered for each benefit, including exclusions and limitations, and for additional benefits that are not included in this summary, please refer to the "Benefits," "Exclusions and Limitations," and "Reductions" sections of this *EOC*. For a list of defined terms, refer to the "Definitions" section of this *EOC*.

All Services except preventive care are subject to the Deductible.

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible	
Self-only Deductible per Year (for a Family of one Member)	$1,750
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$3,500
Family Deductible per Year (for an entire Family)	$3,500
Out-of-Pocket Maximum	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$3,425
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$6,850
Family Out-of-Pocket Maximum per Year (for an entire Family)	$6,850
(Note: All Deductible, Copayments, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise indicated in this *EOC*. The Deductible and Out-of-Pocket Maximum amounts are subject to increase if the U.S. Department of Treasury changes the minimum Deductible and Out-of-Pocket Maximum required in High Deductible Health Plans.)	
Preventive Care Services	**You Pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	**You Pay**
Primary care visit First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 after Deductible for first 3 visits; then 20% Coinsurance after Deductible for additional visits in the same Year
Specialty care visit	20% Coinsurance after Deductible
TMJ therapy visit	20% Coinsurance after Deductible
Routine eye exam (covered until the end of the month in which Member turns 19 years of age)	20% Coinsurance after Deductible
Routine eye exam for Members 19 years and older	20% Coinsurance after Deductible
Nurse treatment room visits to receive injections	20% Coinsurance after Deductible
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
Urgent Care visit	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible

Cochlear implant surgery visit	20% Coinsurance after Deductible
Vasectomy	$0 after Deductible
Interrupted pregnancy surgery	$0 after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Respiratory therapy visit	20% Coinsurance after Deductible
Cardiac rehabilitative therapy visit	20% Coinsurance after Deductible
Inpatient Hospital Services	**You Pay**
Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs	20% Coinsurance after Deductible
Vasectomy	$0 after Deductible
Interrupted pregnancy surgery	$0 after Deductible
Ambulance Services	**You Pay**
Per transport	20% Coinsurance after Deductible
Bariatric Surgery Services	**You Pay**
Inpatient hospital Services	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Behavioral Health Services	**You Pay**
Outpatient Services First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 after Deductible for first 3 visits; then 20% Coinsurance after Deductible for additional visits in the same Year
Intensive outpatient Services First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 after Deductible for first 3 days; then 20% Coinsurance after Deductible for additional days in the same Year
Partial hospitalization First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 after Deductible for first 3 days; then 20% Coinsurance after Deductible for additional days in the same Year
Assertive Community Treatment (ACT) Services	$0 after Deductible
Inpatient hospital Services	20% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible
Dialysis Services	**You Pay**
Outpatient dialysis visit	20% Coinsurance after Deductible
Home dialysis	$0 after Deductible
External Prosthetic Devices and Orthotic Devices	**You Pay**
External Prosthetic Devices	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Fertility Services	**You Pay**
Consultation and office visits for diagnostic Services	20% Coinsurance after Deductible
Diagnostic imaging and laboratory tests	20% Coinsurance after Deductible

Habilitative Services (Visit or day maximums do not apply to habilitative Services for treatment of Behavioral Health Conditions.)	**You Pay**
Outpatient physical, speech, and occupational therapies (up to 60 visits combined per Year)	20% Coinsurance after Deductible
Inpatient Services	20% Coinsurance after Deductible
Hearing Aids and Other Hearing Devices	**You Pay**
Hearing exams, testing, and visits for hearing loss Services	20% Coinsurance after Deductible
Hearing aids and assistive listening devices (for Members who are under the Dependent Limiting Age), limited to once per hearing impaired ear every 36 months.	20% Coinsurance after Deductible
Home Health Services	**You Pay**
Home health (up to 120 visits per Year)	20% Coinsurance after Deductible
Hospice Services	**You Pay**
Hospice Services (respite care limited to no more than five consecutive days in a 30-day period)	20% Coinsurance after Deductible
Limited Outpatient Prescription Drugs and Supplies	**You Pay**
Certain preventive medications (including, but not limited to, aspirin, fluoride, and liquid iron for infants)	$0
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	$0 after Deductible
Blood glucose test strips	Refer to your Outpatient Prescription Drug Rider
Contraceptive drugs or devices	$0
Insulin	Subject to the applicable drug tier Copayment or Coinsurance shown in your Outpatient Prescription Drug Rider, up to $35 for each 30-day supply
Post-surgical immunosuppressive drugs after covered transplant Services	Refer to your Outpatient Prescription Drug Rider
Self-administered chemotherapy medications used for the treatment of cancer	Refer to your Outpatient Prescription Drug Rider
Tobacco use cessation drugs	$0
Maternity and Newborn Care	**You Pay**
Scheduled prenatal care visits and postpartum visits	$0
Maternal diabetes management, including medication and supplies (Medically Necessary Services beginning with conception and ending through six weeks postpartum)	$0 after Deductible
Inpatient hospital Services	20% Coinsurance after Deductible
Newborn nurse home visiting Services	$0 after Deductible
Medical Foods and Formula	**You Pay**
Medical foods and formula	20% Coinsurance after Deductible
Naturopathic Medicine	**You Pay**
Evaluation and treatment First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 after Deductible for first 3 visits; then 20% Coinsurance after Deductible for additional visits in the same Year

Out-of-Area Coverage for Dependents	**You Pay**
Limited office visits, laboratory, diagnostic X-rays, and prescription drug fills as described in the *EOC* under "Out-of-Area Coverage for Dependents" in the "How to Obtain Services" section	after Deductible, 20% of the actual fee the provider, facility, or vendor charged for the Service
Outpatient Durable Medical Equipment (DME)	**You Pay**
Outpatient Durable Medical Equipment (DME)	20% Coinsurance after Deductible
Home ultraviolet light therapy equipment	$0 after Deductible
Peak flow meters, blood glucose monitors, and lancets	20% Coinsurance
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	**You Pay**
Laboratory	20% Coinsurance after Deductible
Genetic testing	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Diagnostic and supplemental breast imaging	$0 after Deductible
CT, MRI, PET scans	20% Coinsurance after Deductible
Reconstructive Surgery Services	**You Pay**
Inpatient hospital Services	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Rehabilitative Therapy Services (Visit or day maximums do not apply to rehabilitative therapy Services for treatment of Behavioral Health Conditions.)	**You Pay**
Outpatient physical, speech, and occupational therapies (up to 60 visits combined per Year)	20% Coinsurance after Deductible
Inpatient Services	20% Coinsurance after Deductible
Skilled Nursing Facility Services	**You Pay**
Inpatient skilled nursing Services (up to 60 days per Year)	20% Coinsurance after Deductible
Substance Use Disorder Services	**You Pay**
Outpatient Services First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 after Deductible for first 3 visits; then 20% Coinsurance after Deductible for additional visits in the same Year
Inpatient hospital Services	20% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible
Day treatment Services First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 after Deductible for first 3 days; then 20% Coinsurance after Deductible for additional days in the same Year
Telemedicine Services	**You Pay**
Telephone visits, video visits, and e-visits Telemedicine Services for primary care count toward the first 3 visits (or days) combined with in-person Services for primary care non-specialty Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$0 after Deductible
Transplant Services	**You Pay**
Inpatient hospital Services	20% Coinsurance after Deductible

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INTRODUCTION

This *Evidence of Coverage* (*EOC*), including the "Benefit Summary" and any benefit riders attached to this *EOC*, describes the health care benefits of this Large Group High Deductible Health Plan provided under the *Group Agreement* (*Agreement)* between Kaiser Foundation Health Plan of the Northwest and your Group. Members are entitled to covered Services only at Participating Facilities and from Participating Providers, except as noted in this *EOC*. For benefits provided under any other Plan, refer to that Plan's evidence of coverage.

This health benefit Plan is a high deductible health Plan that meets the requirements of Section 223 (c)(2) of the Internal Revenue Code. The health care coverage described in this *EOC* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

The tax references contained in this *EOC* relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state income tax laws may differ from the federal tax treatment and differ from state to state. Kaiser Foundation Health Plan of the Northwest does not provide tax advice. You should consult with your financial or tax advisor for tax advice or more information, including information about your eligibility for an HSA.

Please be aware that enrollment in a high deductible health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Some examples of other requirements include that you must not be:

- Covered by another health coverage Plan that is not also an HSA-compatible Plan, with certain exceptions.
- Enrolled in Medicare Part A or Part B.
- Able to be claimed as a dependent on another person's tax return.

The provider network for this High Deductible Health Plan is the Classic network.

The provisions of this *EOC* must be considered together to fully understand the benefits available under the *EOC*. In this *EOC*, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as "Company," "we," "our," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*. See the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* and the "Benefit Summary" completely, so that you can take full advantage of your Plan benefits. Also, if you have special health care needs, carefully read the sections applicable to you.

If you would like additional information about your benefits, important health plan disclosures, or other products and services, please call Member Services or e-mail us by registering at **kp.org/register**.

Term of This EOC

This *EOC* is effective for the period stated on the cover page, unless amended. Your Group's benefits administrator can tell you whether this *EOC* is still in effect.

DEFINITIONS

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

Allowed Amount. The lower of the following amounts:

- The actual fee the provider, facility, or vendor charged for the Service.
- 160 percent of the Medicare fee for the Service, as indicated by the applicable Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code shown on the current Medicare fee schedule. The Medicare fee schedule is developed by the Centers for Medicare and

Medicaid Services (CMS) and adjusted by Medicare geographical practice indexes. When there is no established CPT or HCPCS code indicating the Medicare fee for a particular Service, the Allowed Amount is 70 percent of the actual fee the provider, facility, or vendor charged for the Service.

Ancillary Service. Services that are:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner.
- Provided by assistant surgeons, hospitalists, and intensivists.
- Diagnostic Services, including radiology and laboratory Services.
- Provided by a Non-Participating Provider if there is no Participating Provider who can furnish such Service at the facility.
- Provided as a result of unforeseen, urgent medical needs that arise at the time the Service is provided, regardless of whether the Non-Participating Provider or Non-Participating Facility satisfies the notice and consent requirements under federal law.

Behavioral Health Assessment. Behavioral Health Assessment means an evaluation by a medical or behavioral health provider, in person or using telemedicine, to determine a patient's need for behavioral health treatment, including immediate crisis stabilization.

Behavioral Health Condition. Behavioral Health Condition means a disorder as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association.

Behavioral Health Crisis. Behavioral Health Crisis means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's behavioral or physical health.

Benefit Summary. A section of this *EOC* which provides a brief description of your medical Plan benefits and what you pay for covered Services.

Charges. Charges means the following:

- For Services provided by Medical Group and Kaiser Foundation Hospitals, the amount in Company's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members.
- For Services for which a provider or facility (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the amount in the schedule of charges that Company negotiates with the capitated provider.
- For Services received from other Participating Providers or Participating Facilities we contract with, the amount the provider or facility has agreed to accept as payment.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if the Member's benefit Plan did not cover the pharmacy item. This amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Company.
- For Emergency Services received from a Non-Participating Provider or Non-Participating Facility (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Company pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process.

- For all other Services received from a Non-Participating Provider or Non-Participating Facility (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Participating Provider and Company or, absent such an agreement, the Allowed Amount.

Coinsurance. The percentage of Charges that you must pay when you receive a covered Service.

Company. Kaiser Foundation Health Plan of the Northwest, an Oregon nonprofit corporation. This *EOC* sometimes refers to our Company as "we," "our," or "us."

Copayment. The defined dollar amount that you must pay when you receive a covered Service.

Cost Share. The Deductible, Copayment, or Coinsurance you must pay for covered Services.

Deductible. The amount you must pay for certain Services you receive in a Year before we will cover those Services, subject to any applicable Copayment or Coinsurance, in that Year.

Dependent. A Member who meets the eligibility requirements for a Dependent as described in the "Who Is Eligible" section.

Dependent Limiting Age. The "Premium, Eligibility, and Enrollment" section requires that most types of Dependents (other than Spouses and disabled Dependents as described in the "Dependents" section) be under the Dependent Limiting Age in order to be eligible for membership. The "Benefit Summary" shows the Dependent Limiting Age (the student Dependent Limiting Age is for students, and the general Dependent Limiting Age is for non-students).

Durable Medical Equipment (DME). A non-disposable supply or item of equipment that is able to withstand repeated use, primarily and customarily used to serve a medical purpose and generally not useful to you if you are not ill or injured.

Emergency Medical Condition. An Emergency Medical Condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
  - Placing the person's health (or, with respect to a pregnant person, the health of them or their unborn child) in serious jeopardy.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant person who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of them or the unborn child.
- That is a Behavioral Health Crisis.

Emergency Medical Service Provider. A person who has received formal training in prehospital and emergency care, and is licensed to attend any person who is ill or injured or who has a disability. Police officers, firefighters, funeral home employees and other persons serving in a dual capacity, one of which meets this definition, are considered Emergency Medical Services Providers.

Emergency Medical Services Transport. An Emergency Medical Service Provider's evaluation and stabilization of an individual experiencing an Emergency Medical Condition and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual.

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

- An Emergency Medical Services Transport.
- A medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act, "EMTALA"), or Behavioral Health Assessment, that is within the capability of the emergency department of a hospital, or of an Independent Freestanding Emergency Department, including Ancillary Services and patient observation routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Within the capabilities of the staff and facilities available at the hospital, or Independent Freestanding Emergency Department, the further examination and treatment required under EMTALA (or would be required under EMTALA if it applied to an Independent Freestanding Emergency Department) to Stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished.
- Post-Stabilization Care Services provided by a Non-Participating Provider or Non-Participating Facility are considered Emergency Services when federal law applies, and:
    - Your Non-Participating Provider determines that you are not able to travel using non-medical transportation or non-emergency medical transportation to an available Participating Provider within a reasonable travel distance, taking into account your medical or Behavioral Health Condition; or,
    - You or your authorized representative are not in a condition to provide consent to receiving Post-Stabilization Services or other covered Services from a Non-Participating Provider.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

***Evidence of Coverage* (*EOC*).** This *Evidence of Coverage* document provided to the Subscriber that specifies and describes benefits and conditions of coverage. This document, on its own, is not designed to meet the requirements of a summary plan description (SPD) under ERISA. After you enroll, you will receive a postcard that explains how you may either download an electronic copy of this *EOC* or request that this *EOC* be mailed to you.

External Prosthetic Devices. External prosthetic devices are rigid or semi-rigid external devices required to replace all or any part of a body organ or extremity.

Family. A Subscriber and all of their Dependents.

Gender Affirming Treatment. A Medically Necessary treatment, procedure, drug, device, product, or other Service that a health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth.

Group. The employer, union trust, or association with which we have an *Agreement* that includes this *EOC*.

Health Savings Account (HSA). A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified high deductible health Plan and meet other tax law requirements.

Company does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

Home Health Agency. A "home health agency" is an agency that: (i) meets any legal licensing required by the state or other locality in which it is located; (ii) qualifies as a participating home health agency under Medicare; and (iii) specializes in giving skilled nursing facility care Services and other therapeutic Services,

such as physical therapy, in the patient's home (or to a place of temporary or permanent residence used as your home).

Homemaker Services. Assistance in personal care, maintenance of a safe and healthy environment, and Services to enable the individual to carry out the plan of care.

Independent Freestanding Emergency Department. A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

Kaiser Permanente. Kaiser Foundation Hospitals (a California nonprofit corporation), Medical Group, and Kaiser Foundation Health Plan of the Northwest (Company).

Medical Facility Directory. The *Medical Facility Directory* includes addresses, maps, and telephone numbers for Participating Medical Offices and other Participating Facilities; and provides general information about getting care at Kaiser Permanente. After you enroll, you will receive an email or flyer that explains how you may either download an electronic copy of the *Medical Facility Directory* or request that the *Medical Facility Directory* be mailed to you.

Medical Group. Northwest Permanente, P.C., Physicians and Surgeons, a professional corporation of physicians organized under the laws of the state of Oregon. Medical Group contracts with Company to provide professional medical Services to Members and others primarily on a capitated, prepaid basis in Participating Facilities.

Medically Necessary. Our determination that the Service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and/or your provider; and, (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, "generally accepted standards of medical practice" means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the relevant clinical area or areas within Kaiser Permanente locally or nationally; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service is Medically Necessary. You may appeal our decision as set forth in the "Grievances, Claims, Appeals, and External Review" section. The fact that a Participating Provider has prescribed, recommended, or approved a Service does not, in itself, make such Service Medically Necessary and, therefore, a covered Service.

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

Member. A person who is eligible and enrolled under this *EOC,* and for whom we have received applicable Premium. This *EOC* sometimes refers to a Member as "you." The term Member may include the Subscriber, their Dependent, or other individual who is eligible for and has enrolled under this *EOC.*

Non-Participating Facility. Any of the following licensed institutions that provide Services, but which are not Participating Facilities: hospitals and other inpatient centers; ambulatory surgical or treatment centers; birthing centers; medical offices and clinics; skilled nursing facilities; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation settings. This includes any of these facilities that are owned and operated by a political subdivision or instrumentality of the state and other facilities as required by federal law and implementing regulations.

Non-Participating Provider. A physician or other health care provider, facility, business, or vendor regulated under state law to provide health or health-related services or otherwise providing health care services within the scope of licensure or certification consistent with state law that does not have a written agreement with Kaiser Permanente to participate as a health care provider for this Plan.

Orthotic Devices. Orthotic devices are rigid or semi-rigid external devices (other than casts) required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

Out-of-Pocket Maximum. The total amount of Deductible, Copayments, and Coinsurance you will be responsible to pay in a Year, as described in the "Out-of-Pocket Maximum" section of this *EOC*.

Participating Facility. Any facility listed as a Participating Facility in the *Medical Facility Directory*. Participating Facilities are subject to change.

Participating Hospital. Any hospital listed as a Participating Hospital in the *Medical Facility Directory*. Participating Hospitals are subject to change.

Participating Medical Office. Any outpatient treatment facility listed as a Participating Medical Office in the *Medical Facility Directory*. Participating Medical Offices are subject to change.

Participating Pharmacy. A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate, that is listed as a Participating Pharmacy in the *Medical Facility Directory*. Participating Pharmacies are subject to change.

Participating Physician. Any licensed physician who is an employee of the Medical Group, or contracts directly or indirectly with Medical Group. Participating Physicians are subject to change.

Participating Provider. Any person who is a Participating Physician; or a physician or other health care provider, facility, business, or vendor regulated under state law to provide health or health-related services or otherwise providing health care services within the scope of licensure or certification consistent with state law and which contracts directly or indirectly with Kaiser Permanente to provide Services to Members enrolled in this Plan. Participating Providers are subject to change.

Participating Skilled Nursing Facility. A facility that provides inpatient skilled nursing Services, rehabilitation Services, or other related health Services and is licensed by the state of Oregon or Washington and approved by Company. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Participating Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living. A "Participating Skilled Nursing Facility" may also be a unit or section within another facility (for example, a Participating Hospital) as long as it continues to meet the definition above. Participating Skilled Nursing Facilities are subject to change.

Plan. Any hospital expense, medical expense, or hospital and/or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Post-Stabilization Care. The Services you receive after your treating physician determines that your Emergency Medical Condition is clinically stable.

Premium. Monthly membership charges paid by Group.

Primary Care Provider. An individual, clinic, or team of health care providers licensed or certified in Oregon to provide outpatient, nonspecialty medical services or to provide the coordination of health care for the purpose of:

- Promoting or maintaining mental and physical health and wellness; and
- Diagnosing, treating, or managing acute or chronic conditions caused by disease, injury, or illness.

Service Area. Our Service Area consists of certain geographic areas in the Northwest which we designate by ZIP code. Our Service Area may change. Contact Member Services for a complete listing of our Service Area ZIP codes.

Services. Health care services, supplies, or items.

Specialist. Any licensed Participating Provider who practices in a specialty care area of medicine (not family medicine, pediatrics, gynecology, obstetrics, general practice, or internal medicine). In most cases, you will need a referral in order to receive covered Services from a Specialist.

Spouse. The person to whom you are legally married under applicable law. For the purposes of this *EOC,* the term "Spouse" includes a person who is legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.

Stabilize. With respect to an Emergency Medical Condition, to provide the medical treatment of the 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 person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of them or their unborn child), "Stabilize" means to deliver the infant (including the placenta).

Subscriber. A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber.

Substance Use Disorder. A substance-related or addictive disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

Urgent Care. Treatment for an unforeseen condition that requires prompt medical attention to keep it from becoming more serious, but that is not an Emergency Medical Condition.

Utilization Review. The formal application of clinical criteria and clinical guidance, screening procedures, decision rules, and medical protocols designed to ensure that each Member is receiving Services at the appropriate level. Utilization Review is used to monitor or evaluate:

- Medical necessity, appropriateness, effectiveness, or efficiency of a specific Service, procedure, or setting.
- Appropriateness of a Service for which prior authorization is requested or for which an exception to step therapy has been requested.
- Any other coverage that we indicate is subject to Utilization Review.

When Utilization Review is required to approve certain Services in advance, this is called prior authorization. Utilization Review to approve an ongoing course of treatment to be provided over a period of time or number of treatments is called concurrent review.

Year. A period of time that is either a) a calendar year beginning on January 1 of any year and ending at midnight December 31 of the same year, or b) a plan year beginning on an effective date and ending at midnight prior to the anniversary date agreed to by Company and Group. The "Benefit Summary" shows which period is applicable to this Plan.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

Your Group is responsible for paying the Premium. If you are responsible for any contribution to the Premium, your Group will tell you the amount and how to pay your Group.

Who Is Eligible

General

To be eligible to enroll and to remain enrolled under this employer's *Agreement*, you must meet all of the following requirements:

- You must meet your Group's eligibility requirements that we have approved. (Your Group is required to inform Subscribers of its eligibility requirements.)
- You must meet the Subscriber or Dependent eligibility requirements described below unless your Group has different eligibility requirements that we have approved.

Subscribers

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

- You are an employee of your Group; or
- You are otherwise entitled to coverage through your Group under a trust agreement, retirement benefit program, employment contract, or the rules of a professional, trade, or bona fide association.
- You live or physically work inside our Service Area at least 50 percent of the time. For assistance about the Service Area or eligibility, please contact Member Services. The Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible solely because they live outside our Service Area or in another Kaiser Foundation Health Plan service area.

Dependents

If you are a Subscriber (or if you are a subscriber under our Kaiser Permanente Senior Advantage (HMO) plan offered by your Group), the following persons are eligible to enroll as your Dependents under this *EOC*. (Note: if you are a subscriber under a Kaiser Permanente Senior Advantage plan offered by your Group, all of your Dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to be entitled to Medicare.)

- Your Spouse.
- A person who is under the general Dependent Limiting Age shown in the "Benefit Summary" and who is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.
  - A child placed with you or your Spouse for foster care.
- A person who is over the general Dependent Limiting Age but under the student Dependent Limiting Age shown in the "Benefit Summary," who is a full-time registered student at an accredited college or accredited vocational school, and is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.

Students who suffer a severe illness or injury that causes them to lose full-time student status will continue to be considered full-time students for eligibility purposes, provided that within 31 days after the loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is Medically Necessary. Eligibility as a full-time student under this provision may then continue for up to 12 months from the date that your child's medical leave of absence began, or until your child reaches the student Dependent Limiting Age shown in the "Benefit Summary," whichever comes first.

- A person of any age who is primarily dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of a developmental disability, mental illness, or a physical disability that occurred prior to the person reaching the general Dependent Limiting Age shown in the "Benefit Summary," if the person is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the Dependent Limiting Age shown in the "Benefit Summary."

  We may request proof of incapacity and dependency annually.

Children born to a Dependent other than your Spouse (for example, your grandchildren) are not eligible for coverage beyond the first 31 days of life, including the date of birth, unless: (a) you or your Spouse adopts them or assumes a legal obligation in anticipation of adoption; (b) they are primarily supported by you or your Spouse and you or your Spouse is their court-appointed guardian; or, (c) your Group has different eligibility requirements that we have approved.

Company will not deny enrollment of a newborn child, newly adopted child, child for whom legal obligation is assumed in anticipation of adoption, child newly placed for adoption, or newly placed foster child solely on the basis that: (a) the child was born out of wedlock; (b) the child is not claimed as a dependent on the parent's federal tax return; (c) the child does not reside with the child's parent or in our Service Area; or (d) the mother of the child used drugs containing diethylstilbestrol prior to the child's birth. Also, Company does not discriminate between married and unmarried persons, or between children of married or unmarried persons.

When You Can Enroll and When Coverage Begins

A Group is required to inform employees about when they are eligible to enroll and their effective date of coverage. The effective date of coverage for employees and their eligible Dependents is determined by the Group in accord with waiting period requirements in state and federal law. The Group is required to inform the Subscriber of the date membership becomes effective.

If an individual is eligible to be a Dependent under this *EOC* but the subscriber in their family is enrolled under our Kaiser Permanente Senior Advantage evidence of coverage offered by the Group, the subscriber must follow the rules for adding Dependents as described in this "When You Can Enroll and When Coverage Begins" section.

New Employees and Their Dependents

When a Group informs an employee that they are eligible to enroll as a Subscriber, they may enroll themselves and any eligible Dependents by submitting a Company-approved enrollment application to the Group within 30 days of eligibility for enrollment.

Open Enrollment

The Group will inform an employee of their open enrollment period and effective date of coverage. An eligible employee may enroll as a Subscriber along with any eligible Dependents if they or their Dependents were not previously enrolled. If you are an existing Subscriber, you may add eligible Dependents not previously enrolled following your Group's enrollment process during the open enrollment period.

Special Enrollment

If an eligible employee or their eligible Dependents do not enroll when they are first eligible, and later want to enroll, they can enroll only during open enrollment unless they experience a qualifying event as defined in applicable state and federal law. Your Group will administer special enrollment rights under applicable state and federal law.

Examples of qualifying events include, but are not limited to:

- Loss of minimum essential coverage for any reason other than nonpayment of Premium, rescission of coverage, misrepresentation, fraud or voluntary termination of coverage.
- Gaining a Dependent through marriage or entering into a domestic partnership, birth, adoption, placement for adoption, placement for foster care, or through a child support order or other court order.
- Loss of a Dependent through divorce or legal separation, or if the enrollee, or their Dependent dies.

Note: If the individual is enrolling as a Subscriber along with at least one eligible Dependent, only one enrollee must meet one of the requirements for a qualifying event.

The individual must notify the Group within 30 days of a qualifying event, 60 days if they are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. The Group will determine if the individual is eligible to select or change coverage. Contact the Group for further instructions on how to enroll.

A Group may require an employee declining coverage to provide a written statement indicating whether the coverage is being declined due to other health coverage. If this statement is not provided, or if coverage is not declined due to other health coverage, the employee may not be eligible for special enrollment due to loss of other health coverage. Contact the Group for further information.

Adding New Dependents to an Existing Account

To enroll a Dependent who becomes eligible to enroll after you became a Subscriber, you must submit a Company-approved enrollment application to your Group as described in this "Adding New Dependents to an Existing Account" section.

Newborns, newly adopted children, children newly placed for adoption, or newly placed foster children are covered for 31 days after birth, adoption, placement for adoption, or placement for foster care. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 31 days after the date of birth, adoption, placement for adoption, or placement for foster care if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify your Group and Member Services, to add the child to your Plan.

To add all other newly eligible Dependents (such as a new Spouse), you must submit an enrollment application to your Group within 30 days after the qualifying event.

Contact your Group for further instructions on how to enroll your newly eligible Dependent.

When Coverage Begins

Your Group will notify you of the date your coverage will begin. Membership begins at 12 a.m. PT of the effective date specified.

If an individual enrolls in, adds a Dependent, or changes health plan coverage during a special enrollment period, the membership effective date will be determined by your Group under applicable state and federal law.

HOW TO OBTAIN SERVICES

The provider network for this High Deductible Health Plan is the Classic network.

The Classic network includes Participating Providers who are either employed by us or contract directly or indirectly with us to provide covered Services for Members enrolled in this High Deductible Health Plan. You pay the Cost Share amount shown on your "Benefit Summary" when you receive covered Services from Participating Providers and Participating Facilities.

To receive covered benefits, you must obtain Services from Participating Providers and Participating Facilities except as described under the following sections in this *EOC*:

- "Referrals to Non-Participating Providers and Non-Participating Facilities."
- "Emergency, Post-Stabilization, and Urgent Care."
- "Receiving Care in Another Kaiser Foundation Health Plan Service Area."
- "Out-of-Area Coverage for Dependents."
- "Ambulance Services."

To locate a Participating Provider or Participating Facility, contact Member Services or visit **kp.org/doctors** to see all Kaiser Permanente locations near you, search for Participating Providers, and read online provider profiles.

We will not directly or indirectly prohibit you from freely contracting at any time to obtain health care Services from Non-Participating Providers and Non-Participating Facilities outside the Plan. However, if you choose to receive Services from Non-Participating Providers and Non-Participating Facilities except as otherwise specifically provided in this *EOC*, those Services will not be covered under this *EOC* and you will be responsible for the full price of the Services. Any amounts you pay for non-covered Services will not count toward your Deductible (if any) or Out-of-Pocket Maximum.

Using Your Identification Card

We provide each Member with a Company identification (ID) card that contains the Member health record number. Have your health record number available when you call for advice, make an appointment, or seek Services. We use your health record number to identify your medical records, for billing purposes and for membership information. You should always have the same health record number. If we ever inadvertently issue you more than one health record number, please let us know by calling Member Services. If you need to replace your ID card, please call Member Services.

Your ID card is for identification only, and it does not entitle you to Services. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-member for any Services they receive. If you allow someone else to use your ID card, we may keep your card and terminate your membership (see the "Termination for Cause" section). We may request photo identification in conjunction with your ID card to verify your identity.

Advice Nurses

If you are unsure whether you need to be seen by a physician or where to go for Services, or if you would like to discuss a medical concern, call Member Services during normal business hours, evenings, weekends, and holidays to be directed to one of our advice nurses.

You may also use the Member section of our website, **kp.org**, to send *nonurgent* questions to an advice nurse or pharmacist.

Your Primary Care Provider

We encourage you to choose a Primary Care Provider for each covered Family Member. This decision is important as your Primary Care Provider provides or arranges most of your health care needs.

You may select a Participating Provider from family practice, internal medicine, or pediatrics as your Primary Care Provider. Members also have the option of choosing a women's health care Participating Provider as their Primary Care Provider. A women's health care provider is an obstetrician or gynecologist, a physician associate specializing in women's health, an advanced registered nurse practitioner specializing in women's health, a naturopathic physician specializing in women's health, or a certified nurse midwife. Not all Participating Providers in these specialties are designated Primary Care Providers.

If you do not select a Primary Care Provider within 90 days, we will assign you to an individual Primary Care Provider or primary care team. We will send you a letter that includes information to help you learn more about your provider or care team, how to find information about other Primary Care Providers near you, and how to change your Primary Care Provider. You may select a different Primary Care Provider at any time. The change will take effect immediately.

For more information, visit **kp.org/doctors** to search for Participating Providers and Kaiser Permanente locations near you and read online provider profiles. For help with selecting or changing your Primary Care Provider, contact Member Services.

Appointments for Routine Services

Routine appointments are for medical needs that are not urgent such as checkups and follow-up visits that can wait more than a few days.

If you need to make a routine care appointment, go to **kp.org** to schedule an appointment online or call Member Services. Try to make your routine care appointments as far in advance as possible. For information about getting other types of care, refer to the "Emergency, Post-Stabilization, and Urgent Care" section.

Healthy Resources

You have access to these value-added programs and resources at no cost, unless otherwise noted below. You can register online at **kp.org/register** or on the Kaiser Permanente mobile app. You'll need your health/medical record number, which you can find on your Kaiser Permanente ID card.

- **Sign up for healthy lifestyle programs.** With our online wellness programs, you'll get advice, encouragement, and tools to help you create positive changes in your life. Our programs can help you lose weight, eat healthier, quit smoking, reduce stress, manage ongoing conditions like diabetes or depression. Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. You can also share and discuss the results with your doctor. Visit **kp.org/healthylifestyles**.
- **Get a wellness coach.** If you need a little extra support, we offer Wellness Coaching by Phone. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals. Visit **kp.org/wellnesscoach**.
- **Join health classes.** You can sign up for health classes and support groups. Classes vary at each location and some may require a fee. Visit **kp.org/classes**.
- **Enjoy reduced rates.** Get reduced rates on a variety of health-related products and services through The ChooseHealthy® program. These include:
    - Active&Fit Direct – You pay $25 per month (plus a one-time $25 enrollment fee) for access to a national network of more than 10,000 fitness centers.

- Up to 25% off a contracted provider's regular rates for acupuncture, chiropractic care, and massage therapy.*

Visit **kp.org/choosehealthy**. *Please note that the ChooseHealthy program is not insurance. You should check your benefits before using this discount program, as those benefits may result in lower costs to you than using this discount program.

- **Self-care.** Manage stress, improve your mood, sleep better, and more with the help of wellness apps, available to adult members. Visit **kp.org/selfcareapps**.
- **Health guides.** Stay informed on popular health subjects or discover something new through our healthy living guides. Visit **kp.org/livehealthy**.

The programs and resources described above are not covered under your health plan benefits and are not subject to the terms set forth in this *EOC* or other plan documents. Programs and resources are provided by third-party entities and may be discontinued at any time. If you would like additional information about these programs and resources, call Member Services.

Getting Assistance

We want you to be satisfied with your health care Services. If you have any questions or concerns about Services you received from Participating Providers or Participating Facilities, please discuss them with your Primary Care Provider or with other Participating Providers who are treating you.

Member Services representatives can answer questions you have about your benefits, available Services, and the facilities where you can receive Services. For example, they can explain your benefits, how to make your first medical appointment, what to do if you move, what to do if you need Services while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim, complaint, grievance, or appeal, as described in the "Grievances, Claims, Appeals, and External Review" section. Upon request Member Services can also provide you with written materials about your coverage.

Member Services representatives are available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m. PT.

All areas 1-800-813-2000

TTY for the hearing and speech impaired 711

Language interpretation services..... 1-800-324-8010

You may also e-mail us by registering on our website at **kp.org/register**.

Referrals

Referrals to Participating Providers and Participating Facilities

Primary Care Providers provide primary medical care, including pediatric care and obstetrics/gynecology care. Specialists provide specialty medical care in areas such as surgery, orthopedics, cardiology, oncology, urology, dermatology, and allergy/immunology. Your Primary Care Provider will refer you to a Specialist when appropriate. In most cases, you will need a referral to see a Specialist the first time. Please call Member Services for information about specialty Services that require a referral or discuss your concerns with your Primary Care Provider. In some cases, a standing referral may be allowed to a Specialist for a time period that is in accord with your individual medical needs as determined by the Participating Provider and Company.

Some outpatient specialty care is available in Participating Medical Offices without a referral. You do not need a referral for outpatient Services provided in the following departments at Participating Medical Offices

owned and operated by Kaiser Permanente. Please call Member Services to schedule routine appointments in these departments:

- Audiology (routine hearing exams).
- Cancer Counseling.
- Behavioral Health Services.
- Obstetrics/Gynecology.
- Occupational Health.
- Optometry (eye exams).
- Social Services.
- Substance Use Disorder Services.

Referrals to Non-Participating Providers and Non-Participating Facilities

If your Participating Provider decides that you require Services not available from Participating Providers or Participating Facilities, they will recommend to Medical Group and Company that you be referred to a Non-Participating Provider or Non-Participating Facility. If the Medical Group's assigned Participating Provider determines that the Services are Medically Necessary and are not available from a Participating Provider or Participating Facility and Company determines that the Services are covered Services, Company will authorize your referral to a Non-Participating Provider or Non-Participating Facility for the covered Services. You pay the same Cost Share for authorized referral Services that you would pay if you received the Services from a Participating Provider or at a Participating Facility. You will need written authorization in advance in order for the Services to be covered. If Company authorizes the Services, you will receive a written "Authorization for Outside Medical Care" approved referral to the Non-Participating Provider or Non-Participating Facility, and only the Services and number of visits that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these Services.

Prior Authorization Review Requirements

When you need Services, you should talk with your Participating Provider about your medical needs or your request for Services. Your Participating Provider provides covered Services that are Medically Necessary. Participating Providers will use their judgment to determine if Services are Medically Necessary. Some Services are subject to approval through Utilization Review, based on Utilization Review criteria developed by Medical Group or another organization utilized by the Medical Group and approved by Company. If you seek a specific Service, you should talk with your Participating Provider. Your Participating Provider will discuss your needs and recommend an appropriate course of treatment.

If you request Services that must be approved through Utilization Review and the Participating Provider believes they are Medically Necessary, the Participating Provider may submit the request for Utilization Review on your behalf.

If the request is denied, we will notify you and the requesting Participating Provider of the decision within two business days of the request. The decision letter will explain the reason for the determination along with instructions for filing an appeal.

If more information is needed to make a decision, we will notify you and the requesting Participating Provider in writing, of the specific additional information needed to make the determination, before the initial decision period ends.

We will make a decision and send notification within two business days after we receive the first piece of information (including documents) we requested.

If we do not receive any of the requested information, we will make a decision based on the information we have, 15 days after the date of the request for additional information.

Approved requests for prior authorization of a treatment, other than a prescription drug, are binding on us for a period ending on the later of the following:

- The reasonable duration of the treatment based on clinical standards; or
- Sixty (60) days after the date that the treatment begins following our approval of the prior authorization request.

You may request a copy of the complete Utilization Review criteria used to make the determination by calling Member Services.

If you disagree with the prior authorization review decision made by Company, you may appeal the decision, by following the course of grievances and appeals as outlined in the "Grievances, Claims, Appeals and External Review" section.

Your Participating Provider will request prior authorization when necessary. The following are examples of Services that require prior authorization:

- Bariatric surgery Services.
- Breast reduction surgery.
- Dental and orthodontic Services for the treatment of craniofacial anomalies.
- Drug formulary exceptions.
- Durable Medical Equipment.
- External Prosthetic Devices and Orthotic Devices.
- Gender Affirming Treatment.
- General anesthesia and associated hospital or ambulatory surgical facility Services provided in conjunction with non-covered dental Services.
- Habilitative Services.
- Hospice and home health Services.
- Inpatient hospital Services.
- Inpatient and residential Substance Use Disorder Services.
- Inpatient, residential, and Assertive Community Treatment (ACT) behavioral health Services.
- Non-emergency medical transportation.
- Open MRI.
- Plastic surgery.
- Referrals for any Non-Participating Facility Services or Non-Participating Provider Services.
- Referrals to Specialists who are not employees of Medical Group.
- Rehabilitative therapy Services.
- Routine foot Services.
- Skilled nursing facility Services.
- Transplant Services.
- Travel and lodging expenses.

For more information about Utilization Review, a copy of the complete Utilization Review criteria developed by Medical Group and approved by Company for a specific condition, or to talk to a Utilization Review staff person, please contact Member Services.

If you ask for Services that the Participating Provider believes are not Medically Necessary and does not submit a request on your behalf, you may ask for a second opinion from another Participating Provider. You should contact the manager in the area where the Participating Provider is located. Member Services can connect you with the correct manager, who will listen to your issues and discuss your options.

You may also choose to submit a request for Services that you have not yet received, as described under "Pre-service Claims and Appeals" in the "Grievances, Claims, Appeals, and External Review" section.

Except in the case of misrepresentation, prior authorization determinations that relate to your membership eligibility are binding on us if obtained no more than five business days before you receive the Service. Prior authorization determinations that relate to whether the Service is Medically Necessary or are covered under the Plan are binding on us if obtained no more than 60 days before you receive the Service. We may revoke or amend an authorization for Services you have not yet received if your membership terminates or your coverage changes or you lose your eligibility.

Participating Providers and Participating Facilities Contracts

Participating Providers and Participating Facilities may be paid in various ways, including salary, per diem rates, case rates, fee-for-service, incentive payments, and capitation payments. Capitation payments are based on a total number of Members (on a per-Member per-month basis), regardless of the amount of Services provided. Company may directly or indirectly make capitation payments to Participating Providers and Participating Facilities only for the professional Services they deliver, and not for Services provided by other physicians, hospitals, or facilities. Call Member Services if you would like to learn more about the ways Participating Providers and Participating Facilities are paid to provide or arrange medical and hospital Services for Members.

Our contracts with Participating Providers and Participating Facilities provide that you are not liable for any amounts we owe. You will be liable for the cost of non-covered Services that you receive from any providers or facilities, including Participating Providers and/or Participating Facilities.

Provider Whose Contract Terminates

You may be eligible to continue receiving covered Services from a Participating Provider for a limited period of time after our contract with the Participating Provider terminates.

This continuity of care provision applies when our contract with a Participating Provider terminates, or when a physician's employment with Medical Group terminates, except when the termination is because of quality of care issues or because the Participating Provider:

- Has retired.
- Has died.
- No longer holds an active license.
- Has moved outside our Service Area.
- Has gone on sabbatical.
- Is prevented from continuing to care for patients because of other circumstances.

If you satisfy all of the following requirements, you may qualify for this continuity of care:

- You are a Member on the date you receive the Services.

- You are undergoing an active course of treatment that is Medically Necessary and you and the Participating Provider agree that it is desirable to maintain continuity of care.
- We would have covered the Services if you had received them from a Participating Provider.
- The provider agrees to adhere to the conditions of the terminated contract between the provider and Company or its designee.

Except for the pregnancy situation described below, this extension will continue until the earlier of the following:

- The day following the completion of the active course of treatment giving rise to your exercising your continuity of care right; or
- The 120th day from the date we notify you about the contract termination.

If you are in the second trimester of pregnancy this extension will continue until the later of the following dates:

- The 45th day after the birth; or
- As long as you continue under an active course of treatment, but no later than the 120th day from the date we notify you about the contract termination.

Receiving Care in Another Kaiser Foundation Health Plan Service Area

You may receive covered Services from another Kaiser Foundation Health Plan, if the Services are provided, prescribed, or directed by that other plan, and if the Services would have been covered under this *EOC*. Covered Services are subject to the terms and conditions of this *EOC*, including prior authorization requirements, the applicable Cost Share shown in the "Benefit Summary," and the exclusions, limitations and reductions described in this *EOC*.

For more information about receiving care in other Kaiser Foundation Health Plan service areas, including availability of Services, and provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at **kp.org/travel**.

Out-of-Area Coverage for Dependents

This limited out-of-area benefit is available to Dependent children who are under the Dependent Limiting Age as shown in the "Benefit Summary" and who are outside any Kaiser Foundation Health Plan service area.

We cover certain Medically Necessary Services that a Dependent child receives from Non-Participating Providers inside the United States (which for the purpose of this benefit means the 50 states, the District of Columbia, and United States territories). These out-of-area benefits are limited to the following Services as otherwise covered under this *EOC*. Any other Services not specifically listed as covered are excluded under this out-of-area benefit.

- Office visits are limited to preventive care, primary care, specialty care, outpatient physical therapy visits, outpatient behavioral health and Substance Use Disorder Services, naturopathic medicine Services, and allergy injections – limited to ten visits combined per Year.
- Laboratory and diagnostic X-rays – limited to ten visits per Year. This benefit does not include special diagnostic procedures such as CT, MRI, or PET scans.
- Prescription drug fills – limited to ten fills per Year.

You pay the Cost Share as shown in the "Benefit Summary" under the "Out-of-Area Coverage for Dependents" section.

This out-of-area benefit cannot be combined with any other benefit, so we will not pay under this "Out-of-Area Coverage for Dependents" section for a Service we are covering under another section of this *EOC*, such as:

- "Receiving Care in Another Kaiser Foundation Health Plan Service Area."
- Services covered in the "Emergency, Post-Stabilization, and Urgent Care" section and under "Your Primary Care Provider" in the "How to Obtain Services" section.
- "Transplant Services."

POST-SERVICE CLAIMS – SERVICES ALREADY RECEIVED

In general, if you have a medical or pharmacy bill from a Non-Participating Provider, Non-Participating Facility, or non-participating pharmacy, our Claims Administration Department will handle the claim. Member Services can assist you with questions about specific claims or about the claim procedures in general.

If you receive Services from a Non-Participating Provider following an authorized referral from a Participating Provider, the Non-Participating Provider will send the bill to Claims Administration directly. You are not required to file a claim.

If you receive Services from a Non-Participating Provider or Non-Participating Facility without an authorized referral, or from a pharmacy that is not a Participating Pharmacy, and you believe Company should cover the Services, you need to send a completed medical claim form and the itemized bill to:

Kaiser Permanente
National Claims Administration - Northwest
PO Box 370050
Denver, CO 80237-9998

You can request a claim form from Member Services or download it from **kp.org**. When you submit the claim, please include a copy of your medical records from the Non-Participating Provider or Non-Participating Facility if you have them.

Company accepts CMS 1500 claim forms for professional Services and UB-04 forms for hospital claims. Even if the provider bills Company directly, you still need to submit the claim form.

You must submit a claim for a Service within 12 months after receiving that Service. If it is not reasonably possible to submit a claim within 12 months, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

We will reach a decision on the claim and pay those covered Charges within 30 calendar days from receipt unless additional information, not related to coordination of benefits, is required to make a decision. If the 30-day period must be extended, you will be notified in writing with an explanation about why. This written notice will explain how long the time period may be extended depending on the requirements of applicable state and federal laws, including ERISA.

You will receive written notification about the claim determination. This notification will provide an explanation for any unpaid amounts. It will also tell you how to appeal the determination if you are not satisfied with the outcome, along with other important disclosures required by state and federal laws.

If you have questions or concerns about a bill from Company, you may contact Member Services for an explanation. If you believe the Charges are not appropriate, Member Services will advise you on how to proceed.

EMERGENCY, POST-STABILIZATION, AND URGENT CARE

Emergency Services

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

You pay the emergency department visit Cost Share shown in the "Benefit Summary" under "Outpatient Services" for all Services received in the emergency department.

If you receive covered inpatient hospital Services, you pay the Cost Share shown in the "Benefit Summary" under "Inpatient Hospital Services," regardless of whether the Services also constitute Emergency Services or Post-Stabilization Care. If you visit an emergency department and are not admitted directly as an inpatient, you pay the emergency department visit Cost Share shown in the "Benefit Summary" under "Outpatient Services" for all Services received in the emergency department.

If you have an Emergency Medical Condition, we cover the Services of an Emergency Medical Service (EMS) Provider and transportation to the nearest medical facility that meets your needs. Emergency transportation may be by air, ground, or water.

Emergency Services are available from Participating Hospital emergency departments 24 hours a day, seven days a week. Contact Member Services or see our *Medical Facility Directory* for locations of these emergency departments.

Post-Stabilization Care

We cover Post-Stabilization Care if one of the following is true:

- A Participating Provider or Participating Facility provides the Services.
- We authorize the Services from the Non-Participating Provider or Non-Participating Facility.
- Services are provided after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and Stabilization Services have been furnished.

Coverage for Post-Stabilization Care from a Non-Participating Provider or Non-Participating Facility is limited to the Allowed Amount. In addition to the applicable Cost Share, you are responsible for paying any amount over the Allowed Amount, and any such payments do not count toward the Deductible or the Out-of-Pocket Maximum. You are not responsible for paying any amount over the Allowed Amount for Post-Stabilization Care from a Non-Participating Provider at a Participating Facility.

To request prior authorization for your receiving Post-Stabilization Care from a Non-Participating Provider or Non-Participating Facility, you or someone on your behalf must call us at 503-735-2596, or toll-free at 1-877-813-5993, before you receive the Services if it is reasonably possible to do so, but no later than 24 hours after any admission.

We understand that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or if there is no parent or guardian with a young child. In these cases, you or someone on your behalf must call us as soon as reasonably possible. If you (or someone on your behalf) do not call us by the applicable deadline, we will not cover Post-Stabilization Care that you receive from a Non-Participating Provider or Non-Participating Facility.

After we are notified, we will discuss your condition with the Non-Participating Provider. If we decide that the Post-Stabilization Care is Medically Necessary and would be covered if you received it from a Participating Provider or Participating Facility, we will either authorize the Services from the Non-Participating Provider or Non-Participating Facility, or arrange to have a Participating Provider or Participating Facility provide the Services.

If we decide to arrange to have a Participating Provider or Participating Facility (or other designated provider or facility) provide the Services to you, we may authorize special transportation Services that are medically required to get you to the provider or facility. This may include transportation that is otherwise not covered.

When you receive Emergency Services from Non-Participating Providers, Post Stabilization Care may qualify as Emergency Services pursuant to federal law. We will not require prior authorization for such Post-Stabilization Care when your attending Non-Participating Provider determines that, after you are Stabilized, and taking into account your medical or Behavioral Health Condition, you are not able to travel to an available Participating Provider located within a reasonable travel distance, using non-medical transportation or non-emergency transportation.

Non-Participating Providers may provide notice and seek your consent to provide Post-Stabilization Care Services or other covered Services. Such Services will not be covered if you provide consent and do not obtain prior authorization as described in this section. You will be responsible for paying for the Services.

Urgent Care

Inside Our Service Area

You may receive covered Urgent Care Services from Participating Providers, including Kaiser Permanente Urgent Care. Visit **kp.org/getcare** or call Member Services to find the Kaiser Permanente Urgent Care locations nearest you.

Outside Our Service Area

You may receive covered Urgent Care Services from Participating Providers or Participating Facilities. Visit **kp.org/getcare** or call Member Services to find Urgent Care locations nearest you.

If you are temporarily outside our Service Area, we also cover Urgent Care you receive from a Non-Participating Provider or Non-Participating Facility, if we determine the Services were necessary to prevent serious deterioration of your health and that the Services could not be delayed until you returned to our Service Area.

WHAT YOU PAY

This section contains information to help you understand your health care costs. We also provide a cost estimator tool to assist you in planning for the estimated costs of Services. To access the secure cost estimator tool, log in to your **kp.org** member account and navigate to the cost estimates link on the "Coverage & Costs" tab. If you would like additional information about cost estimates, call Member Services.

Deductible

For each Year, all covered Services are subject to the Deductible and count toward the Deductible, except for certain preventive care Services and other items that are shown as not subject to the Deductible in the "Benefit Summary."

For Services that are subject to the Deductible, you must pay Charges for the Services when you receive them, until you meet your Deductible.

If you are the only Member in your Family, then you must meet the self-only Deductible. If there is at least one other Member in your Family, then you must each meet the individual Family Member Deductible, or

your Family must meet the Family Deductible, whichever occurs first. Each individual Family Member Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further individual Family Member Deductible will be due for the remainder of the Year. The Deductible amounts are shown in the "Benefit Summary."

After you meet the Deductible, you pay the applicable Copayments and Coinsurance for covered Services for the remainder of the Year until you meet your Out-of-Pocket Maximum (see "Out-of-Pocket Maximum" in this "What You Pay" section).

Increasing the Deductible

If the U.S. Department of Treasury increases the minimum Deductible required in high deductible health Plans, we will increase the Deductible if necessary to meet the new minimum Deductible requirement, and we will notify your Group.

Changes to your Family. When your Family changes during a Year from self-only enrollment to two or more Members (or vice versa), the only Deductible payments that will count in the new Family are those for Services that Members in the new Family received in that Year under this *EOC*. For example:

- If you add Dependents to your Family, the only Deductible payments that will count in the new Family are those for Services that Members in the new Family received in that Year under this *EOC*.
- If all of your Dependents cease to be Members in your Family so that your Family becomes a Family of one Member, only the amounts that had been applied toward the Deductible for Services that you received during the Year will be applied toward the Deductible required for self-only enrollment. You must pay Charges for covered Services you receive on or after the date you become a Family of one Member until you meet the Deductible required for self-only enrollment, even if the Family had previously met the Deductible for a Family of two or more Members.

Copayments and Coinsurance

The Copayment or Coinsurance for each covered Service is shown in the "Benefit Summary." Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee may be added to offset handling costs.

Out-of-Pocket Maximum

There is a maximum to the total dollar amount of Deductible, Copayments, and Coinsurance that you must pay for covered Services that you receive within the same Year.

If you are the only Member in your Family, then you must meet the self-only Out-of-Pocket Maximum. If there is at least one other Member in your Family, then you must each meet the individual Family Member Out-of-Pocket Maximum, or your Family must meet the Family Out-of-Pocket Maximum, whichever occurs first. Each individual Family Member Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Out-of-Pocket Maximum amounts are shown in the "Benefit Summary."

All Deductible, Copayments, and Coinsurance count toward the Out-of-Pocket Maximum, unless otherwise indicated. After you reach the Out-of-Pocket Maximum, you are not required to pay Copayments and Coinsurance for these Services for the remainder of the Year. Member Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

The following amounts do not count toward the Out-of-Pocket Maximum and you will continue to be responsible for these amounts even after the Out-of-Pocket Maximum is satisfied:

- Payments for Services that are not covered under this *EOC*.
- Payments that you make because you exhausted (used up) your benefit allowance, or because we already covered the benefit maximum amount or the maximum number of days or visits for a Service.

- Payments for Services under the "Adult Vision Hardware and Optical Services Rider," if purchased by your Group.
- Amounts recovered from a liability claim against another party subject to reimbursement under the "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section.

BENEFITS

The Services described in this "Benefits" section are covered only if all the following conditions are satisfied, and will not be retrospectively denied:

- You are a Member on the date you receive the Services.
- A Participating Provider determines that the Services are Medically Necessary.
- The Services are provided, prescribed, authorized, or directed by a Participating Provider except where specifically noted to the contrary in this *EOC*.
- You receive the Services from a Participating Provider, Participating Facility, or from a Participating Skilled Nursing Facility, except where specifically noted to the contrary in this *EOC*.
- You receive prior authorization for the Services, if required under "Prior Authorization Review Requirements" in the "How to Obtain Services" section.

All Services are subject to the coverage requirements described in this "Benefits" section. Some Services are subject to benefit-specific exclusions and/or limitations, which are listed, when applicable, in each benefit section. A broader list of exclusions and limitations that apply to all benefits is provided under the "Exclusions and Limitations" section.

All covered Services are subject to any applicable Cost Share as described in the "What You Pay" section and in the "Benefit Summary."

The benefits under this Plan are not subject to a pre-existing condition waiting period.

Preventive Care Services

We cover a variety of preventive care Services, which are Services to keep you healthy or to prevent illness, and are not intended to diagnose or treat a current or ongoing illness, injury, sign or symptom of a disease, or condition.

Preventive care Services include:

- Services recommended by, and rated A or B by, the U.S. Preventive Services Task Force (USPSTF). You can access the list of preventive care Services at **www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screenings supported by HRSA. You can access the list of preventive care Services at **www.hrsa.gov/womens-guidelines/**.
- Any additional reproductive health preventive Services for all Members as required by applicable state law.

Services received for a current or ongoing illness, injury, sign or symptom of a disease, or condition during a preventive care examination or procedure may be subject to the applicable Cost Share.

Covered preventive care Services include, but are not limited to:

- Bone densitometry.
- Cervical cancer screening.
- Chlamydia test.
- Cholesterol tests (all types).
- Colorectal cancer screening for Members age 45 or older, or for younger Members who are at high risk, including:
  - Fecal occult blood test yearly plus one flexible sigmoidoscopy every four years, or more frequently as recommended by your Participating Provider.
  - Colonoscopy every ten years, or double contrast barium enema every five years, or more frequently as recommended by your Participating Provider.
  - Follow-up colonoscopy for screening to be achieved following abnormal findings identified by flexible sigmoidoscopy or CT colonography screening.
  - Required specialist consultation prior to the screening procedure.
  - Bowel preparation medications prescribed for the screening procedure.
  - Anesthesia Services performed in connection with the screening procedure.
  - Polyp removal performed during the screening procedure.
  - Any pathology exam on a polyp biopsy performed as part of the screening procedure.
- Contraceptive Services and supplies, including insertion/removal of IUD or implanted birth control drugs and devices.
- Diabetic retinopathy screening.
- Fasting glucose test.
- Healthy diet counseling and counseling for obesity and weight management.
- Immunizations.
- Mammography.
- Prostate screening examinations once every two years for men 50 years of age or older or for younger Members who are at high risk, and more frequently if your Participating Provider recommends it because you are at high risk for prostate cancer or disease.
- Routine preventive physical exam (adult, well-child, and well-baby).
- Screening prostate-specific antigen (PSA) test (not including monitoring or ultrasensitive tests).
- Transabdominal and transcervical sterilization procedures.

When a Participating Provider determines that a recommended Service is medically appropriate for an individual and the individual satisfies the criteria for the Service or treatment, we will provide coverage for the recommended Service regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by us.

If you would like additional information about covered preventive care Services, call Member Services. Information is also available online at **kp.org/prevention**.

Benefits for Outpatient Services

We cover the following outpatient Services for diagnosis, treatment, and preventive medicine upon payment of any applicable Cost Share shown in the "Benefit Summary" in the "Outpatient Services" section. Additional types of outpatient Services are covered as described under other headings in this "Benefits" section.

- Allergy testing and treatment materials.
- Biofeedback.
- Cardiac rehabilitative therapy visits.
- Chemotherapy and radiation therapy Services.
- Child abuse medical assessment including Services provided by an Oregon children's advocacy center that reports to the Child Abuse Multidisciplinary Intervention Program. Services may include, but are not limited to, a physical exam, forensic interview and behavioral health treatment.
- Diagnostic Services and scope insertion procedures, such as colonoscopy, endoscopy, and laparoscopy.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits, subject to the drug formulary and exclusions described under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Emergency department visits.
- Eye exams, including refraction exams.
- Gender Affirming Treatment.
- Internally implanted devices, including bilateral cochlear implants and bone-anchored hearing aids, except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- Interrupted pregnancy surgery performed in an outpatient setting.
- Nurse treatment room visits to receive injections, including allergy injections.
- Outpatient surgery and other outpatient procedures.
- Primary care visits for internal medicine, gynecology, family medicine, and pediatrics.
- Respiratory therapy.
- Routine hearing exams.
- Specialty care visits.
- Treatment for temporomandibular joint (TMJ) disorder.
- Urgent Care visits.
- Vasectomy.

Benefits for Inpatient Hospital Services

We cover the following Services when you are admitted as an inpatient in a Participating Hospital. Additional types of inpatient Services are covered as described under other headings in this "Benefits" section.

- Anesthesia.
- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Chemotherapy and radiation therapy Services.

- Dialysis Services (this benefit is subject to the benefit limitations described under "Dialysis Services" in this "Benefits" section).
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Durable Medical Equipment and medical supplies.
- Emergency detoxification.
- Gender Affirming Treatment.
- General and special nursing care Services.
- Internally implanted devices, except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- Interrupted pregnancy surgery when performed in an inpatient setting.
- Laboratory, X-rays and other imaging, and special diagnostic procedures.
- Medical foods and formulas if Medically Necessary.
- Medical social Services and discharge planning.
- Operating and recovery rooms.
- Orthognathic surgery and supplies for treatment of temporomandibular joint (TMJ) disorder or injury, sleep apnea or congenital anomaly.
- Palliative care.
- Participating Provider's Services, including consultation and treatment by Specialists.
- Prescription drugs, including injections.
- Respiratory therapy.
- Room and board, including a private room if Medically Necessary.
- Specialized care and critical care units.
- Temporomandibular joint (TMJ) surgery for the treatment of TMJ disorders subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.
- Vasectomy.

Ambulance Services

We cover licensed ambulance Services:

- For Emergency Medical Services Transport, or
- If we give prior authorization for an ambulance to transport you to or from a location where you receive covered Services.

Covered Emergency Medical Services Transport includes air, ground and water transportation.

Ambulance Services Exclusions

- Ambulance Services for personal comfort or convenience.

Bariatric Surgery Services

We cover inpatient and outpatient bariatric surgery procedures and related pre-surgery and post-surgery Services for clinically severe obesity in adults, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

You may request Utilization Review criteria, and a list of the approved surgical procedures we cover when criteria is met, by calling Member Services.

In addition to Utilization Review, you must meet one of the following requirements:

- You fully comply with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Company; or,
- You receive the Service at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

Behavioral Health Services

We cover Services to treat Behavioral Health Conditions as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association, including Medically Necessary applied behavior analysis (ABA) for autism spectrum disorder, and Medically Necessary treatment for pervasive developmental disorder (PDD).

Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request the criteria by calling Member Services.

The benefits described in this "Behavioral Health Services" section comply with the Mental Health Parity and Addiction Equity Act.

Outpatient Services

We cover individual office visits, group therapy visits, intensive outpatient visits, partial hospitalization, and Assertive Community Treatment (ACT) Services for behavioral health treatment. ACT Services are designed to provide comprehensive outpatient treatment and support to Members who are diagnosed with a severe mental illness and whose symptoms of mental illness lead to serious dysfunction in daily living.

Inpatient Hospital Services

We cover inpatient hospital Services for behavioral health treatment, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the inpatient facility. Prior authorization is not required for Members who are involuntarily committed and subsequently treated in a state hospital.

Residential Services

We cover residential Services in a residential facility, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the residential facility.

Psychological Testing

If, in the professional judgment of a Participating Provider you require psychological testing as part of diagnostic evaluation, prescribed tests are covered in accord with this "Behavioral Health Services" section. We do not cover court-ordered testing or testing for ability, aptitude, intelligence, or interest unless Medically Necessary.

Dialysis Services

We cover two types of dialysis: hemodialysis and peritoneal dialysis. You pay the Cost Share shown in the "Benefit Summary" under "Dialysis Services." We cover dialysis Services for acute renal failure and end-stage renal disease subject to Utilization Review criteria developed by Medical Group and approved by Company.

We cover treatment at outpatient dialysis facilities.

We also cover home dialysis. Coverage includes necessary equipment, training, and medical supplies.

If you receive dialysis Services as part of an inpatient hospital stay or at a Participating Skilled Nursing Facility, the Services will be covered according to your inpatient hospital or skilled nursing facility benefit.

External Prosthetic Devices and Orthotic Devices

We cover External Prosthetic Devices and Orthotic Devices, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company, when the following are true:

- The device is Medically Necessary to restore or maintain your ability to complete activities of daily living or essential job-related activities and is not solely for comfort or convenience.
- The device is required to replace all or part of an organ or extremity designated by CMS in the "L codes" of the Healthcare Common Procedure Coding System.

This coverage includes Services and supplies that are Medically Necessary for the effective use of an External Prosthetic Device or Orthotic Device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, patient instruction in the use of the device, and repair and replacement of the Medically Necessary device.

Internally implanted prosthetic and Orthotic Devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, are not covered under this "External Prosthetic Devices and Orthotic Devices" benefit, but may be covered if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

Covered External Prosthetic Devices and Orthotic Devices include, but are not limited to:

- Compression garments for burns.
- Diabetic foot care appliances and therapeutic shoes and inserts to prevent and treat diabetes-related complications.
- External prostheses after a Medically Necessary mastectomy, including prostheses when Medically Necessary, and up to four brassieres required to hold a prosthesis every 12 months.
- Fitting and adjustments.
- Halo vests.
- Lymphedema wraps and garments.
- Maxillofacial prosthetic devices: coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Provider. We cover maxillofacial prosthetic devices if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of:
    - Controlling or eliminating infection;
    - Controlling or eliminating pain; or
    - Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.

- Ocular prosthesis.
- Prosthetic devices for treatment of temporomandibular joint (TMJ) conditions.
- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity. This includes but is not limited to ostomy and urological supplies.
- Rigid and semi-rigid Orthotic Devices required to support or correct a defective body part.
- Tracheotomy equipment.

We periodically update the list of approved External Prosthetic Devices and Orthotic Devices to keep pace with changes in medical technology and clinical practice. To find out if a particular prosthetic or orthotic device is on our approved list for your condition, please call Member Services.

Coverage is limited to the standard External Prosthetic Device or Orthotic Device that adequately meets your medical needs. Our guidelines allow you to obtain non-standard devices (those not on our approved list for your condition) if we determine that the device meets all other coverage requirements, and Medical Group or a designated physician determines that the device is Medically Necessary and that there is no standard alternative that will meet your medical needs.

External Prosthetic Devices and Orthotic Devices Exclusions

- Artificial hearts.
- Artificial larynx.
- Comfort, convenience, or luxury equipment or features.
- Dental appliances and dentures.
- Internally implanted insulin pumps.

Fertility Services

Covered fertility Services include:

- Consultation and evaluation of fertility status.
- Diagnostic imaging and laboratory tests, such as tests to rule out sexually transmitted diseases, hormone level tests, and semen analysis.
- Diagnostic laparoscopy or hysteroscopy.
- Other Medically Necessary diagnostic Services to determine if there is an underlying medical condition that may affect fertility.

Diagnostic Services may include both the individual and their partner; however, Services are covered only for the person who is the Member.

You may have additional coverage if your Group has purchased a "Fertility Treatment Services Rider."

Fertility Services Exclusions

- Fertility preservation.
- Inpatient and outpatient fertility treatment Services.
- Oral and injectable drugs prescribed for fertility treatment.
- Services related to conception by artificial means, such as intrauterine insemination (IUI), in vitro fertilization (IVF), ovum transplants, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and artificial insemination.
- Services to reverse voluntary, surgically induced infertility.

Habilitative Services

We cover inpatient and outpatient habilitative Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. Coverage includes the range of Medically Necessary Services or health care devices designed to help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical, occupational, and speech therapy, and other Services for people with disabilities, and that:

- Takes into account the unique needs of the individual.
- Targets measurable, specific treatment goals appropriate for the person's age, and physical and mental condition.

We cover these habilitative Services at the Cost Share shown in the "Benefit Summary." The "Benefit Summary" also shows a visit maximum for habilitative Services. That visit maximum will be exhausted (used up) for a Year when the number of visits that we covered during the Year under this *EOC*, plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year. Visit maximums do not apply to habilitative Services to treat Behavioral Health Conditions covered under this *EOC*.

Habilitative Services Exclusions

- Daycare.
- Exercise programs for healthy individuals (unless Medically Necessary within an applied behavior analysis (ABA) treatment plan).
- Housing.
- Recreational activities (unless Medically Necessary within an applied behavior analysis (ABA) treatment plan).
- Respite care.
- Services and devices delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements.
- Services solely for palliative purposes.
- Social services.
- Specialized job testing.

Health Education Services

We cover a variety of health education Services to help you take an active role in improving and maintaining your health. These Services include:

- Diabetic counseling.
- Diabetic and other outpatient self-management training and education.
- Medical nutritional therapy for diabetes.
- Post coronary counseling and nutritional counseling.
- Tobacco use cessation. For the purposes of this *EOC*, tobacco use is defined as the use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

If you receive health education Services during a primary care visit, you pay the primary care Cost Share shown in the "Benefit Summary." If you receive health education Services during a specialty care visit, you pay the specialty care Cost Share shown in the "Benefit Summary."

Some Health Education Services may also be covered under the "Preventive Care Services" section.

There are fees for some health education classes. For more information about in-person and online health education programs, see our *Healthy Living* catalog, call Member Services, or visit **kp.org** and select Health & Wellness. To register by phone, call 503-286-6816 or 1-866-301-3866 (toll-free) and select option 1.

Hearing Aids and Other Hearing Devices

We cover Medically Necessary Services for the treatment of hearing loss as described in this "Hearing Aids and Other Hearing Devices" section when prescribed by a Participating Provider and obtained from a Participating Provider. You pay the Cost Share shown in the "Benefit Summary." These Services are limited to Members who are under the Dependent Limiting Age shown in the "Benefit Summary." You may have additional coverage if your Group has purchased a "Hearing Aid Rider."

Hearing Exam

We cover exams to determine the need for hearing correction, diagnostic hearing tests appropriate to the Member's age or developmental need, and aided testing. Medically Necessary diagnostic and treatment exams are covered at least twice per Year for Members who are younger than four years of age, and at least once per Year for Members who are four years of age or older. In addition, we cover visits to determine the appropriate hearing aid or hearing device model, visits to verify that the hearing aid or device conforms to the prescription, and visits for fitting, adjustment, cleaning, inspection, counseling, programming, and reprogramming of the hearing device.

Hearing Aids

We cover one hearing aid per impaired ear for the treatment of hearing loss, as shown in the "Benefit Summary", or more frequently if modifications to an existing hearing aid will not meet the needs of the Member. Coverage includes the cost of repair or replacement parts if they are not covered by a warranty and are necessary for the device to function correctly for the Member. Ear molds and replacement ear molds are covered as Medically Necessary and at least four times per Year for Members who are seven years of age or younger, and at least once per Year for Members eight years of age or older.

A hearing aid is any non-disposable, wearable electronic instrument or device designed to aid or compensate for impaired human hearing and any necessary ear molds, parts, attachments, batteries, components, or accessories necessary to the function of the hearing aid, except cords.

The date we cover a hearing aid is the date on which you are fitted for the device. Therefore, if you are fitted for a device while you are covered under this *EOC*, and if we would otherwise cover the device, we will provide the device even if you do not receive it until after you are no longer covered under this *EOC*.

Other Hearing Devices

Assistive Listening Devices

We cover assistive listening devices and bone conduction sound processors for the treatment of hearing loss, as shown in the "Benefit Summary". Coverage includes the cost of repair or replacement parts if they are not covered by a warranty and are necessary for the device to function correctly for the Member.

An assistive listening device is a device used with or without hearing aids or cochlear implants to provide access to sound or improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise, or in a room with poor acoustics or reverberation.

The date we cover an assistive listening device is the date on which you are fitted for the device. Therefore, if you are fitted for a device while you are covered under this *EOC*, and if we would otherwise cover the device, we will provide the device even if you do not receive it until after you are no longer covered under this *EOC*.

Internally Implanted Hearing Devices

We cover cochlear implants and other implantable hearing devices for one or both ears if Medically Necessary for the treatment of hearing loss, including fitting, programming, reprogramming, and repair and replacement parts necessary for the device to function correctly for the Member. Devices such as bone-anchored hearing aids, cochlear implants, and other implantable hearing devices that are internally implanted during a surgical procedure are covered under the benefits for the surgical procedure. Please refer to internally implanted devices in the "Benefits for Outpatient Services" section. Internally implanted hearing devices are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Hearing Aids and Other Hearing Devices Limitations

- Hearing aids are limited to one of the following digital models from a specified collection of hearing aids: (i) in the ear; (ii) behind the ear; (iii) on the body (Body Aid Model); or (iv) canal/CIC aids.
- Replacement batteries are limited to one box per Year for each hearing aid.

Hearing Aids and Other Hearing Devices Exclusions

- Non-prescription hearing aids or hearing aid components, except as described in this "Hearing Aids and Other Hearing Devices" section.
- Replacement of lost hearing aids and devices.

Home Health Services

Home health Services are Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, speech, and respiratory therapists. We cover home health Services only if all of the following are true:

- You are substantially confined to your home (or to a place of temporary or permanent residence used as your home) or the care is provided in lieu of Medically Necessary hospitalization.
- A Medical Group 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.
- You receive prior authorization from Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.
- Services are provided through a licensed Home Health Agency.

The "Benefit Summary" shows a visit maximum for home health Services. That visit maximum will be exhausted (used up) for a Year when the number of visits that we covered during the Year under this *EOC*, plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year.

The following types of Services are covered in the home only as described under these headings in this "Benefits" section:

- "Dialysis Services."
- "Outpatient Durable Medical Equipment (DME)."
- "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."

Home Health Services Exclusions

- "Meals on Wheels" or similar food services.
- Nonmedical, custodial, homemaker or housekeeping type services except by home health aides as ordered in the approved plan of treatment.
- Nutritional guidance.
- Private duty or continuous nursing Services.
- Services designed to maintain optimal health in the absence of symptoms.
- Services not included in an approved plan of treatment.
- Services of a person who normally lives in the home or who is a member of the family.
- Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. These Services are excluded even if we would cover the Services if they were provided by a qualified medical professional in a hospital or skilled nursing facility.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners, and similar appliances and devices.

Hospice Services

Hospice is a specialized form of interdisciplinary care designed to provide palliative care to help alleviate your physical, emotional, and spiritual discomfort through the last phases of life due to a terminal illness. It also provides support to your primary caregiver and your family. When you choose hospice, you are choosing to receive palliative (comfort) care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice Services at any time. You pay the Cost Share shown in the "Benefit Summary" under "Hospice Services."

We cover hospice Services if all of the following requirements are met:

- A Medical Group physician has diagnosed you with a terminal illness and determines that your life expectancy is six months or less.
- The Services are provided in your home (or a place of temporary or permanent residence used as your home).
- The Services are provided by a licensed hospice agency approved by Kaiser Foundation Hospitals.
- The Services are necessary for the palliation and management of your terminal illness and related conditions.
- The Services meet Utilization Review by Company using criteria developed by Medical Group and approved by Company.

We cover the following hospice Services:

- Counseling and bereavement Services for up to one year.
- Durable Medical Equipment (DME).
- Home health aide Services.
- Medical social Services.
- Medication and medical supplies and appliances.
- Participating Provider Services.
- Rehabilitative therapy Services for purposes of symptom control or to enable you to maintain activities of daily living.

- Services of volunteers.
- Short-term inpatient Services including respite care and care for pain control and acute and chronic symptom management.
- Skilled nursing Services, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers.

Limited Dental Services

We do not cover dental Services except as described below. Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request these criteria by calling Member Services.

Covered Dental Services

We cover dental Services only as described below:

- Dental and orthodontic Services for the treatment of craniofacial anomalies if the Services are Medically Necessary to improve or restore function.
- Dental Services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment, limited to (a) emergency dental Services, or (b) extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.
- Dental Services for Members who are potential transplant recipients and require Medically Necessary pre-transplant dental evaluation and clearance before being placed on the waiting list for a covered transplant. Covered Services are routine dental Services necessary to ensure the oral cavity is clear of infection, and may include oral examination, dental x-rays, prophylaxis (dental cleaning), fluoride treatment, fillings, and dental extractions. In the case of urgent transplantation, we will cover these Services when performed post-transplant.
- General anesthesia and associated hospital or ambulatory surgical facility Services in conjunction with non-covered dental Services when Medically Necessary for Members who:
    - have a medical condition that your Participating Provider determines would place you at undue risk if the dental procedure were performed in a dental office; or
    - are physically or developmentally disabled.

Covered Services may be provided by a licensed dentist or other person who is regulated under state law to practice dental or dental-related Services or otherwise practicing dental care Services consistent with state law, including an expanded practice dental hygienist, denturist, dental therapist, or pediatric dental assistant. You pay the Cost Share you would pay if the Services were not related to a covered dental Service.

Limited Dental Services Exclusions

The following dental Services are not covered, except where specifically noted to the contrary in this *EOC*:

- Dental appliances and dentures.
- Dental implants.
- Extraction of teeth, except as described above in the "Covered Dental Services" section.
- Hospital Services for dental care, except as described above in the "Covered Dental Services" section.
- Orthodontics, except as described above in the "Covered Dental Services" section.
- Routine or preventive dental Services.

- Services to correct malocclusion.

Limited Outpatient Prescription Drugs and Supplies

We cover limited outpatient prescription drugs and supplies as described in this "Limited Outpatient Prescription Drugs and Supplies" section. You may have additional coverage if your Group has purchased an "Outpatient Prescription Drug Rider."

Covered drugs or supplies must be prescribed by a Participating Provider or any licensed dentist in accordance with our drug formulary guidelines.

You must obtain drugs or supplies at a Participating Pharmacy (including our Mail-Order Pharmacy). You may obtain a first fill of a drug or supply at any Participating Pharmacy. All refills must be obtained through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy), or at another Participating Pharmacy that we designate for covered refills. See your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Covered Drugs and Supplies

Items covered under this "Limited Outpatient Prescription Drugs and Supplies" benefit include:

- Certain preventive medications (including, but not limited to, aspirin, fluoride, folic acid supplements, liquid iron for infants, and tobacco use cessation drugs) according to, and as recommended by, the USPSTF, when obtained with a prescription order.
- Certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) for up to a 30-day supply, including the supplies and equipment required for their administration.
- Contraceptive drugs and devices approved by the U.S. Food and Drug Administration (FDA), including injectable contraceptives and internally implanted time-release contraceptive drugs, emergency contraceptives, and contraceptive devices such as intrauterine devices, diaphragms, and cervical caps. Over-the-counter contraceptive drugs, devices, and products approved by the FDA do not require a prescription in order to be covered. You may receive a three-month supply for a first dispensing of a contraceptive drug and a 12-month supply of a subsequent dispensing of the same contraceptive drug, unless you request a smaller supply. You pay the Cost Share as shown in the "Benefit Summary."
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits. We cover these items upon payment of the administered medications Cost Share shown under "Outpatient Services" in the "Benefit Summary."
- Glucagon emergency kits, insulin, ketone test strips for urine-testing, blood glucose test strips, and disposable needles and syringes when prescribed for the treatment of diabetes. We cover additional diabetic equipment and supplies, including lancets and injection aids, under the "Outpatient Durable Medical Equipment (DME)" section and the "External Prosthetic Devices and Orthotic Devices" section.
- Self-administered chemotherapy medications used for the treatment of cancer.

These limited drugs and supplies are available to you even if your Group has not purchased additional drug coverage. If your Group has purchased additional drug coverage, the limited drugs and supplies listed in this "Limited Outpatient Prescription Drugs and Supplies" section are not covered under it.

Day Supply Limit

The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-day (or any other number of days) supply for you. When you pay the applicable Cost

Share shown in the "Benefit Summary," you will receive the prescribed supply up to the day supply limit. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantity that exceeds the day supply limit.

You may receive a three-month supply for a first dispensing of a contraceptive drug and a 12-month supply of a subsequent dispensing of the same contraceptive drug, unless you request a smaller supply.

How to Get Covered Drugs or Supplies

Participating Pharmacies are located in many Participating Facilities. To find a Participating Pharmacy please see your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Participating Pharmacies include our Mail-Order Pharmacy. This pharmacy offers postage-paid delivery to residents of Oregon and Washington. Some drugs and supplies are not available through our Mail-Order Pharmacy, for example drugs that require special handling or refrigeration, or are high cost. Drugs and supplies available through our Mail-Order Pharmacy are subject to change at any time without notice.

If you would like to use our Mail-Order Pharmacy, call 1-800-548-9809 or order online at **kp.org/refill**.

About Our Drug Formulary

Our drug formulary is a list of drugs that our Regional Formulary and Therapeutics Committee has reviewed and approved for our Members and includes drugs covered under this *EOC*. Drugs on the formulary have been approved by the FDA.

Our Regional Formulary and Therapeutics Committee is made up of Participating Physicians, other Participating Providers, and administrative staff. The committee chooses drugs for the formulary based on several factors, including safety and effectiveness as determined from a review of the scientific literature. They may not approve a drug if there is not enough scientific evidence that it is clinically effective. They may also exclude a drug if it does not have a clinical or cost advantage over comparable formulary drugs.

The Regional Formulary and Therapeutics Committee meets to review new drugs and reconsider drugs currently on the market. After this review, they may add drugs to the formulary or remove drugs from it. If a drug is removed from the formulary, you will need to switch to another comparable drug that is on the drug formulary, unless your old drug meets exception criteria. Refer to the "Drug Formulary Exception Process" in this "Limited Outpatient Prescription Drugs and Supplies" section for more information.

If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your Participating Provider or another member of your health care team.

To see if a drug or supply is on our drug formulary, go online to **kp.org/formulary**. You may also call our Formulary Application Services Team (FAST) at 503-261-7900. If you would like a copy of our drug formulary or additional information about the formulary process, please call Member Services. The presence of a drug on our drug formulary does not necessarily mean that your Participating Provider will prescribe it for a particular medical condition.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider or any licensed dentist prescribes a drug or supply that our drug formulary does not list for your condition, if the law requires the item to bear the legend "Rx only." The exception process is not available for drugs and supplies that the law does not require to bear this legend, or for any drug or supply prescribed by someone other than a Participating Provider or any licensed dentist.

A Participating Provider or any licensed dentist may request an exception if they determine that the non-formulary drug or supply is Medically Necessary. We will make a coverage determination within 72 hours of

receipt for standard requests and within 24 hours of receipt for expedited requests. We will approve the exception if all of the following requirements are met:

- We determine that the drug or supply meets all other coverage requirements except for the fact that our drug formulary does not list it for your condition.
- Medical Group or a designated physician makes the following determinations:
  - The drug or supply is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs or supplies that our drug formulary lists for your condition.
  - Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug or supply. For this drug or supply, the Participating Pharmacy can provide a copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

If we approve an exception through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the "Benefit Summary."

If we do not approve the formulary exception request, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

Limited Outpatient Prescription Drugs and Supplies Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs prescribed for an indication if the FDA has determined that use of the drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Evidence Review Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs and supplies that are available without a prescription, even if the non-prescription item is in a different form or different strength (or both), except that this exclusion does not apply to non-prescription drugs or supplies described in the "Covered Drugs and Supplies" section.
- Drugs, biological products, and devices that the FDA has not approved.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Injectable drugs that are self-administered (except insulin).
- Mail-order drugs for anyone who is not a resident of Oregon or Washington.
- Nutritional supplements.
- Replacement of drugs and supplies due to loss, damage, or carelessness. This exclusion does not apply to drugs used to treat Substance Use Disorder.
- The following are excluded, but you may have coverage for them if your Group purchased an "Outpatient Prescription Drug Rider":

- Prescription drugs and supplies that are dispensed on an outpatient basis, except those listed under "Covered Drugs and Supplies" of this "Limited Outpatient Prescription Drugs and Supplies" section.
- Drugs prescribed for fertility treatment.
- Drugs and supplies to treat sexual dysfunction are excluded except for drugs that are FDA-approved to treat behavioral health symptoms of sexual dysfunction.
- Drugs used in weight management.

Maternity and Newborn Care

We cover the following maternity and newborn care Services:

- Prenatal care visits and postpartum visits.
- Maternal diabetes management, including medication and supplies (Medically Necessary Services beginning with conception and ending through six weeks postpartum).
- Maternity hospital care for mother and baby, including Services for complications of pregnancy.
- Obstetrical care and delivery (including cesarean section).
- Newborn medical Services following birth and initial physical exam.
- Newborn nurse home visiting Services for Dependent children up to six months of age, if available in your area.
- Newborn PKU test.

We will not limit the length of a maternity hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient stay is determined by an attending Participating Provider, in consultation with the mother. Our policy complies with the federal Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

Newborns are covered from the moment of birth for the first 31 days of life and are subject to their own Cost Share. In order for coverage to continue beyond this 31-day period, you must follow the rules for adding Dependents as described under "Adding New Dependents to an Existing Account" in the "When You Can Enroll and When Coverage Begins" section.

Certain maternity Services, such as screening for gestational diabetes and breastfeeding equipment, supplies, counseling, and support, are covered under the "Preventive Care Services" section. Outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures are covered under the "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" section.

Maternity and Newborn Care Exclusions

- Birthing center Services.
- Home birth Services.

Medical Foods and Formula

We cover the following Medically Necessary medical foods and formula subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company:

- Elemental formula for the treatment of eosinophilic gastrointestinal associated disorder.
- Enteral formula for home treatment of severe intestinal malabsorption when the formula comprises the sole or essential source of nutrition.
- Medical foods and formula necessary for the treatment of phenylketonuria (PKU), specified inborn errors of metabolism, or other metabolic disorders.

Naturopathic Medicine

We cover outpatient visits for naturopathic medicine Services when provided by a Participating Provider in the Participating Provider's office. You do not need a referral or prior authorization.

Naturopathic medicine is a natural approach to health and healing which emphasizes a holistic approach to the diagnosis, treatment and prevention of illness. Naturopathic physicians diagnose and treat patients by using natural modalities such as clinical nutrition, herbal medicine, and homeopathy.

Covered Services include:

- Evaluation and management.
- Health condition related treatments.
- Physical therapy modalities such as hot and cold packs.

To locate a Participating Provider, visit **www.chpgroup.com**. The CHP Group is a Participating Provider we contract with to provide naturopathic medicine Services. If you need assistance searching for a Participating Provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

Outpatient Durable Medical Equipment (DME)

We cover outpatient Durable Medical Equipment (DME) subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

DME must be for use in your home (or a place of temporary or permanent residence used as your home).

When you receive DME in a home health setting in lieu of hospitalization, DME is covered at the same level as if it were received in an inpatient hospital care setting.

We decide whether to rent or purchase the DME, and we select the vendor. We also decide whether to repair, adjust, or replace the DME item when necessary.

Covered DME includes, but is not limited to:

- Bilirubin lights.
- CADD (continuous ambulatory drug delivery) pumps.
- Diabetic equipment and supplies including external insulin pumps, infusion devices, blood glucose monitors, continuous glucose monitors, lancets, and injection aids.
- Enteral pumps and supplies.
- Home ultraviolet light therapy equipment for treatment of certain skin conditions such as cutaneous lymphoma, eczema, psoriasis, and scleroderma.
- Osteogenic bone stimulators.
- Osteogenic spine stimulators.
- Oxygen and oxygen supplies.
- Peak flow meters.
- Ventilators.
- Wheelchairs.
- Wigs following chemotherapy or radiation therapy, limited to one synthetic wig per Year.

We periodically update the list of approved DME items to keep pace with changes in medical technology and clinical practice. To find out if a particular DME item is on our approved list for your condition, please call Member Services.

Coverage is limited to the standard DME item that adequately meets your medical needs. Our guidelines allow you to obtain non-standard DME items (those not on our approved list for your condition) if we determine that the item meets all other coverage requirements, and Medical Group or a designated physician determines that the item is Medically Necessary and that there is no standard alternative that will meet your medical needs.

Outpatient Durable Medical Equipment (DME) Exclusions

- Comfort, convenience, or luxury equipment or features.
- Devices for testing blood or other body substances unless specifically listed as covered in this "Outpatient Durable Medical Equipment (DME)" section.
- Exercise or hygiene equipment.
- Modifications to your home or car.
- More than one corrective appliance or artificial aid or item of DME, serving the same function or the same part of the body, except for necessary repairs, adjustments and replacements as specified under this "Outpatient Durable Medical Equipment (DME)" section.
- Non-medical items, such as sauna baths or elevators.
- Repair or replacement of DME items due to loss or misuse.
- Spare or duplicate use DME.

Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures

We cover outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures. Some Services, such as preventive screenings and routine mammograms, are not covered under this "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" benefit but may be covered under the "Preventive Care Services" section.

Laboratory, X-ray, and Imaging

We cover outpatient laboratory, X-ray, and imaging Services. Covered outpatient laboratory, X-ray, and imaging Services include, but are not limited to:

- Bone densitometry.
- Cardiovascular testing.
- Cultures.
- Diagnostic and supplemental breast imaging, including diagnostic mammography, breast MRI, or breast ultrasound that is used to:
    - Evaluate an abnormality.
    - Screen for breast cancer when there is no abnormality seen or suspected, and is based on personal or family medical history, or additional factors that may increase the individual's risk of breast cancer.
- Glucose tolerance.
- X-ray.
- Ultrasound imaging.
- Urinalysis.

Special Diagnostic Procedures

Special diagnostic procedures may or may not involve radiology or imaging technology. Some special diagnostic Services may be subject to a higher Cost Share, as shown in the "Benefit Summary." Covered special diagnostic procedures include, but are not limited to:

- CT scans.
- MRI.
- Nerve conduction studies.
- PET scans.
- Pulmonary function studies.
- Sleep studies.

You must receive prior authorization by Company for MRI, CT scans, PET scans, and bone density/DXA scans. (See "Prior Authorization Review Requirements" in the "How to Obtain Services" section.)

Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures Limitations

Covered genetic testing Services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when Medically Necessary. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Reconstructive Surgery Services

We cover inpatient and outpatient reconstructive surgery Services as indicated below, when prescribed by a Participating Provider. Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

- To correct disfigurement resulting from an injury or from Medically Necessary surgery.
- To correct a congenital defect, disease, or anomaly in order to produce improvement in physical function.
- To treat congenital hemangioma known as port wine stains on the face.

With respect to maxillofacial prosthetic services, coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Provider. We cover maxillofacial prosthetic Services if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of any of the following:

- Controlling or eliminating infection.
- Controlling or eliminating pain.
- Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy. We cover:

- All stages of reconstruction of the breast on which a mastectomy was performed, including but not limited to nipple reconstruction, skin grafts, and stippling of the nipple and areola.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Mastectomy-related prostheses.

- Treatment of physical complications of the mastectomy, including lymphedemas.
- Inpatient care related to the mastectomy and post-mastectomy Services.

Mastectomy-related prosthetics and Orthotic Devices are covered under and subject to the "External Prosthetic Devices and Orthotic Devices" section.

Rehabilitative Therapy Services

We cover inpatient and outpatient physical, occupational, and speech therapy Services, when prescribed by a Participating Provider, subject to the benefit descriptions and limitations contained in this "Rehabilitative Therapy Services" section. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Outpatient Rehabilitative Therapy Services

We cover outpatient rehabilitative therapy Services for the treatment of conditions which, in the judgment of the Participating Provider, will show sustainable, objective, measurable improvement as a result of the prescribed therapy. Prescribed outpatient therapy Services must receive prior authorization as described under "Prior Authorization Review Requirements" in the "How to Obtain Services" section.

The "Benefit Summary" shows a visit maximum for outpatient rehabilitative therapy Services. That visit maximum will be exhausted (used up) for the Year when the number of visits that we covered during the Year under this *EOC*, plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year. This limitation does not apply to inpatient hospital Services or to outpatient rehabilitative therapy Services to treat Behavioral Health Conditions covered under this *EOC*.

Outpatient Rehabilitative Therapy Services Limitations

- Physical therapy Services and occupational therapy Services are covered as Medically Necessary to restore or improve functional abilities when physical and/or sensory perceptual impairment exists due to injury, illness, stroke, or surgery.
- Speech therapy Services are covered as Medically Necessary for speech impairments of specific organic origin such as cleft palate, or when speech, language, or the swallowing function is lost due to injury, illness, stroke, or surgery.

Inpatient Rehabilitative Therapy Services

We cover inpatient rehabilitative therapy Services for the treatment of conditions which, in the judgment of a Participating Provider, will show sustainable, objective, measurable improvement as a result of the prescribed therapy. Prescribed inpatient therapy Services must receive prior authorization as described under "Prior Authorization Review Requirements" in the "How to Obtain Services" section.

Rehabilitative Therapy Services Exclusions

- Services designed to maintain optimal health in the absence of symptoms.

Services Provided in Connection with Clinical Trials

We cover routine costs of Medically Necessary conventional Services you receive in connection with a clinical trial if all of the following conditions are met:

- We would have covered the Services if they were not related to a clinical trial.

- You are eligible to participate in the clinical trial according to the trial protocol, as determined in one of the following ways:
  - A Participating Provider makes this determination.
  - You provide us with medical and scientific information establishing this determination.
  - If any Participating Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where you live.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial, and it meets one of the following requirements:
  - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
  - The study or investigation is a drug trial that is exempt from having an investigational new drug application.
  - The study or investigation is approved or funded by at least one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
      - It is comparable to the National Institutes of Health system of peer review of studies and investigations.
      - It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Inpatient Hospital Services" in the "Benefit Summary" for the Cost Share that applies to hospital inpatient care.

Services Provided in Connection with Clinical Trials Exclusions

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in your direct clinical management.
- Services required solely for the clinically appropriate monitoring of the Service being tested in the clinical trial.
- Services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial.

- Services that would not be covered outside of the clinical trial.

Skilled Nursing Facility Services

We cover skilled inpatient Services in a licensed Participating Skilled Nursing Facility, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the facility. The skilled inpatient Services must be those customarily provided by Participating Skilled Nursing Facilities. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

When your benefit has a day maximum, the "Benefit Summary" shows a day maximum for skilled nursing facility Services. That day maximum will be exhausted (used up) for a Year when the number of days that we covered during the Year under this *EOC*, plus any days we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the day maximum. After you reach the day maximum, we will not cover any more days for the remainder of the Year.

We cover the following:

- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Dialysis Services.
- DME Services.
- Habilitative Services.
- Medical and biological supplies.
- Medical social Services.
- Nursing Services.
- Rehabilitative therapy Services.
- Room and board.

Substance Use Disorder Services

We cover Substance Use Disorder Services as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association, including medical treatment for withdrawal symptoms. Emergency detoxification for medical conditions associated with acute alcohol, drug, or other substance abuse is covered without prior authorization.

Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request the criteria by calling Member Services.

The benefits described in this "Substance Use Disorder Services" section comply with the Mental Health Parity and Addiction Equity Act.

Outpatient Services for Substance Use Disorder

Covered Services include:

- Individual office visits.
- Group therapy visits.
- Court-ordered screening interviews or treatment programs for a Member convicted of driving under the influence of intoxicants (DUII).

Inpatient Hospital Services for Substance Use Disorder

We cover inpatient hospital Services for Substance Use Disorder, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the inpatient facility.

Residential Services

We cover residential Services in a residential program, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the residential facility.

Day Treatment Services

We cover day treatment Services in a day treatment program.

Telemedicine Services

Telemedicine is a means of delivering health care Services using information and telecommunication technologies to provide consultation and education, or to facilitate diagnosis, treatment, care management or self-management of your health care.

We cover telemedicine Services at the applicable "Telemedicine Services" Cost Share shown in your "Benefit Summary" if:

- The Service is otherwise covered under this EOC if received in person;
- The Service is Medically Necessary;
- The Service is determined to be safely and effectively provided using telemedicine, according to generally accepted health care practices and standards; and
- The application and technology used to provide the Service meets all standards required by state and federal laws governing the privacy and security of protected health information.

During a state of emergency, we will cover telemedicine provided to Members residing in the geographic area specified in the declaration of the state of emergency, if the telemedicine Service is delivered using any commonly available technology, regardless of whether the technology meets all standards required by state and federal laws governing the privacy and security of protected health information.

Covered telemedicine applications and technologies may include:

- Landlines, wireless communications, internet and telephone networks; and
- Synchronous or asynchronous transmission using audio only, video only, audio and video and transmission of data from remote monitoring devices.

You may choose to receive a covered health Service in person or via telemedicine. You are not required to have an established patient-provider relationship with a Participating Provider to receive telemedicine Services from the provider.

Telephone and Video Visits

We cover scheduled telephone visits and video visits.

If you have a minor condition that does not require an in-person medical exam, you have the option to schedule a telephone visit. If you prefer to meet face-to-face with a provider online by computer, smartphone or tablet, you may set up a video visit just as you would with an in-person appointment.

Telephone visits and video visits are appropriate for routine care such as medication management and test results; and urgent care such as cough, cold, flu, bug bite, fever, earache, minor sprain, urinary tract infection, wounds or burns. Video visits are also appropriate for specialty care such as post-op follow-up, behavioral health appointments, dermatology and speech therapy.

To schedule a telephone visit or video visit, sign on to **kp.org** or the Kaiser Permanente app, then select "Appointments" or call Member Services.

E-Visits

We cover e-visits for common conditions such as cough/cold, nausea/vomiting, pink eye, urinary tract infection, sore throat, sinus problems, constipation or diarrhea. To access an e-visit, log in to your **kp.org** member account on your desktop, laptop, or tablet and fill out a questionnaire about your symptoms. A nurse will get back to you with a care plan, usually within six hours. If needed, a prescription may be sent to your pharmacy. E-visits may include secure chat instant messaging.

To learn more about telephone, video and e-visits, including a short instructional video and troubleshooting tips, visit **kp.org/telehealth/northwest**.

Transplant Services

We cover inpatient and outpatient Services for the transplants listed in this "Transplant Services" section. These Services are covered only when received from Participating Providers and Participating Facilities, and only at National Transplant Network facilities we designate. Services are subject to Utilization Review criteria developed by Medical Group and approved by Company.

You pay the applicable Cost Share you would pay if the Services were not related to a transplant. Inpatient Services associated with a covered transplant are covered at the "Inpatient Hospital Services" Cost Share shown on your "Benefit Summary." Outpatient Services associated with a covered transplant are covered at the applicable Cost Share shown on your "Benefit Summary" for the corresponding benefit, for example, "Outpatient Services," "Outpatient Durable Medical Equipment," and "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."

A National Transplant Network facility is a transplant facility that meets all of the following requirements:

- It is licensed in the state where it operates.
- It is certified by Medicare as a transplant facility for the specific transplant.
- It is designated by Company as a transplant facility for the specific transplant.
- It is able to meet reasonable access standards for organ transplants based on Regional Organ Procurement Agency statistics for the facility location (a Regional Organ Procurement Agency is the geographic area designated by a state-licensed organ procurement organization for transplants in the state of Oregon).

We cover only the following transplants at National Transplant Network facilities:

- Bone marrow.
- Cornea.
- Heart.
- Heart-lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas after kidney.
- Simultaneous kidney-pancreas.
- Small bowel.

- Small bowel/liver.
- Stem cell.

Transplant Services Limitations

After the referral to a transplant facility, the following apply:

- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made.
- Company, Participating Hospitals, Medical Group, and Participating Providers are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.
- We provide or pay for certain donation-related Services for a donor, or an individual identified by Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for coverage of Services for living transplant donors are available by calling Member Services.
- If we refer you for or preauthorize transplant Services at a distant location (farther away than the normal community patterns of care) and you choose to obtain your transplant at this distant location, we cover appropriate travel and lodging expenses for you and a caregiver. Your transplant coordinator can provide information about covered expenses.

Transplant Services Exclusions

- Non-human and artificial organs and tissues, and their implantation.

EXCLUSIONS AND LIMITATIONS

The Services listed in this "Exclusions and Limitations" section are either completely excluded from coverage or partially limited under this *EOC*. These exclusions and limitations apply to all Services that would otherwise be covered under this *EOC* and are in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in this *EOC*.

Acupuncture. Services for acupuncture are excluded unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred acupuncture Services.

Certain Exams and Services. Physical examinations and other Services are excluded when: (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or governmental licensing, or (c) court ordered or required for parole or probation. This exclusion does not apply to Medically Necessary court-ordered Services that are covered under "Substance Use Disorder Services" or "Behavioral Health Services" in the "Benefits" section.

Chiropractic Services. Chiropractic and related Services are excluded, unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred chiropractic Services.

Cosmetic Services. Services that are intended primarily to change or maintain your appearance and will not result in significant improvement of the condition being treated. This exclusion does not apply to Medically Necessary Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section, Gender Affirming Treatment, or any other Services that are Medically Necessary.

Custodial Care. Assistance with activities of daily living (such as walking, getting in and out of a bed or chair, bathing, dressing, eating, using the toilet, and taking medicine) or personal care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure, certification, or the presence of a supervising licensed nurse.

Dental Services. This exclusion does not apply to Services that are covered under "Limited Dental Services" in the "Benefits" section.

Designated Blood Donations. Collection, processing, and storage of blood donated by donors whom you designate, and procurement and storage of cord blood is covered only when Medically Necessary for the imminent use at the time of collection for a designated recipient.

Employer Responsibility. We do not reimburse the employer for any Services that the law requires an employer to provide. When we cover any of these Services we may recover the Charges for the Services from the employer.

Experimental or Investigational Services. Services are excluded if any of the following is true about the Service:

- They cannot be legally marketed in the United States without the approval of the U.S. Food and Drug Administration (FDA), and the FDA has not granted this approval.
- They are the subject of a current new drug or new device application on file with the FDA.
- They are provided as part of a Phase I, Phase II, or Phase IV clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Services.
- They are provided pursuant to a written protocol or other document that lists an evaluation of the Services' safety, toxicity, or efficacy as among its objectives.
- They are subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of Services.
- They are provided pursuant to informed consent documents that describe the Services as experimental or investigational, or in other terms that indicate that the Services are being evaluated for their safety, toxicity, or efficacy.
- The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:
    - Use of the Services should be substantially confined to research settings, or
    - Further research is necessary to determine the safety, toxicity, or efficacy of the Services.

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

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

We consult Medical Group and then use the criteria described above to decide if a particular Service is experimental or investigational.

This exclusion does not apply to Services that we cover under "Services Provided in Connection with Clinical Trials" in the "Benefits" section of this *EOC*.

Eye Surgery. Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.

Family Services. Services provided by a member of your immediate family.

Genetic Testing. Genetic testing and related Services are excluded except as described under "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" in the "Benefits" section.

Government Agency Responsibility. We do not reimburse the government agency for any Services that the law requires be provided only by or received only from a government agency. When we cover any of these Services, we may recover the Charges for the Services from the government agency. However, this exclusion does not apply to Medicaid.

Hearing Aids. Hearing aids, tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid are excluded, unless your Group has purchased the "Hearing Aid Rider." This exclusion does not apply to Services that are covered under "Hearing Aids and Other Hearing Devices" in the "Benefits" section.

Hypnotherapy. All Services related to hypnotherapy.

Intermediate Services. Services in an intermediate care facility are excluded.

Low-Vision Aids. Low-vision aids are excluded, unless your employer Group has purchased the "Pediatric Vision Hardware and Optical Services Rider" or "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider."

Massage Therapy Services. Massage therapy and related Services are excluded, unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred massage therapy Services.

Non-Medically Necessary Services. Services that are not Medically Necessary.

Nonreusable Medical Supplies. Nonreusable medical supplies, such as splints, slings, and wound dressing, including bandages and ace wrap bandages, are limited to those supplied and applied by a licensed health care provider, while providing a covered Service. Nonreusable medical supplies that a Member purchases or obtains from another source are excluded.

Optometric Vision Therapy and Orthoptics (Eye Exercises). Services related to optometric vision therapy and orthoptics (eye exercises) are excluded.

Professional Services for Evaluation, Fitting, and Follow-Up Care for Contact Lenses. This exclusion does not apply to Services that are covered under the "Pediatric Vision Hardware and Optical Services Rider" or "Adult Vision Hardware and Optical Services Rider," if purchased by your Group.

Services Related to a Non-Covered Service. When a Service is not covered, all Services related to the non-covered Service are also excluded. However, this exclusion does not apply to Services we would otherwise cover if they are to treat complications which arise from the non-covered Service and to Medically Necessary Services for a Member enrolled in and participating in a qualifying clinical trial if we would typically cover those Services absent a clinical trial.

Services That are Not Health Care Services, Supplies, or Items. This exclusion does not apply to Medically Necessary applied behavior analysis (ABA) Services. For example, we do not cover:

- Teaching manners and etiquette.
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning.

- Items and services that increase academic knowledge or skills.
- Teaching and support services to increase intelligence.
- Academic coaching or tutoring for skills such as grammar, math, and time management.
- Teaching you how to read, whether or not you have dyslexia.
- Educational testing.
- Teaching art, dance, horse riding, music, play or swimming.
- Teaching skills for employment or vocational purposes.
- Vocational training or teaching vocational skills.
- Professional growth courses.
- Training for a specific job or employment counseling.
- Aquatic therapy and other water therapy.

Supportive Care and Other Services. Supportive care primarily to maintain the level of correction already achieved; care primarily for the convenience of the Member; and care on a non-acute, symptomatic basis are excluded.

Surrogacy. Services for anyone in connection with a Surrogacy Arrangement, whether traditional or gestational, except for otherwise-covered Services provided to a Member who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. See "Surrogacy Arrangements – Traditional and Gestational Carriers" in the "Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and Lodging. Transportation or living expenses for any person, including the patient, are limited to travel and lodging expenses needed for Member to receive covered Services at Non-Participating Facilities, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Travel Immunizations. Travel-related immunizations for yellow fever, typhoid, and Japanese encephalitis, unless your Group has purchased a "Travel Immunizations Rider."

Vision Hardware and Optical Services. Corrective lenses, eyeglasses, and contact lenses are excluded, unless your Group has purchased an "Adult Vision Hardware and Optical Services Rider" and/or "Pediatric Vision Hardware and Optical Services Rider" or "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider."

REDUCTIONS

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable expense.

Definitions

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

(1) Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, group or individual closed panel Plans, other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; Medicare or any other federal governmental Plan, as permitted by law; and group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

(2) Plan does not include: independent, non-coordinated hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100 percent of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of Services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement

methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary plan.

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Plan covering the Custodial parent;
2. The Plan covering the spouse of the Custodial parent;
3. The Plan covering the non-custodial parent; and then
4. The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(d) For a dependent child:

(i) Who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent and the dependent's spouse.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as

a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel Plan, COB shall not apply between that Plan and other Closed panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

Hospitalization on Your Effective Date

If you are an inpatient in a hospital on your membership effective date but had other Group coverage on the day before your membership effective date, your other Group coverage will be responsible for covering the Services you receive until you are released from the hospital, or until you have exhausted your benefit with the other Group coverage and the benefits available under this Plan will be reduced accordingly.

Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance

This "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section applies if you receive covered Services for an injury or illness alleged to be any of the following:

- Caused by another party's act or omission.
- Received on the premises of another party.
- Covered by a no-fault insurance provision.

For purposes of this section, "no-fault insurance" means a type of insurance policy that covers your medical expenses for injury or illness due to an accident, regardless of who caused the accident.

Subject to applicable law, if you obtain a settlement, award, or judgment from or on behalf of another party or insurer, or a payment under a no-fault insurance provision, you must ensure we are reimbursed for covered Services that you receive for the injury or illness.

This "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section does not affect your obligation to pay any applicable Cost Share for these covered Services. The amount of reimbursement due to the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

If you do not recover anything from or on behalf of the other party, or no-fault insurance, then you are responsible only for any applicable Cost Share.

To the extent permitted by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party, or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by another party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant covered Services.

To secure our rights, we will have a lien on the proceeds of any judgment, award, or settlement you or we (when we subrogate) obtain against another party, or any other insurer, regardless of how those proceeds may be characterized or designated. Subject to applicable law, the proceeds of any judgment, award, or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against another party, or any insurer, you must send written notice of the claim or legal action to us at:

The Phia Group, LLC
40 Pequot Way
Canton, MA 02021
Fax: 781-848-1154

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

You must provide us written notice before you settle a claim or obtain a judgment or award, or if it appears you will make a recovery of any kind. Subject to applicable law, if you recover any amounts from another party or any other insurer based on your injury or illness, you must pay us after you are reimbursed the total amount of the actual losses and damages you incurred. Sufficient funds to satisfy our claims must be held in a specifically identifiable account until our claims are resolved. Pending final resolution of our claims, you must retain control over the recovered amounts to which we may assert a right.

If reasonable collections costs have been incurred by your attorney in connection with obtaining recovery, we will reduce the amount of our claim by the amount of an equitable apportionment of the collection costs between us and you. This reduction will be made only if:

- We receive a list of the fees and associated costs before settlement, and
- Your attorney's actions were directly related to securing a recovery for you.

In addition to the rights set forth above, we shall also be entitled to all of the remedies, benefits, and other rights of sections 742.520 – 742.544, Oregon Revised Statutes.

If your estate, parent, guardian, or conservator asserts a claim against another party or any insurer based on your injury or illness, any settlement or judgment recovered shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

Surrogacy Arrangements – Traditional and Gestational Carriers

If you enter into a Surrogacy Arrangement, whether traditional or gestational, you must ensure we are reimbursed for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount we collect will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.

This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and includes both traditional surrogacy and gestational carriers. Note: This "Surrogacy Arrangements – Traditional and Gestational Carriers" section does not affect your obligation to pay any applicable Cost Share, or other amounts you are required to pay for these Services. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

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

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee

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

You must send this information to:

Surrogacy Other Party Liability Supervisor
Equian
P.O. Box 36380
Louisville, KY 40233-6380
Fax: 1-502-214-1137
Phone: 1-800-552-8314

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

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement, award, or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against that party. We may assign our rights to enforce our liens and other rights.

Workers' Compensation or Employer's Liability

If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services even if it is unclear whether you are entitled to a payment or settlement under the law. You have an obligation to reimburse us to the extent of a payment or any other benefit, including any amount you receive as a settlement under the law.

In addition, we or our Participating Providers will be permitted to seek reimbursement for these Services directly from the responsible employer or the government agency that administers the law.

GRIEVANCES, CLAIMS, APPEALS, AND EXTERNAL REVIEW

Important Information for Members Whose Benefit Plans are Subject to ERISA.

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates employee benefits, including the claim and appeal procedures for benefit plans offered by certain employers. If an employer's benefit plan is subject to ERISA, each time you request Services that must be approved before the Service is provided, you are filing a "pre-service claim" for benefits. You are filing a "post-service claim" when you ask us to pay for or cover Services that have already been received. You must follow our procedure for filing claims, and we must follow certain rules established by ERISA for responding to claims.

Terms We Use in This Section

The following terms have the following meanings when used in this "Grievances, Claims, Appeals, and External Review" section:

- A claim is a request for us to:
  - Provide or pay for a Service that you have not received (pre-service claim);

- Continue to provide or pay for a Service that you are currently receiving (concurrent care claim); or
- Pay for a Service that you have already received (post-service claim).

- An adverse benefit determination is our decision to deny, reduce or terminate a Service, or failure or refusal to provide or to make a payment in whole or in part for a Service that is based on:
  - Denial or termination of enrollment of an individual in a health benefit plan;
  - Rescission or cancellation of a policy;
  - Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered Services;
  - Determination that a Service is experimental or investigational or not Medically Necessary or appropriate; or
  - Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care; or
  - Denial, in whole or in part, of a request for prior authorization, a request for an exception to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to Utilization Review requirements.
- A grievance is communication expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:
  - In writing, for an internal appeal or an external review;
  - In writing or orally for an expedited response or an expedited external review; or
  - A complaint regarding the:
    - Availability, delivery, or quality of a Service;
    - Claims payment, handling or reimbursement for Services and, unless a request for an appeal has not been submitted, the complaint is not disputing an adverse benefit determination; or
    - Matters pertaining to the contractual relationship between the Member and Company.
- An internal appeal is a request for us to review our initial adverse benefit determination.

Member Satisfaction Procedure

We want you to be satisfied with the Services you receive from Kaiser Permanente. We encourage you to discuss any questions or concerns about your care with your provider or another member of your health care team. If you are not satisfied with your provider, you may request another. Contact Member Services for assistance. You always have the right to a second opinion from a qualified provider at the applicable Cost Share.

If you are not satisfied with the Services received at a particular medical office, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by following one of the procedures listed below:

- Call Member Services; or

- Send your written complaint to Member Relations at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

All complaints are handled in a confidential manner.

After you notify us of a complaint, this is what happens:

- A representative reviews the complaint and conducts an investigation, verifying all the relevant facts.
- The representative or a physician evaluates the facts and makes a recommendation for corrective action, if any.
- When you file a complaint, we will respond within 30 calendar days.

We want you to be satisfied with our facilities, Services, and providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know.

Language and Translation Assistance

If we send you grievance or adverse benefit determination correspondence, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-324-8010. The notice of language assistance "Help in Your Language" is also included in this *EOC*.

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative, an individual who by law or by your consent may act on your behalf. You must make this appointment in writing. Contact Member Services for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

While you are encouraged to use our appeal procedures, you have the right to file a complaint or seek other assistance from the Consumer Advocacy Section of the Division of Financial Regulation. Contact them by mail, email, telephone, fax, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
Email: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll-Free: 1-888-877-4894
Fax: 503-378-4351
https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

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 (including

complete medical necessity criteria, benefit provisions, guidelines, or protocols) used to make a denial determination. 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 Member Services.

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 mail or fax all additional information to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

To arrange to give testimony by telephone, you should contact Member Services.

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

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue another 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.

Internal Claims and Appeals Procedures

Company will review claims and appeals, and we may use medical experts to help us review them.

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this "Internal Claims and Appeals Procedures" section:

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

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will they be the subordinate of someone who did participate in our original decision.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur (urgent pre-service appeal and urgent concurrent appeal), you must exhaust the internal claims and appeals procedures described below before initiating an external review.

Pre-service Claims and Appeals

Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of the 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 contact Member Services.

Here are the procedures for filing a non-urgent pre-service claim, an urgent pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

Non-Urgent Pre-service Claim

- You may request a pre-service benefit determination on your own behalf. Tell us in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You may email your request to us at **https://healthy.kaiserpermanente.org/oregon-washington/support**, mail or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Attn: Utilization Management
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-877-899-4972

- 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. 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 or health, the life or health of a fetus, or your ability to regain maximum function; (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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

- 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 no later than two business days after we receive your claim.

  We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial decision period.

  If more information is needed to make a decision, we will ask you for the information in writing within two business days after we receive your claim, and we will give you 15 calendar days to send the information.

  We will make a decision and send notification within two business 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 15 calendar days after we send our request, we will make a decision based on the information we have no later than 15 calendar days following the date the additional information was requested.

If we notify you of our decision orally, we will send you written confirmation no later than two business days after the oral notification.

- We will send written notice of our decision to you and, if applicable, to your provider.

Urgent Pre-service Claim

- 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 no later than two business days after we receive your claim.
- We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial decision period.
- If more information is needed to make a decision, we will ask you for the information in writing within 2 business days after we receive your claim, and we will give you 15 calendar days to send the information.
- We will make a decision and send notification within two business 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 15 calendar days after we send our request, we will make a decision based on the information we have no later than 15 calendar days following the date the additional information was requested.

  If we notify you of our decision orally, we will send you written confirmation no later than two business days after the oral notification.
- If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Pre-service Appeal

- Within 180 calendar 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 health 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 determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

- We will acknowledge your appeal in writing within five calendar days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 30 calendar days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Urgent Pre-service Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following:

  (1) Your name and health 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 determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must call Member Services, mail, or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239
- When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section), if our internal appeal decision is not in your favor.
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function; (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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and give you oral or written notice of our decision 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 three calendar days after the oral notification.

- 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, which may be available to you.

Concurrent Care Claims and Appeals

Concurrent care claims are requests that Company continues to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call Member Services.

Unless you are appealing an urgent care claim, 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 Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then you will have to pay for the Services that we decide are not covered.

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

Non-Urgent Concurrent Care Claim

- Tell us 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 call Member Services, mail, or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Attn: Utilization Management
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-877-899-4972

- If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your authorized care ends, you may request that we review your concurrent care claim on an urgent basis. We will decide whether your claim is urgent or non-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 or health, the life or health of a fetus, or your ability to regain maximum function; (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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

- 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 authorized 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 no later than 15 calendar days after we receive your claim.

  We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we send you notice before the initial decision period ends.

If more information is needed to make a decision, we will ask you for the information in writing before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 calendar days to send us the information.

We will make our decision as soon as possible if your care has not ended, or within 15 calendar 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 45 calendar days after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 calendar 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.

Urgent Concurrent Care Claim

- If we consider your concurrent care claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 24 hours after we receive your claim. If we notify you of our decision orally, we will send you written confirmation within three calendar days after the oral notification.
- If more information is needed to make a decision, we will give you seven calendar days to send the information.
- We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.

  We will notify you of our decision within 48 hours of receiving the first piece of requested information or by the deadline for receiving the information, whichever is sooner.
- If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Concurrent Care Appeal

- Within 180 calendar 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 health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The ongoing course of covered treatment that you want to continue or extend;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and all supporting documents constitute your appeal. You must mail or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239
- We will fully and fairly review all available information relevant to your appeal without deferring to

prior decisions.

- We will review your appeal and send you a written decision as soon as possible if your care has not ended but no later than 30 calendar days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, which may be available to you.

Urgent Concurrent Care Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent care claim. Please include the following:

  (1) Your name and health record number;

  (2) Your medical condition or relevant 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 call Member Services, mail, or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

- When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section).
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function; (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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- 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 three calendar days after the oral notification.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

Post-service Claims and Appeals

Post-service claims are requests that we pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call Member Services.

Here are the procedures for filing a post-service claim and a post-service appeal:

Post-service Claim

- Within 12 months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following:

  (1) The date you received the Services;

  (2) Where you received them;

  (3) Who provided them;

  (4) Why you think we should pay for the Services; and

  (5) A copy of the bill and any supporting documents, including medical records.

  Your letter and the related documents constitute your claim. You may contact Member Services to obtain a claim form. You must mail your claim to the Claims Department at:

  Kaiser Foundation Health Plan of the Northwest
  National Claims Administration – Northwest
  PO Box 370050
  Denver, CO 80237-9998

- We will not accept or pay for claims received from you after 12 months from the date of Service, 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 calendar days after we receive your claim.

  We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you within 30 calendar days after we receive your claim.

  If more information is needed to make a decision, we will ask you for the information before the initial decision period ends, and we will give you 45 calendar days to send us the information.

  We will make a decision within 15 calendar 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 calendar days after we send our request, we will make a decision based on the information we have within 15 calendar days following the end of the 45 calendar-day period.

- If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Post-service Appeal

- Within 180 calendar 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 health record number;

(2) Your medical condition or relevant symptoms;

(3) The specific 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 or fax your appeal to us at:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

- We will acknowledge your appeal in writing within five calendar days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 30 calendar days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

External Review

If you are dissatisfied with our final adverse benefit determination, you have a right to request an external review. An external review is a request for an independent review organization (IRO) to determine whether our internal appeal decision is correct. For example, you have the right to request external review of an adverse decision that is based on any of the following:

- Relies on medical judgment, including but not limited to, medical necessity, appropriateness, health care setting, level of care, or that the requested Service is not efficacious or otherwise unjustified under evidence-based medical criteria.
- Concludes that a treatment is experimental or investigational.
- Whether a course or plan of treatment is an active course of treatment for purposes of continuity of care when a Participating Provider's contract with us is terminated.
- Whether an exception to the prescription drug formulary or step therapy prescribing criteria should be granted.
- Concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or Substance Use Disorder) benefits.
- Involves consideration of whether we are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130).
- Involves a decision related to rescission of your coverage.

You must exhaust our internal claims and appeals procedure for your claim before you may request external review unless one of the following is true:

- External review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal;
- Your request qualifies for expedited external review;
- We have failed to comply with federal requirements regarding our claims and appeals procedures.

You are not responsible for the costs of the external review, and you may name someone else to file the request for external review for you if you give permission in writing and include that with your request for external review. Company will be bound by and act in accordance with the decision of the independent review organization (IRO) notwithstanding the definition of Medically Necessary care. If we do not follow a decision of an IRO, you have the right to sue us.

Within 180 calendar days after the date of our appeal denial letter you must send your request for external review to Member Relations in writing (via mail, fax, or online through our website at **kp.org**). If you wish to mail or fax your request, you may send it to us at:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

You may be required to provide us with a signed waiver form that enables us to disclose your protected health information, including pertinent medical records, to the IRO that will evaluate your request. The "Authorization for Use or Disclosure of Protected Health Information" form is also available at **info.kaiserpermanente.org/northwest/roi/forms.html**.

The appeal denial letter that we send to you explains the external review process and includes the waiver form. Member Relations will forward your request to the director of the Oregon Department of Consumer and Business Services (DCBS), Division of Financial Regulation (DFR), within two business days after receiving your request. Your request for external review will be assigned to one of the nationally accredited IROs contracted by DCBS no later than the next business day after the director receives your request for external review from us.

Within two business days of receiving notice of your request, DCBS will send you a written description of the IRO they selected along with more information about the process. They will also notify us of the IRO they selected, and within five business days after receiving notification from DCBS, we will send the IRO any documents and information we considered in making our adverse benefit determination.

You will have five business days to submit to the IRO, in writing, any additional information that the IRO must consider when conducting the external review. The IRO will forward to us any additional information you submit within one business day of receipt. We may also forward additional information directly to the IRO. The IRO will have one business day after receiving the additional information to forward that information to you.

Unless your external review is expedited, the IRO will issue a decision within 30 calendar days after the date when we receive your request for external review. The IRO will notify you and us of its decision no later than five calendar days after the decision is issued.

You may also contact DCBS directly to request an external review. If DCBS receives a request for external review directly from you, they will notify us of your request no later than the next business day. Upon receipt of your request from DCBS, we will follow the process described above. You may contact the Oregon DCBS by mail, e-mail, telephone, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
E-mail: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll-Free: 1-888-877-4894
https://dfr.oregon.gov/help/Pages/index.aspx

Expedited External Review

We shall expedite the external review if:

- The adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care Service for a medical condition for which you received Emergency Services and you have not been discharged from a health care facility; or
- A provider you have an established relationship with certifies in writing and provides supporting documentation that the ordinary time period for external review would (a) seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function; (b) 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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures. 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.

TERMINATION OF *AGREEMENT*

If the *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination no later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

TERMINATION OF MEMBERSHIP

If your membership terminates, all rights to benefits end at 11:59 p.m. PT on the termination date. In addition, Dependents' memberships end at the same time the Subscribers' membership ends.

You will be billed as a non-member for any Services you receive after your membership terminates. Company and Participating Providers and Participating Facilities have no further liability or responsibility under this *EOC* after your membership terminates.

Termination During Confinement in a Hospital

If you are hospitalized on the date when your membership terminates, we will continue to cover otherwise covered Services in that hospital if all of the following conditions are met:

- The coverage under this *EOC* is being immediately replaced by another insured group health insurance policy.
- You are an inpatient receiving covered Services on the date your membership ends.
- You must continue to pay any applicable Cost Share.

Your coverage under this provision continues until the earlier of:

- Your discharge from the hospital or
- Your exhaustion of hospital benefits under this *EOC*.

Termination Due to Loss of Eligibility

You and your Dependents must remain eligible to maintain your Group coverage. You must immediately report to your Group any changes in eligibility status, such as a Spouse's loss of eligibility due to divorce or a Dependent child who has reached the Dependent Limiting Age. If you no longer meet the eligibility requirements described in this *EOC*, please confirm with your Group's benefits administrator when your membership will end.

Termination for Cause

If you or any other Member in your Family knowingly commits fraud in connection with membership, Company, or a Participating Provider, we may terminate your membership under this employer's *Agreement* by sending written notice, including the specific reason for termination with supporting evidence to the Subscriber at least 31 days before the membership termination date. Some examples of fraud include:

- Misrepresenting eligibility information about yourself or a Dependent.
- Presenting an invalid prescription or physician order for Services.
- Intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services pretending to be you).
- Giving us incorrect or incomplete material information.
- Failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

We may report fraud and other illegal acts to the authorities for prosecution.

If we terminate your membership for cause, we will:

- Refund any amounts we owe your Group for Premium paid for the period after the termination date.
- Pay you any amounts we have determined that we owe you for claims during your membership.

We may deduct any amounts you owe Company, Participating Providers, or Participating Facilities from any payment we make to you.

If your coverage is terminated for any of the above reasons, you have the right to file an appeal. For more information, please contact Member Services.

Termination of Your Group's *Agreement* with Us

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. We require the Group to notify Subscribers in writing if the *Agreement* with us terminates.

Termination of Certain Types of Health Benefit Plans by Us

We may terminate a particular Plan or all Plans offered in the group market as permitted by law. If we discontinue offering a particular Plan in the group market, we will terminate the particular Plan upon 90 days prior written notice to you. If we discontinue offering all Plans in the group market, we may terminate the *Agreement* upon 180 days prior written notice to you.

CONTINUATION OF MEMBERSHIP

Strike, Lock-Out, or Other Labor Disputes

If your compensation is suspended directly or indirectly as a result of a strike, lock-out, or other labor dispute, you may continue membership under this *EOC* by paying Premium for yourself and eligible Dependents directly to the Group for up to six months. If the Group's coverage is terminated by Company, reinstatement with Company is subject to all terms and conditions of your Group's *Agreement* with Company. When your Group continuation coverage under this *EOC* stops, you and your Dependents may be eligible to purchase an individual plan offered by Company.

Illness, Temporary Plant Shut Down, or Leave of Absence

If you are off work due to illness, temporary plant shutdown, or other leave of absence authorized by your Group, you may make arrangements to make monthly payments through your Group for up to 12 weeks. The 12-week period may be extended by advance arrangements confirmed in writing by Company. Once the 12-week period is exhausted, you may also be eligible to convert to an individual plan. (See the "Conversion to an Individual Plan" section.)

Continuation of Group Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to most employees (and most of their covered dependents) of most employers with 20 or more employees (however, it does not apply to church plans as defined by federal law). Please contact your Group for details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group for the coverage.

Federal or State-Mandated Continuation of Coverage

Termination of coverage will be postponed if the Member is on a leave of absence and continuation of coverage is required by the federal or state-mandated family or medical leave act or law, as amended.

State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or Older

If your Group has 20 or more employees, you and your Dependents may be able to continue your coverage under this *EOC* through your Group if you meet all of the following criteria:

- You are the Subscriber's Spouse.
- You are age 55 or older.
- The Subscriber died, or you divorced or are legally separated from the Subscriber.
- You are not eligible for Medicare.

To continue coverage, you must notify Member Services in writing within 60 days after legal separation or divorce, or the Group must notify us in writing within 30 days after the death of the Subscriber. Within 14 days after we receive the notice, we will send you an election form, payment information, and instructions for

electing continuation coverage. You must return the completed election form no later than 60 days after the date we mailed it to you.

The first Premium payment must be paid within 45 days of your coverage election date. Your right to continue coverage as a surviving, separated, or divorced Spouse will end upon the earliest of the following events:

- You fail to pay your Premium.
- The Group's *Agreement* with us terminates.
- You become covered under another group health coverage.
- You, as a separated or divorced Spouse, remarry.
- You become eligible for Medicare.

State Continuation Coverage for Non-COBRA Groups

You may be able to continue coverage under this *EOC* for up to nine months if all of the following requirements are met:

- Your Group is not subject to COBRA law.
- The Subscriber in your Family was covered continuously under this *EOC* during the three-month period ending on the date of the qualifying event.
- You were covered under this *EOC* on the day before the qualifying event, or you are a child born to or adopted by the Subscriber while the Subscriber has continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section and you would have been covered under this *EOC* if you had been born or adopted on the day before the qualifying event. For the purposes of this "State Continuation Coverage for Non-COBRA Groups" section, "qualifying event" means the loss of membership under this *EOC* caused by one of the following:
  - Voluntary or involuntary termination of the employment of the Subscriber.
  - A reduction in hours worked by the Subscriber.
  - The Subscriber's becoming eligible for Medicare.
  - A Dependent's losing Dependent child status under this *EOC*.
  - Termination of membership in your Group resulting in loss of eligibility under the Group's evidence of coverage.
  - The death of the Subscriber.
- You are not eligible for Medicare, and you are not eligible for coverage under any other hospital or medical coverage or program that was not covering you on the day before the qualifying event.

To request continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section, you must send us a written request for this continuation coverage no later than 15 days after the later of the following:

- The date of your qualifying event.
- The date on which we sent you notice of your right to continue coverage under this *EOC*.

You must mail or fax your written request to us at:

Consolidated Service Center (CSC)
PO Box 23127
San Diego, CA 92193
Fax: 866-311-5974

Your Premium will be 100 percent of the applicable Premium. You must pay your first Premium payment to your Group within 31 days after the date of your qualifying event. Subsequent Premium payments are due on the last day of the month preceding the month of membership.

Continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section ends on the earliest of the following dates:

- The date that is nine months after your qualifying event.
- The end of the period for which we received your last timely Premium payment.
- The Premium due date coinciding with or next following the date that you become eligible for Medicare or for coverage under any other hospital or medical coverage or program that was not covering you on the day before the qualifying event.
- The date on which your Group's *Agreement* with us terminates.

If you are a surviving, divorced, or separated Spouse and are not eligible for continuation coverage under the "State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or Older" section you may continue coverage for yourself and your Dependents under this "State Continuation Coverage for Non-COBRA Groups" section under the same terms as the Subscriber.

If you are a Subscriber who is laid off and then rehired by the same employer within nine months and you were eligible for coverage at the time of the layoff, you may not be subjected to any waiting period even if you chose not to continue coverage under this "State Continuation Coverage for Non-COBRA Groups" section.

If your Group coverage was under another evidence of coverage on the date of your qualifying event and you later became covered under this *EOC*, you may be able to continue coverage under this *EOC* if you otherwise meet the eligibility requirements in this "State Continuation Coverage for Non-COBRA Groups" section. The period of state continuation coverage includes the number of months you were covered under the previous evidence of coverage plus the number of months of coverage under this *EOC*, not to exceed nine months.

State Continuation Coverage after Workers' Compensation Claim

If you are a Subscriber and you file a workers' compensation claim for an injury or illness, you may be able to continue coverage under this *EOC* for up to six months after you would otherwise lose eligibility. Please contact your Group for details such as how to elect coverage and how much you must pay your Group for the coverage.

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 *EOC* for a limited time after you would otherwise lose eligibility, if required by federal law (USERRA).

You must submit an USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage and how much you must pay your Group for the coverage.

Conversion to an Individual Plan

After your Group notifies us to terminate your membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Member. You may contact Member Services if you have questions.

Moving to Another Kaiser Foundation Health Plan Service Area

If you move to another Kaiser Foundation Health Plan service area, you should contact your Group's benefits administrator to learn about your Group health care options. You may be eligible to enroll in a plan in the other Kaiser Foundation Health Plan service area. Eligibility requirements, benefits, premium, deductible, copayments, and coinsurance may not be the same in the other service area.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Agreement Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to make revised materials available to you.

Annual Summaries and Additional Information

Additional information that we have filed with the Oregon Department of Consumer and Business Services (DCBS) is available to you upon request. You may contact the Oregon DCBS to request the following:

- Our annual summary of grievances and appeals.
- Our annual summary of the utilization management program.
- Our annual summary of quality assurance activities.
- The results of publicly available accreditation surveys of our health plan.
- Our annual summary of health-promotion and disease-prevention activities.
- An annual summary of scope of network and accessibility of Services.

Contact the Oregon DCBS by mail, e-mail, telephone, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
E-mail: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll-Free: 1-888-877-4894
https://dfr.oregon.gov/help/Pages/index.aspx

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*. In the absence of fraud, all statements made by an applicant, Group, or Subscriber shall be deemed representations and not warranties. No statement made for the purpose of effecting coverage shall void coverage or reduce benefits unless contained in a written instrument signed by the Group or Subscriber, a copy of which has been furnished to the Group or Subscriber.

Assignment

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

Attorney Fees and Expenses

In any dispute between a Member and Company or Medical Group or Kaiser Foundation Hospitals, each party will bear its own attorney fees and other expenses, except as otherwise required by law.

Exercise of Conscience

We recognize the right to exercise religious beliefs and conscience. If a Participating Provider or Participating Facility declines to provide a covered Service for reasons of conscience or religion, we will make arrangements to provide the covered Services.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with Oregon law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Company whether or not set forth in this *EOC*.

Group and Members not Company Agents

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

Information about New Technology

When a new medical technology or procedure needs review, our Inter-regional New Technology Committee examines and evaluates data from government agencies, medical experts, medical journals, and medical specialty societies. Recommendations from this inter-regional committee then are passed onto the local committee. The committee reviews the national recommendations to see how they apply to local medical practices. Once this review takes place, the committee makes recommendations for the new technology or procedure to become a covered benefit. In addition, the committee communicates practice guidelines to network providers and related health care providers. If the committee's recommendation is accepted, the new technology is added to the covered benefits, either immediately or when this contract renews.

No Waiver

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

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of race, ethnicity, nationality, actual or perceived gender, age, physical or mental disability, marital status, sexual orientation, genetic information, or religion.

Notices

We will send our notices to you to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives an overpayment, or from any person or organization obligated to pay for the Services.

Privacy Practices

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

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

You have the right to request that Kaiser Permanente send your PHI directly to you, and not to the Subscriber of your Plan. You have the right to tell us where you want us to redirect communications containing your PHI, including a different mailing address, email address or telephone number. To make a request for confidential communication, please call Member Services and ask for a "Confidential Communication Request" form. It may take up to 30 days from the date of receipt of the form for us to process your request.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices,* which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, please call Member Services. You can also find the notice on our website at **kp.org**.

Unusual Circumstances

In the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, labor disputes, disability of a large share of personnel at Participating Facilities, and complete or partial destruction of Participating Facilities, we will make a good faith effort to provide or arrange for covered Services within the limitations of available personnel and facilities. Kaiser Permanente shall have no other liability or obligation if covered Services are delayed or unavailable due to unusual circumstances.

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex,

gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Help in Your Language

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-800-813-2000**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-813-2000** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-813-2000**（TTY: **711**）まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-813-2000** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-813-2000** (TTY: **711**).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network and/or your plan does not cover out-of-network services.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than your in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. Your health plan coverage may not cover out-of-network services when you agree (consent) to receive services from the out-of-network providers.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service. Providers and facilities are not balance billing you when they seek to collect cost sharing or another amount that you agreed to pay or are required to pay under your plan for the services that they provided.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, or when an in-network provider is not available. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers and facilities.
  - Base what you owe the provider or facility (your cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or non-emergency services provided by certain out-of-network providers at an in-network facility toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed by a provider or facility, contact the federal government at **www.cms.gov/nosurprises/consumers** or by calling **1-800-985-3059**; or the Division of Financial Regulation, Department of Consumer and Business Services at **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx** or call **1-888-877-4894**.

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ALTERNATIVE CARE SERVICES RIDER

This rider is part of the *Evidence of Coverage (EOC)* to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Alternative Care Services Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*, unless otherwise indicated.

Alternative Care Services

We cover the self-referred alternative care Services described in this "Alternative Care Services Rider" when Services are received from a Participating Provider and provided as outpatient Services in the provider's office.

To locate a Participating Provider, visit **www.chpgroup.com**. The CHP Group is a Participating Provider we contract with to provide alternative care Services. If you need assistance searching for a Participating Provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

Benefits are subject to visit limits and applicable Cost Shares shown in the "Alternative Care Services Rider Benefit Summary."

Acupuncture Services

Acupuncturists influence the health of the body by the insertion of very fine needles. Acupuncture treatment is primarily used to relieve pain, reduce inflammation, and promote healing. Covered Services include:

- Evaluation and management.
- Acupuncture.
- Electro acupuncture.

Chiropractic Services

Chiropractic and manual manipulation of the spine, joints or soft tissue focuses on reducing pain and improving the function and structure of the body. It is a system of therapy that involves non-invasive care promoting science-based approaches to a variety of ailments. Covered Services include:

- Evaluation and management.
- Musculoskeletal treatments.
- Physical therapy modalities such as hot and cold packs.

When prescribed, X-ray procedures are covered as described in the "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" section in the "Benefits" section of the *EOC*.

Alternative Care Services Exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Laserpuncture.
- Nambudripad allergy elimination technique (NAET).
- Point injection therapy.
- Qi gong.

- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Alternative Care Services Rider Benefit Summary

	You Pay
Acupuncture Services (up to 20 visits per Year)	20% Coinsurance after Deductible
Chiropractic Services (up to 20 visits per Year)	20% Coinsurance after Deductible

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST OUTPATIENT PRESCRIPTION DRUG RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. This rider becomes part of the *EOC* "Benefits" section, except for the "Outpatient Prescription Drug Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." The provisions of the *EOC* apply to this entire rider.

Note: We also cover some outpatient drugs and supplies in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.

Covered Drugs and Supplies

We cover outpatient prescription drugs and supplies as described in this "Outpatient Prescription Drug Rider."

Covered drugs and supplies must be prescribed by a Participating Provider or any licensed dentist in accordance with our drug formulary guidelines.

You must obtain drugs and supplies at a Participating Pharmacy (including our Mail-Order Pharmacy). You may obtain a first fill of a drug or supply at any Participating Pharmacy. All refills must be obtained through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy), or at another Participating Pharmacy that we designate for covered refills. See your *Medical Facility Directory*, visit **kp.org**, or contact Member Services.

Cost Share for Covered Drugs and Supplies

When you get a prescription from a Participating Pharmacy, or order a prescription from our Mail-Order Pharmacy, you pay the applicable Cost Share as shown in the "Outpatient Prescription Drug Rider Benefit Summary." This applies for each prescription consisting of up to the day supply shown in the "Outpatient Prescription Drug Rider Benefit Summary."

Outpatient prescription drugs and supplies are subject to the applicable Cost Share until the medical Out-of-Pocket Maximum is met.

If Charges for the drug or supply are less than your Copayment, you pay the lesser amount.

When you obtain your prescription through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy) you may be able to use an approved drug manufacturer coupon as payment for your prescription Copayment or Coinsurance, after you satisfy your Plan's required Deductible. Drug manufacturer coupons cannot be used toward payment of the Deductible in this HSA-compatible high deductible health Plan.

If the coupon does not cover the entire amount of your Copayment or Coinsurance, you are responsible for the additional amount up to the applicable Copayment or Coinsurance as shown in the "Benefit Summary." When you use an approved coupon for payment of your Copayment or Coinsurance, the coupon amount will count toward the Out-of-Pocket Maximum. For more information about the Kaiser Permanente coupon program rules and limitations, please call Member Services or go to **kp.org/rxcoupons**.

Day Supply Limit

The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-day (or any other number of days) supply for you. When you pay the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary," you will receive the prescribed

supply up to the day supply limit. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantity that exceeds the day supply limit.

Medication Synchronization

Medication synchronization is the coordination of medication refills, if you are taking two or more medications for a chronic condition, so that your medications are refilled on the same schedule. You may request medication synchronization for a new prescription from the prescribing provider or a Participating Pharmacy who will determine the appropriateness of medication synchronization for the drugs being dispensed and inform you of the decision.

How to Get Covered Drugs or Supplies

Participating Pharmacies are located in many Participating Facilities. To find a Participating Pharmacy, please see your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Participating Pharmacies include our Mail-Order Pharmacy. This pharmacy offers postage-paid delivery to addresses in Oregon and Washington. Some drugs and supplies are not available through our Mail-Order Pharmacy, for example drugs that require special handling or refrigeration, or are high cost. Drugs and supplies available through our Mail-Order Pharmacy are subject to change at any time without notice.

If you would like to use our Mail-Order Pharmacy, call 1-800-548-9809 or order online at **kp.org/refill**.

Definitions

The following terms, when capitalized and used in this "Outpatient Prescription Drug Rider," mean:

- **Brand-Name Drug.** The first approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Generic Drug.** A drug that contains the same active ingredient as a Brand-Name Drug and is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent and having the same active ingredients(s) as the Brand-Name Drug. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.
- **Non-Preferred Brand-Name Drug.** A Brand-Name drug or supply that is not approved by Company's Regional Formulary and Therapeutics Committee and requires prior authorization for coverage.
- **Preferred Brand-Name Drug.** A Brand-Name drug or supply that Company's Regional Formulary and Therapeutics Committee has approved. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Specialty Drug.** A drug or supply, including many self-injectables as well as other medications, often used to treat complex chronic health conditions, is generally high cost, and is approved by the U.S. Food and Drug Administration (FDA). Specialty drug treatments often require specialized delivery, handling, monitoring, and administration.

About Our Drug Formulary

Our drug formulary is a list of drugs that our Regional Formulary and Therapeutics Committee has reviewed and approved for our Members and includes drugs covered under this rider. Drugs on the formulary have been approved by the FDA.

Our Regional Formulary and Therapeutics Committee is made up of Participating Physicians, other Participating Providers, and administrative staff. The committee chooses drugs for the formulary based on several factors, including safety and effectiveness as determined from a review of the scientific literature. They may not approve a drug if there is not enough scientific evidence that it is clinically effective. They may also exclude a drug if it does not have a clinical or cost advantage over comparable formulary drugs.

The Regional Formulary and Therapeutics Committee meets to review new drugs and reconsider drugs currently on the market. After this review, they may add drugs to the formulary or remove drugs from it. If a drug is removed from the formulary, you will need to switch to another comparable drug that is on the drug formulary, unless your old drug meets exception criteria. Refer to the "Drug Formulary Exception Process" in this rider for more information.

If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your Participating Provider or another member of your health care team.

Drugs on our formulary may move to a different drug tier during the Year. For example, a drug could move from the Non-Preferred Brand-Name Drug list to the Preferred Brand-Name Drug list. If a drug you are taking is moved to a different drug tier, this could change the Cost Share you pay for that drug.

To see if a drug or supply is on our drug formulary, or to find out what drug tier the drug is in, go online to **kp.org/formulary**. You may also call our Formulary Application Services Team (FAST) at 503-261-7900 or toll-free at 1-888-572-7231. If you would like a copy of our drug formulary or additional information about the formulary process, please call Member Services. The presence of a drug on our drug formulary does not necessarily mean that your Participating Provider will prescribe it for a particular medical condition.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider or any licensed dentist prescribes a drug or supply that our drug formulary does not list for your condition, if the law requires the item to bear the legend "Rx only." The exception process is not available for drugs and supplies that the law does not require to bear this legend, or for any drug or supply prescribed by someone other than a Participating Provider or any licensed dentist.

A Participating Provider or any licensed dentist may request an exception if they determine that the non-formulary drug or supply is Medically Necessary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests.

We will approve the exception if all of the following requirements are met:

- We determine that the drug or supply meets all other coverage requirements except for the fact that our drug formulary does not list it for your condition.
- Medical Group or a designated physician makes the following determinations:
    - The drug or supply is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs or supplies that our drug formulary lists for your condition.
    - Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug or supply. For this drug or supply, the Participating Pharmacy can provide a copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

If we approve an exception through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary."

If we do not approve the formulary exception request, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

Prior Authorization and Step Therapy Prescribing Criteria

Prior authorization is required when you are prescribed certain drugs or supplies before they can be covered. A Participating Provider may request prior authorization if they determine that the drug or supply is Medically

Necessary. Prescribing Participating Providers must supply to Company the medical information necessary for Company to make the prior authorization determination. Coverage for a prescribed drug or supply that is approved for prior authorization begins on the date Company approves the request.

Approved requests for prior authorization are binding on us for one year from the date that the treatment begins following our approval if the drug:

- Is prescribed as a maintenance therapy that is expected to last at least 12 months based on medical or scientific evidence;
- Continues to be prescribed throughout the 12-month period; and
- Is prescribed for a condition that is within the scope of use for the drug as approved by the FDA, or has been proven to be a safe and effective form of treatment for your medical condition based on clinical practice guidelines developed from peer-reviewed medical literature.

A list of those drugs and supplies that require prior authorization and the Utilization Review criteria we use are available online at **kp.org/formulary** or you may contact Member Services.

We apply step therapy prescribing criteria, developed by Medical Group and approved by Company, to certain drugs and supplies. The step therapy prescribing criteria require that you try a therapeutically similar drug (step 1) for a specified length of time before we will cover another drug (step 2) prescribed for the same condition. A list of drugs and supplies subject to step therapy prescribing criteria, and the requirements for moving to the next step drug, are available online at **kp.org/formulary** or you may contact Member Services.

Prior Authorization Exception Process

We have a process for you or your prescribing Participating Provider to request a review of a prior authorization determination that a drug or supply is not covered. This exception process is not available for drugs and supplies that the law does not require to bear the legend "Rx only."

Your prescribing Participating Provider may request an exception if they determine that the drug or supply is Medically Necessary. Prescribing Participating Providers must supply to the Participating Pharmacy the medical information necessary to review the request for exception. A coverage determination will be made within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests.

If the exception request is approved through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary."

If the exception request is not approved, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

Emergency Fill

For purposes of this section, "emergency fill" means a limited dispensed amount of the prescribed drug that allows time for the processing of a prior authorization request. You may have the right to receive an emergency fill of a prescription drug that requires prior authorization under the following circumstances:

- The Participating Pharmacy is unable to reach the Company's prior authorization department by phone, as it is outside the department's business hours; or
- The Participating Pharmacy is unable to reach the prescribing Participating Provider for full consultation, and
- Delay in treatment would result in imminent emergency care, hospital admission or might seriously jeopardize the life or health of the patient or others in contact with the patient.

An emergency fill must be received at a Participating Pharmacy and is subject to the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary." An emergency fill is limited to no more than a seven-day supply or the minimum packaging size available.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy Services. You also have the right to know what drugs are covered under this Plan and the limits that apply. If you have a question or a concern about your prescription drug benefits, please contact Member Services or visit us online at **kp.org**.

Medication Management Program

The Medication Management Program is available at no extra cost to Members who use Participating Pharmacies. The program's primary focus is on reducing cardiovascular risk by controlling lipid levels and high blood pressure. Providers, including pharmacists, nurse care managers, and other staff, work with Members to educate, monitor, and adjust medication doses.

Outpatient Prescription Drug Rider Limitations

- If your prescription allows refills, there are limits to how early you can receive a refill. In most cases, we will refill your prescription when you have used at least 70 percent of the quantity. Prescriptions for most controlled substances cannot be refilled early. Please ask your pharmacy if you have questions about when you can get a covered refill.
- The Participating Pharmacy may reduce the day supply dispensed at the applicable Cost Share to a 30-day supply in any 30-day period if it determines that the drug or supply is in limited supply in the market or for certain other items. Your Participating Pharmacy can tell you if a drug or supply you use is one of these items.
- For certain drugs or supplies we may limit the amount of a drug or supply that is covered for a specified time frame. Quantity limits are in place to ensure safe and appropriate use of a drug or supply. Drugs and supplies subject to quantity limits are indicated on our drug formulary, available at **kp.org/formulary**. You may also contact Member Services for more information.
- Not all drugs are available through mail order. Examples of drugs that cannot be mailed include controlled substances as determined by state and/or federal regulations, drugs that require special handling, and drugs affected by temperature.

Outpatient Prescription Drug Rider Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Brand-Name Drugs for which a Generic Drug is available, unless approved. Refer to the "Prior Authorization and Step Therapy Prescribing Criteria" section.
- Drugs prescribed for an indication if the FDA has determined that use of that drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Evidence Review Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs and supplies ordered from the Mail-Order Pharmacy to addresses outside of Oregon or Washington.

- Drugs and supplies that are available without a prescription, even if the non-prescription item is in a different form or different strength (or both), except that this exclusion does not apply to non-prescription drugs or supplies described under "Covered Drugs and Supplies" in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.
- Drugs, biological products, and devices that the FDA has not approved.
- Drugs and supplies to treat sexual dysfunction are excluded except for drugs that are FDA-approved to treat behavioral health symptoms of sexual dysfunction.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Internally implanted time-release drugs, except that internally implanted time-release contraceptive drugs are covered.
- Nutritional supplements.
- Outpatient drugs that require professional administration by medical personnel or observation by medical personnel during self-administration (refer instead to the "Limited Outpatient Prescription Drugs and Supplies" section).
- Replacement of drugs and supplies due to loss, damage, or carelessness. This exclusion does not apply to drugs used to treat Substance Use Disorder.

Outpatient Prescription Drug Rider Benefit Summary

Outpatient Prescription Drugs and Supplies	**Participating Pharmacies You Pay**
Generic Drugs	$10 for up to a 30-day supply after Deductible
Generic Drugs from our Mail-Order Pharmacy	$10 for up to a 30-day supply after Deductible $20 for a 31- to 90-day supply after Deductible
Preferred Brand-Name Drugs or supplies	30% Coinsurance up to $100 maximum for up to a 30-day supply after Deductible
Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	30% Coinsurance up to $100 maximum for up to a 30-day supply after Deductible 30% Coinsurance up to $200 maximum for a 31- to 90-day supply after Deductible
Non-Preferred Brand-Name Drugs or supplies	40% Coinsurance up to $350 maximum for up to a 30-day supply after Deductible
Non-Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	40% Coinsurance up to $350 maximum for up to a 30-day supply after Deductible 40% Coinsurance up to $700 maximum for a 31- to 90-day supply after Deductible
Specialty Drugs or supplies	30% Coinsurance up to $250 maximum for up to a 30-day supply after Deductible

Outpatient Prescription Drugs and Supplies	Participating Pharmacies You Pay
Blood glucose test strips	Subject to the applicable drug tier Copayment or Coinsurance
HIV post-exposure prophylaxis (PEP) drugs	$0 after Deductible
Self-administered chemotherapy medications used for the treatment of cancer	20% Coinsurance after Deductible or subject to the applicable drug tier Cost Share, whichever is less
Fertility drugs up to a $10,000 lifetime benefit maximum	20% Coinsurance for up to a 30-day supply after Deductible

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST HEARING AID RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Hearing Aid Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*. The hearing aid exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

Hearing aid Services covered under this "Hearing Aid Rider" are only for Members who are the Dependent Limiting Age and older, as shown in the "Benefit Summary." Dependents who are under the Dependent Limiting Age are not covered under this "Hearing Aid Rider," but are covered instead as described under "Hearing Aids and Other Hearing Devices" in the "Benefits" section of the *EOC*.

Hearing Aids

We cover prescription hearing aids, visits to determine the appropriate hearing aid model, visits to verify that the hearing aid conforms to the prescription, and visits for fitting, counseling, adjustment, cleaning, and inspection. These Services are covered only when received from Participating Providers.

Hearing exams to determine the need for hearing correction and to provide a prescription for hearing aids are not covered under this "Hearing Aid Rider" (see the "Benefits" section of the *EOC*).

We provide an allowance for each ear toward the price of a hearing aid. The allowance is shown in the "Hearing Aid Rider Benefit Summary." You do not have to use the allowances for both ears at the same time, but we will not provide the allowance for an ear if we have previously covered a hearing aid for that ear within the same benefit period shown in the "Hearing Aid Rider Benefit Summary," under this or any other evidence of coverage (including riders) with the same group number printed on this *EOC*.

The date we cover a hearing aid is the date on which you are fitted for the hearing aid. Therefore, if you are fitted for a hearing aid while you are covered under this *EOC*, and if we would otherwise cover the hearing aid, we will cover the hearing aid even if you do not receive the hearing aid until after you are no longer covered under this *EOC*.

Covered hearing aids are electronic devices worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold, if necessary, and are limited to one of the following digital models: (i) in-the-ear; (ii) behind-the-ear; (iii) on-the-body (Body Aid Model); or (iv) canal/CIC aids.

Hearing Aid Exclusions

- Bone anchored hearing aids.
- Cleaners, moisture guards, and assistive listening devices (for example, FM systems, cell phone or telephone amplifiers, and personal amplifiers designed to improve your ability to hear in a specific listening situation).
- Hearing aids that were fitted before you were covered under this *EOC* (for example, a hearing aid that was fitted during the previous contract year will not be covered under this *EOC*, though it might be covered under your evidence of coverage for the previous contract year).
- Internally implanted hearing aids.
- Non-prescription hearing aids.
- Repair of hearing aids beyond the warranty period.
- Replacement of lost or broken hearing aids, if you have exhausted (used up) your allowance.

- Replacement parts and batteries.

Hearing Aid Rider Benefit Summary

Hearing Aid Services	You Pay
Visits for hearing aid Services	20% Coinsurance after Deductible
Hearing aids $2,000 allowance for each hearing aid per ear every 36 months	After Deductible is met, you pay any amount by which price exceeds allowance

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST FERTILITY TREATMENT SERVICES RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Fertility Treatment Services Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*. The "Fertility Services Exclusions" section in the *EOC* does not apply to Services we cover under this rider.

The following section is added to the *EOC* "Benefits" section:

Fertility Treatment Services

We cover fertility treatment Services, including Services related to conception by artificial means, such as artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request Utilization Review criteria by calling Member Services. These Services are covered only when received from Participating Providers.

Diagnostic Services for fertility are covered as described under the "Fertility Services" section in the "Benefits" section of the *EOC*.

This benefit has a Lifetime Benefit Maximum. For purposes of this rider, a Lifetime Benefit Maximum means we will not cover more than the amount shown in the "Fertility Treatment Services Rider Benefit Summary" for all covered fertility treatment Services during your lifetime. Your Lifetime Benefit Maximum is calculated by adding up the Charges for all Services we covered for treatment of fertility and subtracting any Cost Share you paid for those Services.

Fertility Treatment Services Exclusions

- The cost of donor semen, donor eggs, and Services related to their procurement and storage (such as cryopreservation).
- Oral and injectable drugs prescribed for fertility treatment unless your Group has purchased an "Outpatient Prescription Drug Rider" that includes coverage for fertility drugs.
- Services to reverse voluntary, surgically induced infertility.

Fertility Treatment Services Rider Benefit Summary

	You Pay
Fertility treatment Services up to a $20,000 Lifetime Benefit Maximum	20% Coinsurance after Deductible

NOTES

KAISER PERMANENTE®

2025 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups

This is a summary of changes and clarifications that we made to your *Group Agreement* for the 2025 plan year. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), *Benefit Summary*, and any applicable notices, riders, and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*, or changes that may occur throughout the remainder of the plan year as a result of federal or state mandates.

Other plan-specific or product-specific benefit changes, including changes to deductible, copayment, or coinsurance amounts, may apply to your plan. Please refer to the 2025 renewal proposal and/or confirmation for your group and the 2025 Oregon and Washington Plan Changes document for information about these types of changes.

This Summary of Changes and Clarifications supplements the information contained in your *Group Agreement*. In the event of conflict between this summary and the *Group Agreement*, the *Group Agreement* shall control. Unless another date is listed, the changes described in this summary are effective when your *Group Agreement* renews in 2025. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and Clarifications that Apply to Medical Plans

These changes apply to Kaiser Permanente's commercial (non-Medicare) group plans. Changes to our Senior Advantage plans may be found at the end of this summary.

Benefit Changes

- **Kaiser Permanente at Home in HDHP Plans**. The Kaiser Permanente at Home benefit has been removed from High Deductible plans.

Benefit Clarifications

- **Bariatric Surgery Services.** For groups that cover Bariatric Surgery, the "Bariatric Surgery Services" section of the *Benefit Summary* was updated to include a row for "Outpatient surgery visit." This change is also reflected in the "Bariatric Surgery Services" section of the *EOC*.
- **Cochlear Implants**. We added a "Cochlear implant surgery visit" row under the "Outpatient Services" section of the *Benefit Summary* to indicate the cost share for this service is only subject to the Deductible in High-Deductible plans. Additionally, we removed mention of cochlear implants from the "Benefits for Inpatient Hospital Services" section of the *EOC* as this service is performed as an outpatient procedure.
- **Eye Exam Clarifying Language**. In the "Benefits for Outpatient Services" section of the *EOC*, the eye exam bullet was altered to clarify that refraction exams are included in covered eye exams.
- **Hearing Aids Age Limit Language**. We made minor revisions in the "Hearing Aids and Other Hearing Devices" section of the *EOC* and *Benefit Summary* to clarify that Services covered under the section are available to all Members under the Dependent Limiting Age. One such revision included changing the section title from "Hearing Aids and Other Hearing Devices for Dependents" to "Hearing Aids and Other Hearing Devices."

- **Rehabilitative Therapy Services**. We removed the rehabilitative therapy Services bullet from the "Benefits for Outpatient Services" and "Benefits for Inpatient Hospital Services" sections of the *EOC* to reduce redundancy, as more information about these Services can be found in the "Rehabilitative Therapy Services" section.
- **Substance Use Disorder Prescriptions**. In accordance with OR House Bill 4002, we made minor edits in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC* and in the "Outpatient Prescription Drug Rider" to clarify the early refill and prior authorization requirements around Substance Use Disorder medications.

Other Changes or Clarifications

- **Added Choice Network Name Change**. The term "Select," which was used to describe the facility, pharmacy, physician, or provider that contracts directly with Kaiser Permanente in the Added Choice® product documents, was changed to "KP Select".
- **Allowances.** We added clarification in the Added Choice® and PPO Plus *Benefit Summaries* that any applicable day limits are also combined for benefits received from all provider types unless otherwise indicated in the *EOC*.
- ***Benefit Summary* Introductory Paragraph Edit**. In the Traditional, Deductible, and High-Deductible *Benefit Summary* introductory paragraphs, we removed the sentence referencing exclusions, limitations, and reductions, as this information is redundant and already provided in the *EOC*.
- **External Review.** We revised the "External Review" section of the *EOC* to reflect that in certain circumstances, the external review process no longer requires a signed waiver prior to review.
- **Gender Inclusivity.** Throughout the *EOC* we have made minor updates to remove some gendered language.
- **Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance.** In the *EOC*, the Third Party Administrator and address for filing claims or legal action against another party or insurer has changed from "Equian, LLC" to "The Phia Group, LLC."
- **Member Register URL.** The URL in the sections of the *EOC* that direct members where to register was updated from **kp.org** to **kp.org/register** for a more direct link to register.
- **Post-Service Claims - Services Already Received Revisions.** We made minor revisions in the "Post-Service Claims - Services Already Received" section of the *EOC* to make it clear that information in this section also applies to pharmacy claims.
- **Primary Care Provider Paneling**. In accordance with 2022 Oregon Senate Bill 1529 and 2024 Oregon House Bill 4010, we have made several changes to the *EOC* including:
    - Adding a definition of "Primary Care Provider" to the "Definitions" section;
    - Revising the "Your Primary Care Provider" section to include information on the Primary Care Provider (PCP) paneling process and create standardized language between product types; and
    - In the PPO Plus plan, adding the "Your Primary Care Provider" section to the *EOC* to match the other products.
- **Provider Title Change.** In accordance with Oregon House Bill 4010, we have revised our *EOC* to update the term "Physician Assistant" to "Physician Associate."
- **Removal of the "Women's Health Care Services" Section.** We removed the "Women's Health Care Services" section in the *EOC* to reduce redundancy, as the information in that section is addressed in

other "Benefits" sections. This does not apply to the PPO Plus or Dual Choice *EOC*, as the "Women's Health Care Services" section was not present in those products.

Changes and Clarifications that Apply to Medical Benefit Riders

Other Changes or Clarifications

- **Hearing Aids Age Limit Language**. We made minor revisions in the "Hearing Aid Rider" to clarify that Services covered under the Rider are available to Members who are the Dependent Limiting Age and older. Members under the Dependent Limiting Age are covered as described under the "Hearing Aids and Other Hearing Devices" section of the *EOC*.
- **URL Changes for Dual Choice Riders.** The existing product specific URL page (**kp.org/dualchoice/nw**) was changed in the Dual Choice "Pediatric Vision Hardware and Optical Services Rider" and "Hearing Aid Rider" to the more general **kp.org/choiceproducts/nw** landing page to improve members' navigation experience at **kp.org**, and match the information members will see on their ID cards and other member materials.

Changes and Clarifications that Apply to Dental Plans

Benefit Changes

- **Nightguard Frequency Limitation**. We added a nightguard frequency limitation of one every five years.
- **Prior Authorization Revisions**. In the PPO Dental *EOC,* we made minor language modifications in the "Prior Authorization" section to improve readability and minimize redundant language found in other sections.

Benefit Clarifications

- **Full Mouth Gross Debridement Limitation**. In the "Exclusions and Limitations" section of the Traditional Dental plan *EOC* we added a limitation for full mouth gross debridement of once every 36 months.

Other Changes or Clarifications

- **Deductible Definition**. We removed redundant language from the "Deductible" definition in the PPO Dental *EOC*.
- **Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance.** In the *EOC*, the Third Party Administrator and address for filing claims or legal action against another party or insurer has changed from "Equian, LLC" to "The Phia Group, LLC."
- **Least Costly Treatment Alternative**. We altered the least costly treatment language in the "Benefits" section of the Traditional Dental *EOC* for improved readability and to reduce redundancy.
- **Member Register URL.** In the Traditional Dental *EOC*, the URL in the sections of the *EOC* that direct members where to register was updated from **kp.org/dental/nw** to **kp.org/register** for a more direct registration link.
- **Post-Service Claims Address**. In the "Post-Service Claims – Services Already Received" and "Post-service Claim" sections of the Traditional Dental *EOC*, we updated the address where Members can send dental claims for services they received from Non-Participating Providers without a referral.

- **Provider Definition Changes**. We made edits to the "Non-Participating Provider," "Participating Dentist," and "Participating Provider" definitions in the *EOC* for added clarity and alignment across products.

Changes and Clarifications that Apply to Senior Advantage Plans

Benefit Changes or Clarifications

- **Primary Care Provider Paneling.** We updated *EOC* language in Chapter 3, Section 2.1, to show that Members will be required to choose one of our available network providers to be their primary care provider (PCP). If a member does not choose a PCP, a PCP or primary care team will be assigned to the member, and the member will be notified. Members can change their assigned PCP at any time.
- **Fitness Benefit.** We updated the *Medical Benefits Chart* to show that the Silver&Fit® fitness program has been replaced with the One Pass™ fitness program, which includes access to in-network gyms, online fitness classes and resources, home fitness kits, and an online brain health program.
- **"Drug List" Change.** For groups with Part D coverage, we updated *EOC* language in Chapter 5, Section 6.2, and definitions in Chapter 12 related to biological products and biosimilars. As part of changes to our "Drug List," starting in 2025, original biological products can be immediately replaced with certain biosimilars. This means, for instance, if a member is taking an original biological product that is being replaced by a biosimilar, the member may not get notice of the change 30 days before we make it or get a month's supply of the original biological product at a network pharmacy. If the member is taking the original biological product at the time we make the change, the member will still get information on the specific change we made, but it may arrive after we make the change.
- **Part D Out-of-Pocket Costs.** For groups with Part D coverage, we updated Chapter 6, Sections 1.3, 5.5, and 6 of the *EOC* to show that the amount of out-of-pocket costs that a member must pay for Part D prescription drugs before moving from the Initial Coverage Stage to the Catastrophic Coverage Stage has been reduced from $8,000 to $2,000.
- **Prescription Payment Option.** For groups with Part D coverage, we added language to the *EOC* in Chapter 1, Section 4.5, and Chapter 2, Section 7, about the Medicare Prescription Payment Plan, a new payment option that works with your current drug coverage and can help you manage your drug costs by spreading them across monthly payments that vary throughout the year (January – December).

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Plan
Group Agreement

Group Name: Bmo Financial Corp.

Group Number: 3992-011, 012

Term of *Agreement*

1/1/2025 through 12/31/2025

Anniversary date

January 1



Jeffrey A. Collins
President, Kaiser Foundation Health Plan
and Hospitals of the Northwest

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KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

This *Group Agreement* (*Agreement*), including the attached *Evidence of Coverage* (*EOC)* incorporated herein by reference, and any amendments, constitutes the contract between Kaiser Foundation Health Plan of the Northwest (Company) and **Bmo Financial Corp.** (Group). In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document for terms you should know.

To be eligible under this *Agreement*, the Group must meet the underwriting requirements set forth in Company's Rate Assumptions and Requirements document.

PREMIUM

Group will pay to Company, for each Subscriber and their Dependents, the Premium amount(s) specified for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date to which Company and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Premium Due Date").

When this *Agreement* terminates, if Group does not have another agreement with Company, then the due date for all Premium amounts will be the earlier of: (1) the last Premium Due Date, or (2) the termination date of this *Agreement*.

Monthly Premium Amounts

Group will pay Company the following Premium amount(s) each month for each Subscriber and their Dependents. Only Members for whom Company has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Company has received appropriate payment.

Subscriber only: $592.39

Subscriber and Spouse: $1303.26

Subscriber, Spouse, and child(ren): $2464.31

Subscriber and child(ren): $1155.16

Medicare as Secondary Payer

Members who are eligible and enrolled in Medicare Part A or B and for whom Medicare is secondary payer are subject to the same Premium amounts (shown above) and receive the same benefits as Members who are not eligible for Medicare. Members who are eligible and enrolled in Medicare Parts A and B as secondary payer and who meet applicable eligibility requirements may also enroll in a Kaiser Permanente Senior Advantage Plan. These Members receive the coverages described in both the non-Medicare Plan and the Senior Advantage Plan, and the Premium amounts for these Members are the Premium amounts for the non-Medicare Plan (shown above).

Medicare as Primary Payer

Premium amounts are based on the assumption that Company or its designee will receive Medicare payments for Medicare-covered Services provided to certain types of Members. For each Member to whom this "Medicare as Primary Payer" section applies, Group must pay the applicable Premium shown above in this

"Monthly Premium Amounts" section if the Member is for any reason not enrolled through Group in Kaiser Permanente Senior Advantage (including inability to enroll because they do not meet the Senior Advantage Plan's eligibility requirements or Group does not offer a Senior Advantage Plan).

Those Members eligible for Medicare based on disability, end stage renal disease (ESRD), domestic partner status, or who are Medicare eligible and enrolled in COBRA will be charged the Premium amount for the non-Medicare Plan (shown above).

Members to whom this "Medicare as Primary Payer" section applies. This "Medicare as Primary Payer" section applies to Members who meet all of the following requirements:

- They are age 65 or over.
- They are eligible for Medicare Parts A and B as primary payer (i.e., retirees).

TERM OF *AGREEMENT*, ACCEPTANCE OF *AGREEMENT*, AND RENEWAL

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective for the term shown on the cover page.

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement*, if Group pays Company any amount toward Premium.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Company account manager. Company might not respond to any changes or comments that Group may submit. Group may not construe Company's lack of response to any submitted changes or comments to imply acceptance. Company will issue a new *agreement* or amendment if Company and Group agree on any changes.

Renewal

This *Agreement* is guaranteed renewable but does not automatically renew. If Group complies with all of the terms of this *Agreement,* Company will offer to renew this *Agreement,* upon not less than 30 days prior written notice to Group, either by sending Group a new group *agreement* to become effective immediately after termination of this *Agreement,* or by extending the term of this *Agreement* pursuant to "Amendments Effective on Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended group *agreement* will include a new term of *agreement* and other changes. If Group does not renew this *Agreement*, Group must give Company written notice as described under "Termination on Notice" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

Upon not less than 30 days prior written notice to Group, Company may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on the anniversary date of any year (see cover page for anniversary date).

Amendment due to Tax or Other Charges

If during the term of this *Agreement* a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Company, Medical Group, or Kaiser Foundation Hospitals or upon any activity of any of them, then upon 31 days prior written notice, Company may increase Group's Premium to include Group's share of the new or increased tax or charge.

Other Amendments

Company may amend this *Agreement* at any time by giving written notice to Group, in order to: (a) address any law or regulatory requirement; (b) reduce or expand the Company Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed in this "Termination of *Agreement*" section. All rights to benefits under this *Agreement* end at 11:59 p.m. PT on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of *the EOC*.

If this *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination not later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

If Company fails to give notice as required, this *Agreement* shall continue in effect from the date notice should have been given until the date the Group receives the notice. Company will waive the Premium for the period for which coverage is continued and the time period within which Member may exercise any right to continuation shall commence on the date that Group receives the notice. Company will properly notify Members of their right to continuation of coverage under federal and state law.

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Company not less than 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement*, including Premium, for the period through the termination date.

Termination due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Company written notice of nonacceptance at least 15 days before the effective date of the amendment in which case this *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

When Group fails to pay Premium on or before the Premium Due Date, Group shall have a period of at least 31 days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Premium Due Date. If Group fails to pay all Premiums owed (including those owed for the Grace Period) on or before the last day of the Grace Period, then Company may, at its option and in lieu of any other remedy, terminate this Agreement without further extension or consideration.

Company will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least 10 days prior to the effective date of termination. Group shall continue to be liable for all Premiums due through the date of termination.

This Agreement will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums. If Company receives full payment of Premiums on or before the last day of the Grace Period, this Agreement will remain in effect according to its terms and conditions.

If Premiums are paid after the Grace Period ends, Company may charge interest on the overdue Premiums. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be 6 percent per year or the maximum amount permitted by applicable law, whichever is less.

Termination for Fraud

Company may terminate this *Agreement* by giving at least 30 days prior written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Company or is aware that incorrect or incomplete material information has been provided to Company on enrollment or other Company forms.

Termination for Violation of Contribution or Participation Requirements

Company may terminate this *Agreement* upon 31 days prior written notice to Group, if Group fails to comply with Company's contribution or participation requirements (including those listed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Company may terminate a particular product or all products offered in the group market as permitted by law.

Company may terminate this *Agreement* if it ceases to write new business in the group market in Oregon or in a specific service area within Oregon, or elects not to renew all of its group Plans in Oregon or in a specific service area within Oregon, or both cease offering and cease renewing all products in Oregon or a specific service area in Oregon, if Company fails to reach an agreement with health care providers. To discontinue all products, Company must: (a) notify the Director of the Department of Consumer and Business Services and all Groups; and (b) not cancel coverage for 180 days after the date of notice to the Director and Groups.

Company may terminate this *Agreement* if it elects not to offer or renew, or offer and renew, this type of Plan in Oregon or within a specific service area within Oregon. Except as provided below regarding failure to reach agreement with providers, in order to discontinue a product, Company must: (a) cease to offer and/or cease to renew this Plan for all groups; (b) offer (in writing) to each group covered by this Plan, enrollment in any other Plan offered by Company in the group market, not less than 90 days prior to discontinuance; and (c) act uniformly without regard to claims experience of affected groups or the health status of any current or prospective Member.

Company may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Company to discontinue coverage upon finding that continuation of coverage (a) would not be in the best interests of the Members; or (b) would impair Company's ability to meet its contractual obligations.

Company may terminate this *Agreement* by providing not less than 90 days prior written notice if there are no Members covered under this *Agreement*.

Company may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Company must: (a) cease to offer and cease to renew this Plan for all groups within the service area; and (b) not less than 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue offering the Plan(s) and offer all other group Plans available in that service area.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS

No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Company consents in writing.

Group must:

- Meet all underwriting requirements set forth in Company's Rate Assumptions and Requirements document.
- With respect to all persons entitled to coverage under Group's Plan(s), offer enrollment in Company's Plan to all such persons on conditions no less favorable than those for any other Plan available through Group.
- Permit Company to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

Company may adopt policies, procedures, rules, and interpretations to promote efficient administration of this *Agreement*.

Assignment

Company may assign this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Company's prior written consent. This *Agreement* shall be binding on the successors and permitted assignees of Company and Group.

Attorney Fees and Costs

If Company or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable costs of collection, including attorneys' fees, by the other party.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with Oregon law and any provision that is required to be in this *Agreement* by state or federal law shall bind Group and Company regardless of whether that provision is set forth in this *Agreement*.

Grandfathered Health Plan Coverage

For any coverage identified in an *EOC* as a "grandfathered health plan" under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Company if this coverage does not meet (or no longer meets) the requirements for grandfathered status. This includes, but is not limited to, any change in its contribution rate to the cost of any grandfathered health plan(s) during the contract year. Group represents that, for any coverage identified as a grandfathered health plan in the applicable *EOC*, Group has not decreased its contribution rate more than five percent for any rate tier in that plan when compared to the contribution rate in effect on March 23, 2010, for the same plan. Company will rely on Group's representation when issuing and/or continuing grandfathered health plan coverage.

Nonduplication Agreement

Company agrees to undertake performance of the following regulatory requirements, and Group may rely on Company's performance in order to satisfy its obligation to perform the same activities with respect to the coverages issued to Group by Company:

- Preparation and publication of machine-readable files on a public website for in-network rates and billed charges and Allowed Amounts for out-of-network providers in the required form and manner as set forth in applicable regulations and any sub-regulatory guidance;

- Provision of an internet, self-service tool as well as paper reports and telephone assistance to provide personalized estimates of cost sharing for 500 shoppable services beginning on January 1, 2023, and for all covered services as of January 1, 2024, as set forth in applicable regulations and any sub-regulatory guidance;
- Annual reporting of prescription drug and health care costs reporting required to be furnished in accordance with applicable regulations and any sub-regulatory guidance;
- Publication of a consumer notice regarding federal and, when applicable, any state legal requirements related to balance billing by non-participating providers in accordance with applicable regulations and any sub-regulatory guidance;
- Annual reporting of data related to the provision and cost of air ambulance services for 2022 and 2023 in the required form and manner as set forth in applicable regulations and any sub-regulatory guidance; and
- Annual submission of a Gag Clause Prohibition Compliance Attestation in the required form and manner as set forth in applicable regulations, if any, and sub-regulatory guidance.

No Waiver

Company's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision or impair Company's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below, except that Company or Group may change its address for notices by giving written notice to the other. Notices are deemed given when delivered in person, sent via email, or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Company to Group will be sent to:

Group Contact	Shannon Sarcia-Carlson
Group Name	Bmo Financial Corp.
Group Address	395 N Executive Dr
Group Address	
Group Address	Brookfield, WI 53005
Producer Contact	Beth Grellner
Producer Name	Willis Towers Watson US LLC (Los Angeles)
Producer Address	Lockbox 28852
Producer Address	
Producer Address	New York, NY 10087

Note: When Company sends Group a new (or renewed) group *agreement*, Company will enclose a summary that discusses the changes Company has made to this *Agreement*. Groups that want information about changes before receiving the new group *agreement* may request advance information from Group's Company account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Company may send the advance information to the third party rather than to Group (unless Group requests a copy also).

Notices from Group to Company regarding billing and enrollment must be sent to:

Kaiser Foundation Health Plan of the Northwest
P.O. Box 23127
San Diego, CA 92193
Or emailed to: **csc-den-roc-group@kp.org**

Notices from Group to Company regarding Premium payments must be sent to:

Kaiser Foundation Health Plan of the Northwest
PO Box 34178
Seattle, WA 98124

Notices from Group to Company regarding termination of this *Agreement* must be sent to the Group's account manager at:

Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah Street, Suite 100
Portland, OR 97232

Other Group Coverages that Cover Essential Health Benefits (EHBs)

Essential Health Benefits means benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. Essential Health Benefits must be equal to the scope of benefits provided under a typical employer plan, except that they must include at least the following: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

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

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

Premium Rebates

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

Reporting Membership Changes and Retroactivity

Company's billing statement to Group explains how to report membership changes. Group's Kaiser Permanente account manager can also provide Group with this information. Group must report membership changes (including sending Company-approved membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership changes is the calendar month when Company's San Diego Service Center receives Group's notification of the change plus the previous two months unless Company agrees otherwise in writing.

Representation Regarding Waiting Periods

Pursuant to section 2708 of the Public Health Service Act (PHSA) and 45 CFR 147.116(b), Group hereby represents that Group does not impose a waiting period exceeding 90 days on its employees who meet

Group's substantive eligibility requirements. (A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, including completion of Group's reasonable and bona fide employment-based orientation period that does not exceed one month, if any.)

In addition, Group represents that eligibility data provided by the Group to Company will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in 45 CFR 147.116.

Social Security and Tax Identification Numbers

Within 60 days after Company sends Group a written request, Group will send Company a list of all Members covered under this *Agreement,* along with the following:

- The Member's Social Security number.
- The tax identification number of the employer of the Subscriber in the Member's Family.
- Any other information that Company is required by law to collect.

Summaries of Benefits and Coverage

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

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Plan
Group Agreement

Group Name: Bmo Financial Corp.

Group Number: 3992-013-016

Term of *Agreement*

1/1/2025 through 12/31/2025

Anniversary date

January 1



Jeffrey A. Collins
President, Kaiser Foundation Health Plan
and Hospitals of the Northwest

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KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST

A Nonprofit Corporation

Group Agreement

INTRODUCTION

This *Group Agreement* (*Agreement*), including the attached *Evidence of Coverage* (*EOC)* incorporated herein by reference, and any amendments, constitutes the contract between Kaiser Foundation Health Plan of the Northwest (Company) and **Bmo Financial Corp.** (Group). In this *Agreement,* some capitalized terms have special meaning; please see the "Definitions" section in the *EOC* document for terms you should know.

To be eligible under this *Agreement*, the Group must meet the underwriting requirements set forth in Company's Rate Assumptions and Requirements document.

PREMIUM

Group will pay to Company, for each Subscriber and their Dependents, the Premium amount(s) specified for each month on or before the date on the monthly invoice or, if Group is self-pay, then the date to which Company and Group agree in writing, but in no event later than the last day of the month preceding the month of coverage (the "Premium Due Date").

When this *Agreement* terminates, if Group does not have another agreement with Company, then the due date for all Premium amounts will be the earlier of: (1) the last Premium Due Date, or (2) the termination date of this *Agreement*.

Monthly Premium Amounts

Group will pay Company the following Premium amount(s) each month for each Subscriber and their Dependents. Only Members for whom Company has received the appropriate Premium payment listed below are entitled to coverage under this *Agreement*, and then only for the period for which Company has received appropriate payment.

Subscriber only: $1017.24

Subscriber and Spouse: $2237.92

Subscriber, Spouse, and child(ren): $4231.70

Subscriber and child(ren): $1983.61

Medicare as Secondary Payer

Members who are eligible and enrolled in Medicare Part A or B and for whom Medicare is secondary payer are subject to the same Premium amounts (shown above) and receive the same benefits as Members who are not eligible for Medicare. Members who are eligible and enrolled in Medicare Parts A and B as secondary payer and who meet applicable eligibility requirements may also enroll in a Kaiser Permanente Senior Advantage Plan. These Members receive the coverages described in both the non-Medicare Plan and the Senior Advantage Plan, and the Premium amounts for these Members are the Premium amounts for the non-Medicare Plan (shown above).

Medicare as Primary Payer

Premium amounts are based on the assumption that Company or its designee will receive Medicare payments for Medicare-covered Services provided to certain types of Members. For each Member to whom this "Medicare as Primary Payer" section applies, Group must pay the applicable Premium shown above in this

"Monthly Premium Amounts" section if the Member is for any reason not enrolled through Group in Kaiser Permanente Senior Advantage (including inability to enroll because they do not meet the Senior Advantage Plan's eligibility requirements or Group does not offer a Senior Advantage Plan).

Those Members eligible for Medicare based on disability, end stage renal disease (ESRD), domestic partner status, or who are Medicare eligible and enrolled in COBRA will be charged the Premium amount for the non-Medicare Plan (shown above).

Members to whom this "Medicare as Primary Payer" section applies. This "Medicare as Primary Payer" section applies to Members who meet all of the following requirements:

- They are age 65 or over.
- They are eligible for Medicare Parts A and B as primary payer (i.e., retirees).

TERM OF *AGREEMENT*, ACCEPTANCE OF *AGREEMENT*, AND RENEWAL

Term of *Agreement*

Unless terminated as set forth in the "Termination of *Agreement*" section, this *Agreement* is effective for the term shown on the cover page.

Acceptance of *Agreement*

Group will be deemed as having accepted this *Agreement* and any amendments issued during the term of this *Agreement*, if Group pays Company any amount toward Premium.

Group may **not** change this *Agreement* by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Company account manager. Company might not respond to any changes or comments that Group may submit. Group may not construe Company's lack of response to any submitted changes or comments to imply acceptance. Company will issue a new *agreement* or amendment if Company and Group agree on any changes.

Renewal

This *Agreement* is guaranteed renewable but does not automatically renew. If Group complies with all of the terms of this *Agreement,* Company will offer to renew this *Agreement,* upon not less than 30 days prior written notice to Group, either by sending Group a new group *agreement* to become effective immediately after termination of this *Agreement,* or by extending the term of this *Agreement* pursuant to "Amendments Effective on Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended group *agreement* will include a new term of *agreement* and other changes. If Group does not renew this *Agreement*, Group must give Company written notice as described under "Termination on Notice" in the "Termination of *Agreement*" section.

AMENDMENT OF *AGREEMENT*

Amendments Effective on Anniversary Date

Upon not less than 30 days prior written notice to Group, Company may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective on the anniversary date of any year (see cover page for anniversary date).

Amendment due to Tax or Other Charges

If during the term of this *Agreement* a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Company, Medical Group, or Kaiser Foundation Hospitals or upon any activity of any of them, then upon 31 days prior written notice, Company may increase Group's Premium to include Group's share of the new or increased tax or charge.

Other Amendments

Company may amend this *Agreement* at any time by giving written notice to Group, in order to: (a) address any law or regulatory requirement; (b) reduce or expand the Company Service Area; or (c) increase any benefits of any Medicare product approved by the Centers for Medicare and Medicaid Services (CMS), if applicable to this *Agreement*.

TERMINATION OF *AGREEMENT*

This *Agreement* will terminate under any of the conditions listed in this "Termination of *Agreement*" section. All rights to benefits under this *Agreement* end at 11:59 p.m. PT on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of *the EOC*.

If this *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination not later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

If Company fails to give notice as required, this *Agreement* shall continue in effect from the date notice should have been given until the date the Group receives the notice. Company will waive the Premium for the period for which coverage is continued and the time period within which Member may exercise any right to continuation shall commence on the date that Group receives the notice. Company will properly notify Members of their right to continuation of coverage under federal and state law.

Termination on Notice

Group may terminate this *Agreement* by giving prior written notice to Company not less than 30 days prior to the termination date and remitting all amounts payable relating to this *Agreement*, including Premium, for the period through the termination date.

Termination due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Company written notice of nonacceptance at least 15 days before the effective date of the amendment in which case this *Agreement* will terminate the day before the effective date of the amendment.

Termination for Nonpayment

When Group fails to pay Premium on or before the Premium Due Date, Group shall have a period of at least 31 days to pay all Premiums owed ("Grace Period"). The Grace Period shall begin the day after the Premium Due Date. If Group fails to pay all Premiums owed (including those owed for the Grace Period) on or before the last day of the Grace Period, then Company may, at its option and in lieu of any other remedy, terminate this Agreement without further extension or consideration.

Company will notify Group of the past-due amount and the effective date of termination. Such notice shall be sent at least 10 days prior to the effective date of termination. Group shall continue to be liable for all Premiums due through the date of termination.

This Agreement will remain in full force and effect throughout the Grace Period and Group will remain responsible for payment of Premiums. If Company receives full payment of Premiums on or before the last day of the Grace Period, this Agreement will remain in effect according to its terms and conditions.

If Premiums are paid after the Grace Period ends, Company may charge interest on the overdue Premiums. Interest shall not accrue during the Grace Period, and the (simple) interest rate shall be 6 percent per year or the maximum amount permitted by applicable law, whichever is less.

Termination for Fraud

Company may terminate this *Agreement* by giving at least 30 days prior written notice to Group, if Group commits fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. For example, an intentional misrepresentation of material fact occurs if Group intentionally furnishes incorrect or incomplete material information to Company or is aware that incorrect or incomplete material information has been provided to Company on enrollment or other Company forms.

Termination for Violation of Contribution or Participation Requirements

Company may terminate this *Agreement* upon 31 days prior written notice to Group, if Group fails to comply with Company's contribution or participation requirements (including those listed in the "Contribution and Participation Requirements" section).

Termination for Discontinuance of a Product or all Products within a Market

Company may terminate a particular product or all products offered in the group market as permitted by law.

Company may terminate this *Agreement* if it ceases to write new business in the group market in Oregon or in a specific service area within Oregon, or elects not to renew all of its group Plans in Oregon or in a specific service area within Oregon, or both cease offering and cease renewing all products in Oregon or a specific service area in Oregon, if Company fails to reach an agreement with health care providers. To discontinue all products, Company must: (a) notify the Director of the Department of Consumer and Business Services and all Groups; and (b) not cancel coverage for 180 days after the date of notice to the Director and Groups.

Company may terminate this *Agreement* if it elects not to offer or renew, or offer and renew, this type of Plan in Oregon or within a specific service area within Oregon. Except as provided below regarding failure to reach agreement with providers, in order to discontinue a product, Company must: (a) cease to offer and/or cease to renew this Plan for all groups; (b) offer (in writing) to each group covered by this Plan, enrollment in any other Plan offered by Company in the group market, not less than 90 days prior to discontinuance; and (c) act uniformly without regard to claims experience of affected groups or the health status of any current or prospective Member.

Company may terminate this *Agreement* if the Director of the Department of Consumer and Business Services orders Company to discontinue coverage upon finding that continuation of coverage (a) would not be in the best interests of the Members; or (b) would impair Company's ability to meet its contractual obligations.

Company may terminate this *Agreement* by providing not less than 90 days prior written notice if there are no Members covered under this *Agreement*.

Company may terminate this *Agreement* if it is unable to reach an agreement with the health care providers to provide Services within a specific service area. Company must: (a) cease to offer and cease to renew this Plan for all groups within the service area; and (b) not less than 90 days prior to discontinuance, notify the Director of the Department of Consumer and Business Services and each group in that service area of the decision to discontinue offering the Plan(s) and offer all other group Plans available in that service area.

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No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Company consents in writing.

Group must:

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Company may adopt policies, procedures, rules, and interpretations to promote efficient administration of this *Agreement*.

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If Company or Group institutes legal action against the other to collect any sums owed under this *Agreement*, the party that substantially prevails will be reimbursed for its reasonable costs of collection, including attorneys' fees, by the other party.

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with Oregon law and any provision that is required to be in this *Agreement* by state or federal law shall bind Group and Company regardless of whether that provision is set forth in this *Agreement*.

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For any coverage identified in an *EOC* as a "grandfathered health plan" under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Company if this coverage does not meet (or no longer meets) the requirements for grandfathered status. This includes, but is not limited to, any change in its contribution rate to the cost of any grandfathered health plan(s) during the contract year. Group represents that, for any coverage identified as a grandfathered health plan in the applicable *EOC*, Group has not decreased its contribution rate more than five percent for any rate tier in that plan when compared to the contribution rate in effect on March 23, 2010, for the same plan. Company will rely on Group's representation when issuing and/or continuing grandfathered health plan coverage.

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Company agrees to undertake performance of the following regulatory requirements, and Group may rely on Company's performance in order to satisfy its obligation to perform the same activities with respect to the coverages issued to Group by Company:

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- Annual submission of a Gag Clause Prohibition Compliance Attestation in the required form and manner as set forth in applicable regulations, if any, and sub-regulatory guidance.

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Company's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision or impair Company's right thereafter to require Group's strict performance of any provision.

Notices

Notices must be sent to the addresses listed below, except that Company or Group may change its address for notices by giving written notice to the other. Notices are deemed given when delivered in person, sent via email, or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Company to Group will be sent to:

Group Contact	Shannon Sarcia-Carlson
Group Name	Bmo Financial Corp.
Group Address	395 N Executive Dr
Group Address	
Group Address	Brookfield, WI 53005
Producer Contact	Beth Grellner
Producer Name	Willis Towers Watson US LLC (Los Angeles)
Producer Address	Lockbox 28852
Producer Address	
Producer Address	New York, NY 10087

Note: When Company sends Group a new (or renewed) group *agreement*, Company will enclose a summary that discusses the changes Company has made to this *Agreement*. Groups that want information about changes before receiving the new group *agreement* may request advance information from Group's Company account manager. Also, if Group designates in writing a third party such as a "Producer of Record," Company may send the advance information to the third party rather than to Group (unless Group requests a copy also).

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Or emailed to: **csc-den-roc-group@kp.org**

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Notices from Group to Company regarding termination of this *Agreement* must be sent to the Group's account manager at:

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Essential Health Benefits means benefits that the U.S. Department of Health and Human Services (HHS) Secretary defines as essential health benefits. Essential Health Benefits must be equal to the scope of benefits provided under a typical employer plan, except that they must include at least the following: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).

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- Ensure that the sum of the OOPM in Company's coverage plus the OOPMs that apply to those Essential Health Benefits in all of the other medical and dental coverages does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

Premium Rebates

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

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Group's substantive eligibility requirements. (A waiting period is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, including completion of Group's reasonable and bona fide employment-based orientation period that does not exceed one month, if any.)

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KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation
Portland, Oregon

Large Group
Deductible Plan
Evidence of Coverage

Group Name: Bmo Financial Corp.

Group Number: 3992-011-016

This *Evidence of Coverage* is effective 1/1/2025 through 12/31/2025.

Printed: Monday, January 13, 2025

Member Services

Monday through Friday (except holidays)
8 a.m. to 6 p.m. PT

All areas.....1-800-813-2000

TTY

All areas..... 711

Language interpretation services

All areas.....1-800-324-8010

kp.org

DEDUCTIBLE PLAN BENEFIT SUMMARY

This "Benefit Summary," which is part of the *Evidence of Coverage (EOC)*, is a summary of answers to the most frequently asked questions about benefits. This summary does not fully describe benefits, limitations, or exclusions. To see complete explanations of what is covered for each benefit, including exclusions and limitations, and for additional benefits that are not included in this summary, please refer to the "Benefits," "Exclusions and Limitations," and "Reductions" sections of this *EOC*. For a list of defined terms, refer to the "Definitions" section of this *EOC*.

Calendar year is the time period (Year) in which dollar, day, and visit limits, Deductibles and Out-of-Pocket Maximums accumulate.

Deductible	
Self-only Deductible per Year (for a Family of one Member)	$750
Individual Family Member Deductible per Year (for each Member in a Family of two or more Members)	$750
Family Deductible per Year (for an entire Family)	$1,500
Out-of-Pocket Maximum	
Self-only Out-of-Pocket Maximum per Year (for a Family of one Member)	$3,000
Individual Family Member Out-of-Pocket Maximum per Year (for each Member in a Family of two or more Members)	$3,000
Family Out-of-Pocket Maximum per Year (for an entire Family)	$6,000
(Note: All Deductible, Copayments, and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise indicated in this *EOC*.)	
Preventive Care Services	**You Pay**
Routine preventive physical exam (includes adult, well baby, and well child)	$0
Immunizations	$0
Preventive tests	$0
Outpatient Services	**You Pay**
Primary care visit First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 for first 3 visits; then $25 for additional visits in the same Year
Specialty care visit	$40
TMJ therapy visit	$25
Routine eye exam (covered until the end of the month in which Member turns 19 years of age)	$25
Routine eye exam for Members 19 years and older	$25
Nurse treatment room visits to receive injections	$10
Administered medications, including injections (all outpatient settings)	20% Coinsurance after Deductible
Urgent Care visit	$40
Emergency department visit	$300 (Waived if admitted)
Outpatient surgery visit	20% Coinsurance after Deductible
Cochlear implant surgery visit	20% Coinsurance
Vasectomy	$0
Interrupted pregnancy surgery	$0

Chemotherapy/radiation therapy visit	$25
Respiratory therapy visit	$25
Cardiac rehabilitative therapy visit	$25
Inpatient Hospital Services	**You Pay**
Room and board, surgery, anesthesia, X-ray, imaging, laboratory, and drugs	20% Coinsurance after Deductible
Vasectomy	$0
Interrupted pregnancy surgery	$0
Kaiser Permanente at Home™	**You Pay**
Medical Services in your home as an alternative to receiving acute care in a hospital	$0
Ambulance Services	**You Pay**
Per transport	20% Coinsurance after Deductible
Bariatric Surgery Services	**You Pay**
Inpatient hospital Services	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Behavioral Health Services	**You Pay**
Outpatient Services First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 for first 3 visits; then $25 per visit for additional visits in the same Year
Intensive outpatient Services First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 for first 3 days; then $25 per day for additional days in the same Year
Partial hospitalization First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 for first 3 days; then $25 per day for additional days in the same Year
Assertive Community Treatment (ACT) Services	$0
Inpatient hospital Services	20% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible
Dialysis Services	**You Pay**
Outpatient dialysis visit	$25
Home dialysis	$0
External Prosthetic Devices and Orthotic Devices	**You Pay**
External Prosthetic Devices	20% Coinsurance after Deductible
Orthotic Devices	20% Coinsurance after Deductible
Fertility Services	**You Pay**
Consultation and office visits for diagnostic Services	20% Coinsurance after Deductible
Diagnostic imaging and laboratory tests	20% Coinsurance after Deductible

Habilitative Services (Visit or day maximums do not apply to habilitative Services for treatment of Behavioral Health Conditions.)	**You Pay**
Outpatient physical, speech, and occupational therapies (up to 60 visits combined per Year)	$25
Inpatient Services	20% Coinsurance after Deductible
Hearing Aids and Other Hearing Devices	**You Pay**
Hearing exams, testing, and visits for hearing loss Services	$40
Hearing aids and assistive listening devices (for Members who are under the Dependent Limiting Age), limited to once per hearing impaired ear every 36 months.	20% Coinsurance
Home Health Services	**You Pay**
Home health (up to 120 visits per Year)	$0
Hospice Services	**You Pay**
Hospice Services (respite care limited to no more than five consecutive days in a 30-day period)	$0
Limited Outpatient Prescription Drugs and Supplies	**You Pay**
Certain preventive medications (including, but not limited to, aspirin, fluoride, and liquid iron for infants)	$0
Certain self-administered IV drugs, fluids, additives, and nutrients including the supplies and equipment required for their administration	$0
Blood glucose test strips	Refer to your Outpatient Prescription Drug Rider
Contraceptive drugs or devices	$0
Insulin	Subject to the applicable drug tier Copayment or Coinsurance shown in your Outpatient Prescription Drug Rider, up to $35 for each 30-day supply
Post-surgical immunosuppressive drugs after covered transplant Services	Refer to your Outpatient Prescription Drug Rider
Self-administered chemotherapy medications used for the treatment of cancer	Refer to your Outpatient Prescription Drug Rider
Tobacco use cessation drugs	$0
Maternity and Newborn Care	**You Pay**
Scheduled prenatal care visits and postpartum visits	$0
Maternal diabetes management, including medication and supplies (Medically Necessary Services beginning with conception and ending through six weeks postpartum)	$0
Inpatient hospital Services	20% Coinsurance after Deductible
Newborn nurse home visiting Services	$0
Medical Foods and Formula	**You Pay**
Medical foods and formula	20% Coinsurance after Deductible
Naturopathic Medicine	**You Pay**
Evaluation and treatment First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 for first 3 visits; then $25 for additional visits in the same Year

Out-of-Area Coverage for Dependents	**You Pay**
Limited office visits, laboratory, diagnostic X-rays, and prescription drug fills as described in the *EOC* under "Out-of-Area Coverage for Dependents" in the "How to Obtain Services" section	20% of the actual fee the provider, facility, or vendor charged for the Service
Outpatient Durable Medical Equipment (DME)	**You Pay**
Outpatient Durable Medical Equipment (DME)	20% Coinsurance after Deductible
Home ultraviolet light therapy equipment	$0
Peak flow meters, blood glucose monitors, and lancets	20% Coinsurance
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	**You Pay**
Laboratory	20% Coinsurance after Deductible
Genetic testing	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Diagnostic and supplemental breast imaging	$0
CT, MRI, PET scans	20% Coinsurance after Deductible
Reconstructive Surgery Services	**You Pay**
Inpatient hospital Services	20% Coinsurance after Deductible
Outpatient surgery visit	20% Coinsurance after Deductible
Rehabilitative Therapy Services (Visit or day maximums do not apply to rehabilitative therapy Services for treatment of Behavioral Health Conditions.)	**You Pay**
Outpatient physical, speech, and occupational therapies (up to 60 visits combined per Year)	$25
Inpatient Services	20% Coinsurance after Deductible
Skilled Nursing Facility Services	**You Pay**
Inpatient skilled nursing Services (up to 100 days per Year)	20% Coinsurance after Deductible
Substance Use Disorder Services	**You Pay**
Outpatient Services First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 for first 3 visits; then $25 per visit for additional visits in the same Year
Inpatient hospital Services	20% Coinsurance after Deductible
Residential Services	20% Coinsurance after Deductible
Day treatment Services First 3 visits (or days) are any combination of in-person or telemedicine Services for primary care non-specialty medical Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$5 for first 3 days; then $25 per day for additional days in the same Year
Telemedicine Services	**You Pay**
Telephone visits, video visits, and e-visits Telemedicine Services for primary care count toward the first 3 visits (or days) combined with in-person Services for primary care non-specialty Services, behavioral health outpatient Services, naturopathic medicine, or Substance Use Disorder outpatient Services.	$0
Transplant Services	**You Pay**
Inpatient hospital Services	20% Coinsurance after Deductible

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INTRODUCTION

This *Evidence of Coverage* (*EOC*), including the "Benefit Summary" and any benefit riders attached to this *EOC*, describes the health care benefits of this Large Group Deductible Plan provided under the *Group Agreement* (*Agreement)* between Kaiser Foundation Health Plan of the Northwest and your Group. Members are entitled to covered Services only at Participating Facilities and from Participating Providers, except as noted in this *EOC*. For benefits provided under any other Plan, refer to that Plan's evidence of coverage.

The provider network for this Deductible Plan is the Classic network.

The provisions of this *EOC* must be considered together to fully understand the benefits available under the *EOC*. In this *EOC*, Kaiser Foundation Health Plan of the Northwest is sometimes referred to as "Company," "we," "our," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*. See the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* and the "Benefit Summary" completely, so that you can take full advantage of your Plan benefits. Also, if you have special health care needs, carefully read the sections applicable to you.

If you would like additional information about your benefits, important health plan disclosures, or other products and services, please call Member Services or e-mail us by registering at **kp.org/register**.

Term of This EOC

This *EOC* is effective for the period stated on the cover page, unless amended. Your Group's benefits administrator can tell you whether this *EOC* is still in effect.

DEFINITIONS

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

Allowed Amount. The lower of the following amounts:

- The actual fee the provider, facility, or vendor charged for the Service.
- 160 percent of the Medicare fee for the Service, as indicated by the applicable Current Procedural Terminology (CPT) code or Healthcare Common Procedure Coding System (HCPCS) code shown on the current Medicare fee schedule. The Medicare fee schedule is developed by the Centers for Medicare and Medicaid Services (CMS) and adjusted by Medicare geographical practice indexes. When there is no established CPT or HCPCS code indicating the Medicare fee for a particular Service, the Allowed Amount is 70 percent of the actual fee the provider, facility, or vendor charged for the Service.

Ancillary Service. Services that are:

- Related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner.
- Provided by assistant surgeons, hospitalists, and intensivists.
- Diagnostic Services, including radiology and laboratory Services.
- Provided by a Non-Participating Provider if there is no Participating Provider who can furnish such Service at the facility.
- Provided as a result of unforeseen, urgent medical needs that arise at the time the Service is provided, regardless of whether the Non-Participating Provider or Non-Participating Facility satisfies the notice and consent requirements under federal law.

Behavioral Health Assessment. Behavioral Health Assessment means an evaluation by a medical or behavioral health provider, in person or using telemedicine, to determine a patient's need for behavioral health treatment, including immediate crisis stabilization.

Behavioral Health Condition. Behavioral Health Condition means a disorder as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association.

Behavioral Health Crisis. Behavioral Health Crisis means a disruption in an individual's mental or emotional stability or functioning resulting in an urgent need for immediate outpatient treatment in an emergency department or admission to a hospital to prevent a serious deterioration in the individual's behavioral or physical health.

Benefit Summary. A section of this *EOC* which provides a brief description of your medical Plan benefits and what you pay for covered Services.

Charges. Charges means the following:

- For Services provided by Medical Group and Kaiser Foundation Hospitals, the amount in Company's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members.
- For Services for which a provider or facility (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the amount in the schedule of charges that Company negotiates with the capitated provider.
- For Services received from other Participating Providers or Participating Facilities we contract with, the amount the provider or facility has agreed to accept as payment.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if the Member's benefit Plan did not cover the pharmacy item. This amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Company.
- For Emergency Services received from a Non-Participating Provider or Non-Participating Facility (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Company pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process.
- For all other Services received from a Non-Participating Provider or Non-Participating Facility (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Participating Provider and Company or, absent such an agreement, the Allowed Amount.

Coinsurance. The percentage of Charges that you must pay when you receive a covered Service.

Company. Kaiser Foundation Health Plan of the Northwest, an Oregon nonprofit corporation. This *EOC* sometimes refers to our Company as "we," "our," or "us."

Copayment. The defined dollar amount that you must pay when you receive a covered Service.

Cost Share. The Deductible, Copayment, or Coinsurance you must pay for covered Services.

Deductible. The amount you must pay for certain Services you receive in a Year before we will cover those Services, subject to any applicable Copayment or Coinsurance, in that Year. Deductible amounts include the Deductible take-over amounts as described in the "Deductible" section of this *EOC*.

Dependent. A Member who meets the eligibility requirements for a Dependent as described in the "Who Is Eligible" section.

Dependent Limiting Age. The "Premium, Eligibility, and Enrollment" section requires that most types of Dependents (other than Spouses and disabled Dependents as described in the "Dependents" section) be under the Dependent Limiting Age in order to be eligible for membership. The "Benefit Summary" shows the Dependent Limiting Age (the student Dependent Limiting Age is for students, and the general Dependent Limiting Age is for non-students).

Durable Medical Equipment (DME). A non-disposable supply or item of equipment that is able to withstand repeated use, primarily and customarily used to serve a medical purpose and generally not useful to you if you are not ill or injured.

Emergency Medical Condition. An Emergency Medical Condition means a medical condition:

- That manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
  - Placing the person's health (or, with respect to a pregnant person, the health of them or their unborn child) in serious jeopardy.
  - Serious impairment to bodily functions.
  - Serious dysfunction of any bodily organ or part.
- With respect to a pregnant person who is having contractions, for which there is inadequate time to effect a safe transfer to another hospital before delivery or for which a transfer may pose a threat to the health or safety of them or the unborn child.
- That is a Behavioral Health Crisis.

Emergency Medical Service Provider. A person who has received formal training in prehospital and emergency care, and is licensed to attend any person who is ill or injured or who has a disability. Police officers, firefighters, funeral home employees and other persons serving in a dual capacity, one of which meets this definition, are considered Emergency Medical Services Providers.

Emergency Medical Services Transport. An Emergency Medical Service Provider's evaluation and stabilization of an individual experiencing an Emergency Medical Condition and the transportation of the individual to the nearest medical facility capable of meeting the needs of the individual.

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

- An Emergency Medical Services Transport.
- A medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act, "EMTALA"), or Behavioral Health Assessment, that is within the capability of the emergency department of a hospital, or of an Independent Freestanding Emergency Department, including Ancillary Services and patient observation routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Within the capabilities of the staff and facilities available at the hospital, or Independent Freestanding Emergency Department, the further examination and treatment required under EMTALA (or would be required under EMTALA if it applied to an Independent Freestanding Emergency Department) to Stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished.
- Post-Stabilization Care Services provided by a Non-Participating Provider or Non-Participating Facility are considered Emergency Services when federal law applies, and:

- Your Non-Participating Provider determines that you are not able to travel using non-medical transportation or non-emergency medical transportation to an available Participating Provider within a reasonable travel distance, taking into account your medical or Behavioral Health Condition; or,
- You or your authorized representative are not in a condition to provide consent to receiving Post-Stabilization Services or other covered Services from a Non-Participating Provider.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

***Evidence of Coverage* (*EOC*).** This *Evidence of Coverage* document provided to the Subscriber that specifies and describes benefits and conditions of coverage. This document, on its own, is not designed to meet the requirements of a summary plan description (SPD) under ERISA. After you enroll, you will receive a postcard that explains how you may either download an electronic copy of this *EOC* or request that this *EOC* be mailed to you.

External Prosthetic Devices. External prosthetic devices are rigid or semi-rigid external devices required to replace all or any part of a body organ or extremity.

Family. A Subscriber and all of their Dependents.

Gender Affirming Treatment. A Medically Necessary treatment, procedure, drug, device, product, or other Service that a health care provider prescribes to treat an individual for incongruence between the individual's gender identity and the individual's sex assignment at birth.

Group. The employer, union trust, or association with which we have an *Agreement* that includes this *EOC*.

Home Health Agency. A "home health agency" is an agency that: (i) meets any legal licensing required by the state or other locality in which it is located; (ii) qualifies as a participating home health agency under Medicare; and (iii) specializes in giving skilled nursing facility care Services and other therapeutic Services, such as physical therapy, in the patient's home (or to a place of temporary or permanent residence used as your home).

Homemaker Services. Assistance in personal care, maintenance of a safe and healthy environment, and Services to enable the individual to carry out the plan of care.

Independent Freestanding Emergency Department. A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

Kaiser Permanente. Kaiser Foundation Hospitals (a California nonprofit corporation), Medical Group, and Kaiser Foundation Health Plan of the Northwest (Company).

***Medical Facility Directory*.** The *Medical Facility Directory* includes addresses, maps, and telephone numbers for Participating Medical Offices and other Participating Facilities; and provides general information about getting care at Kaiser Permanente. After you enroll, you will receive an email or flyer that explains how you may either download an electronic copy of the *Medical Facility Directory* or request that the *Medical Facility Directory* be mailed to you.

Medical Group. Northwest Permanente, P.C., Physicians and Surgeons, a professional corporation of physicians organized under the laws of the state of Oregon. Medical Group contracts with Company to provide professional medical Services to Members and others primarily on a capitated, prepaid basis in Participating Facilities.

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

scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the relevant clinical area or areas within Kaiser Permanente locally or nationally; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service is Medically Necessary. You may appeal our decision as set forth in the "Grievances, Claims, Appeals, and External Review" section. The fact that a Participating Provider has prescribed, recommended, or approved a Service does not, in itself, make such Service Medically Necessary and, therefore, a covered Service.

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

Member. A person who is eligible and enrolled under this *EOC,* and for whom we have received applicable Premium. This *EOC* sometimes refers to a Member as "you." The term Member may include the Subscriber, their Dependent, or other individual who is eligible for and has enrolled under this *EOC*.

Non-Participating Facility. Any of the following licensed institutions that provide Services, but which are not Participating Facilities: hospitals and other inpatient centers; ambulatory surgical or treatment centers; birthing centers; medical offices and clinics; skilled nursing facilities; residential treatment centers; diagnostic, laboratory, and imaging centers; and rehabilitation settings. This includes any of these facilities that are owned and operated by a political subdivision or instrumentality of the state and other facilities as required by federal law and implementing regulations.

Non-Participating Provider. A physician or other health care provider, facility, business, or vendor regulated under state law to provide health or health-related services or otherwise providing health care services within the scope of licensure or certification consistent with state law that does not have a written agreement with Kaiser Permanente to participate as a health care provider for this Plan.

Orthotic Devices. Orthotic devices are rigid or semi-rigid external devices (other than casts) required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

Out-of-Pocket Maximum. The total amount of Deductible, Copayments, and Coinsurance you will be responsible to pay in a Year, as described in the "Out-of-Pocket Maximum" section of this *EOC*.

Participating Facility. Any facility listed as a Participating Facility in the *Medical Facility Directory*. Participating Facilities are subject to change.

Participating Hospital. Any hospital listed as a Participating Hospital in the *Medical Facility Directory*. Participating Hospitals are subject to change.

Participating Medical Office. Any outpatient treatment facility listed as a Participating Medical Office in the *Medical Facility Directory*. Participating Medical Offices are subject to change.

Participating Pharmacy. A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate, that is listed as a Participating Pharmacy in the *Medical Facility Directory*. Participating Pharmacies are subject to change.

Participating Physician. Any licensed physician who is an employee of the Medical Group, or contracts directly or indirectly with Medical Group. Participating Physicians are subject to change.

Participating Provider. Any person who is a Participating Physician; or a physician or other health care provider, facility, business, or vendor regulated under state law to provide health or health-related services or otherwise providing health care services within the scope of licensure or certification consistent with state law and which contracts directly or indirectly with Kaiser Permanente to provide Services to Members enrolled in this Plan. Participating Providers are subject to change.

Participating Skilled Nursing Facility. A facility that provides inpatient skilled nursing Services, rehabilitation Services, or other related health Services and is licensed by the state of Oregon or Washington

and approved by Company. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Participating Skilled Nursing Facility" does not include a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living. A "Participating Skilled Nursing Facility" may also be a unit or section within another facility (for example, a Participating Hospital) as long as it continues to meet the definition above. Participating Skilled Nursing Facilities are subject to change.

Plan. Any hospital expense, medical expense, or hospital and/or medical expense policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Post-Stabilization Care. The Services you receive after your treating physician determines that your Emergency Medical Condition is clinically stable.

Premium. Monthly membership charges paid by Group.

Primary Care Provider. An individual, clinic, or team of health care providers licensed or certified in Oregon to provide outpatient, nonspecialty medical services or to provide the coordination of health care for the purpose of:

- Promoting or maintaining mental and physical health and wellness; and
- Diagnosing, treating, or managing acute or chronic conditions caused by disease, injury, or illness.

Service Area. Our Service Area consists of certain geographic areas in the Northwest which we designate by ZIP code. Our Service Area may change. Contact Member Services for a complete listing of our Service Area ZIP codes.

Services. Health care services, supplies, or items.

Specialist. Any licensed Participating Provider who practices in a specialty care area of medicine (not family medicine, pediatrics, gynecology, obstetrics, general practice, or internal medicine). In most cases, you will need a referral in order to receive covered Services from a Specialist.

Spouse. The person to whom you are legally married under applicable law. For the purposes of this *EOC,* the term "Spouse" includes a person who is legally recognized as your domestic partner in a valid Certificate of Registered Domestic Partnership issued by the state of Oregon, validly registered as your domestic partner under the laws of another state, or otherwise recognized as your domestic partner under criteria agreed upon, in writing, by Kaiser Foundation Health Plan of the Northwest and your Group.

Stabilize. With respect to an Emergency Medical Condition, to provide the medical treatment of the 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 person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of them or their unborn child), "Stabilize" means to deliver the infant (including the placenta).

Subscriber. A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber.

Substance Use Disorder. A substance-related or addictive disorder listed in the most current version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* published by the American Psychiatric Association.

Urgent Care. Treatment for an unforeseen condition that requires prompt medical attention to keep it from becoming more serious, but that is not an Emergency Medical Condition.

Utilization Review. The formal application of clinical criteria and clinical guidance, screening procedures, decision rules, and medical protocols designed to ensure that each Member is receiving Services at the appropriate level. Utilization Review is used to monitor or evaluate:

- Medical necessity, appropriateness, effectiveness, or efficiency of a specific Service, procedure, or setting.
- Appropriateness of a Service for which prior authorization is requested or for which an exception to step therapy has been requested.
- Any other coverage that we indicate is subject to Utilization Review.

When Utilization Review is required to approve certain Services in advance, this is called prior authorization. Utilization Review to approve an ongoing course of treatment to be provided over a period of time or number of treatments is called concurrent review.

Year. A period of time that is either a) a calendar year beginning on January 1 of any year and ending at midnight December 31 of the same year, or b) a plan year beginning on an effective date and ending at midnight prior to the anniversary date agreed to by Company and Group. The "Benefit Summary" shows which period is applicable to this Plan.

PREMIUM, ELIGIBILITY, AND ENROLLMENT

Premium

Your Group is responsible for paying the Premium. If you are responsible for any contribution to the Premium, your Group will tell you the amount and how to pay your Group.

Who Is Eligible

General

To be eligible to enroll and to remain enrolled under this employer's *Agreement*, you must meet all of the following requirements:

- You must meet your Group's eligibility requirements that we have approved. (Your Group is required to inform Subscribers of its eligibility requirements.)
- You must meet the Subscriber or Dependent eligibility requirements described below unless your Group has different eligibility requirements that we have approved.

Subscribers

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

- You are an employee of your Group; or
- You are otherwise entitled to coverage through your Group under a trust agreement, retirement benefit program, employment contract, or the rules of a professional, trade, or bona fide association.
- You live or physically work inside our Service Area at least 50 percent of the time. For assistance about the Service Area or eligibility, please contact Member Services. The Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible solely because they live outside our Service Area or in another Kaiser Foundation Health Plan service area.

Dependents

If you are a Subscriber (or if you are a subscriber under our Kaiser Permanente Senior Advantage (HMO) plan offered by your Group), the following persons are eligible to enroll as your Dependents under this *EOC*. (Note: if you are a subscriber under a Kaiser Permanente Senior Advantage plan offered by your Group, all of your Dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by

your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to be entitled to Medicare.)

- Your Spouse.
- A person who is under the general Dependent Limiting Age shown in the "Benefit Summary" and who is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.
  - A child placed with you or your Spouse for foster care.
- A person who is over the general Dependent Limiting Age but under the student Dependent Limiting Age shown in the "Benefit Summary," who is a full-time registered student at an accredited college or accredited vocational school, and is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian.

  Students who suffer a severe illness or injury that causes them to lose full-time student status will continue to be considered full-time students for eligibility purposes, provided that within 31 days after the loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is Medically Necessary. Eligibility as a full-time student under this provision may then continue for up to 12 months from the date that your child's medical leave of absence began, or until your child reaches the student Dependent Limiting Age shown in the "Benefit Summary," whichever comes first.
- A person of any age who is primarily dependent upon you or your Spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of a developmental disability, mental illness, or a physical disability that occurred prior to the person reaching the general Dependent Limiting Age shown in the "Benefit Summary," if the person is any of the following:
  - Your or your Spouse's child.
  - A child adopted by you or your Spouse, or for whom you or your Spouse have assumed legal obligation in anticipation of adoption.
  - Any other person for whom you or your Spouse is a court-appointed guardian and was a court-appointed guardian prior to the person reaching the Dependent Limiting Age shown in the "Benefit Summary."

  We may request proof of incapacity and dependency annually.

Children born to a Dependent other than your Spouse (for example, your grandchildren) are not eligible for coverage beyond the first 31 days of life, including the date of birth, unless: (a) you or your Spouse adopts them or assumes a legal obligation in anticipation of adoption; (b) they are primarily supported by you or your Spouse and you or your Spouse is their court-appointed guardian; or, (c) your Group has different eligibility requirements that we have approved.

Company will not deny enrollment of a newborn child, newly adopted child, child for whom legal obligation is assumed in anticipation of adoption, child newly placed for adoption, or newly placed foster child solely on

the basis that: (a) the child was born out of wedlock; (b) the child is not claimed as a dependent on the parent's federal tax return; (c) the child does not reside with the child's parent or in our Service Area; or (d) the mother of the child used drugs containing diethylstilbestrol prior to the child's birth. Also, Company does not discriminate between married and unmarried persons, or between children of married or unmarried persons.

When You Can Enroll and When Coverage Begins

A Group is required to inform employees about when they are eligible to enroll and their effective date of coverage. The effective date of coverage for employees and their eligible Dependents is determined by the Group in accord with waiting period requirements in state and federal law. The Group is required to inform the Subscriber of the date membership becomes effective.

If an individual is eligible to be a Dependent under this *EOC* but the subscriber in their family is enrolled under our Kaiser Permanente Senior Advantage evidence of coverage offered by the Group, the subscriber must follow the rules for adding Dependents as described in this "When You Can Enroll and When Coverage Begins" section.

New Employees and Their Dependents

When a Group informs an employee that they are eligible to enroll as a Subscriber, they may enroll themselves and any eligible Dependents by submitting a Company-approved enrollment application to the Group within 30 days of eligibility for enrollment.

Open Enrollment

The Group will inform an employee of their open enrollment period and effective date of coverage. An eligible employee may enroll as a Subscriber along with any eligible Dependents if they or their Dependents were not previously enrolled. If you are an existing Subscriber, you may add eligible Dependents not previously enrolled following your Group's enrollment process during the open enrollment period.

Special Enrollment

If an eligible employee or their eligible Dependents do not enroll when they are first eligible, and later want to enroll, they can enroll only during open enrollment unless they experience a qualifying event as defined in applicable state and federal law. Your Group will administer special enrollment rights under applicable state and federal law.

Examples of qualifying events include, but are not limited to:

- Loss of minimum essential coverage for any reason other than nonpayment of Premium, rescission of coverage, misrepresentation, fraud or voluntary termination of coverage.
- Gaining a Dependent through marriage or entering into a domestic partnership, birth, adoption, placement for adoption, placement for foster care, or through a child support order or other court order.
- Loss of a Dependent through divorce or legal separation, or if the enrollee, or their Dependent dies.

Note: If the individual is enrolling as a Subscriber along with at least one eligible Dependent, only one enrollee must meet one of the requirements for a qualifying event.

The individual must notify the Group within 30 days of a qualifying event, 60 days if they are requesting enrollment due to a change in eligibility for Medicaid or Child Health Insurance Program (CHIP) coverage. The Group will determine if the individual is eligible to select or change coverage. Contact the Group for further instructions on how to enroll.

A Group may require an employee declining coverage to provide a written statement indicating whether the coverage is being declined due to other health coverage. If this statement is not provided, or if coverage is not

declined due to other health coverage, the employee may not be eligible for special enrollment due to loss of other health coverage. Contact the Group for further information.

Adding New Dependents to an Existing Account

To enroll a Dependent who becomes eligible to enroll after you became a Subscriber, you must submit a Company-approved enrollment application to your Group as described in this "Adding New Dependents to an Existing Account" section.

Newborns, newly adopted children, children newly placed for adoption, or newly placed foster children are covered for 31 days after birth, adoption, placement for adoption, or placement for foster care. In order for coverage to continue beyond this 31-day period, you must submit an enrollment application to your Group within 31 days after the date of birth, adoption, placement for adoption, or placement for foster care if additional Premium is required to add the Dependent. If additional Premium is not required, the application requirement is waived; however, please notify your Group and Member Services, to add the child to your Plan.

To add all other newly eligible Dependents (such as a new Spouse), you must submit an enrollment application to your Group within 30 days after the qualifying event.

Contact your Group for further instructions on how to enroll your newly eligible Dependent.

When Coverage Begins

Your Group will notify you of the date your coverage will begin. Membership begins at 12 a.m. PT of the effective date specified.

If an individual enrolls in, adds a Dependent, or changes health plan coverage during a special enrollment period, the membership effective date will be determined by your Group under applicable state and federal law.

HOW TO OBTAIN SERVICES

The provider network for this Deductible Plan is the Classic network.

The Classic network includes Participating Providers who are either employed by us or contract directly or indirectly with us to provide covered Services for Members enrolled in this Deductible Plan. You pay the Cost Share amount shown on your "Benefit Summary" when you receive covered Services from Participating Providers and Participating Facilities.

To receive covered benefits, you must obtain Services from Participating Providers and Participating Facilities except as described under the following sections in this *EOC*:

- "Referrals to Non-Participating Providers and Non-Participating Facilities."
- "Emergency, Post-Stabilization, and Urgent Care."
- "Receiving Care in Another Kaiser Foundation Health Plan Service Area."
- "Out-of-Area Coverage for Dependents."
- "Ambulance Services."

To locate a Participating Provider or Participating Facility, contact Member Services or visit **kp.org/doctors** to see all Kaiser Permanente locations near you, search for Participating Providers, and read online provider profiles.

We will not directly or indirectly prohibit you from freely contracting at any time to obtain health care Services from Non-Participating Providers and Non-Participating Facilities outside the Plan. However, if you choose to receive Services from Non-Participating Providers and Non-Participating Facilities except as otherwise specifically provided in this *EOC*, those Services will not be covered under this *EOC* and you will

be responsible for the full price of the Services. Any amounts you pay for non-covered Services will not count toward your Deductible (if any) or Out-of-Pocket Maximum.

Using Your Identification Card

We provide each Member with a Company identification (ID) card that contains the Member health record number. Have your health record number available when you call for advice, make an appointment, or seek Services. We use your health record number to identify your medical records, for billing purposes and for membership information. You should always have the same health record number. If we ever inadvertently issue you more than one health record number, please let us know by calling Member Services. If you need to replace your ID card, please call Member Services.

Your ID card is for identification only, and it does not entitle you to Services. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-member for any Services they receive. If you allow someone else to use your ID card, we may keep your card and terminate your membership (see the "Termination for Cause" section). We may request photo identification in conjunction with your ID card to verify your identity.

Advice Nurses

If you are unsure whether you need to be seen by a physician or where to go for Services, or if you would like to discuss a medical concern, call Member Services during normal business hours, evenings, weekends, and holidays to be directed to one of our advice nurses.

You may also use the Member section of our website, **kp.org**, to send *nonurgent* questions to an advice nurse or pharmacist.

Your Primary Care Provider

We encourage you to choose a Primary Care Provider for each covered Family Member. This decision is important as your Primary Care Provider provides or arranges most of your health care needs.

You may select a Participating Provider from family practice, internal medicine, or pediatrics as your Primary Care Provider. Members also have the option of choosing a women's health care Participating Provider as their Primary Care Provider. A women's health care provider is an obstetrician or gynecologist, a physician associate specializing in women's health, an advanced registered nurse practitioner specializing in women's health, a naturopathic physician specializing in women's health, or a certified nurse midwife. Not all Participating Providers in these specialties are designated Primary Care Providers.

If you do not select a Primary Care Provider within 90 days, we will assign you to an individual Primary Care Provider or primary care team. We will send you a letter that includes information to help you learn more about your provider or care team, how to find information about other Primary Care Providers near you, and how to change your Primary Care Provider. You may select a different Primary Care Provider at any time. The change will take effect immediately.

For more information, visit **kp.org/doctors** to search for Participating Providers and Kaiser Permanente locations near you and read online provider profiles. For help with selecting or changing your Primary Care Provider, contact Member Services.

Appointments for Routine Services

Routine appointments are for medical needs that are not urgent such as checkups and follow-up visits that can wait more than a few days.

If you need to make a routine care appointment, go to **kp.org** to schedule an appointment online or call Member Services. Try to make your routine care appointments as far in advance as possible. For information about getting other types of care, refer to the "Emergency, Post-Stabilization, and Urgent Care" section.

Healthy Resources

You have access to these value-added programs and resources at no cost, unless otherwise noted below. You can register online at **kp.org/register** or on the Kaiser Permanente mobile app. You'll need your health/medical record number, which you can find on your Kaiser Permanente ID card.

- **Sign up for healthy lifestyle programs.** With our online wellness programs, you'll get advice, encouragement, and tools to help you create positive changes in your life. Our programs can help you lose weight, eat healthier, quit smoking, reduce stress, manage ongoing conditions like diabetes or depression. Start with a Total Health Assessment, a simple online survey to give you a complete look at your health. You can also share and discuss the results with your doctor. Visit **kp.org/healthylifestyles**.
- **Get a wellness coach.** If you need a little extra support, we offer Wellness Coaching by Phone. You'll work one-on-one with your personal coach to make a plan to help you reach your health goals. Visit **kp.org/wellnesscoach**.
- **Join health classes.** You can sign up for health classes and support groups. Classes vary at each location and some may require a fee. Visit **kp.org/classes**.
- **Enjoy reduced rates.** Get reduced rates on a variety of health-related products and services through The ChooseHealthy® program. These include:
  - Active&Fit Direct – You pay $25 per month (plus a one-time $25 enrollment fee) for access to a national network of more than 10,000 fitness centers.
  - Up to 25% off a contracted provider's regular rates for acupuncture, chiropractic care, and massage therapy.*

  Visit **kp.org/choosehealthy**. *Please note that the ChooseHealthy program is not insurance. You should check your benefits before using this discount program, as those benefits may result in lower costs to you than using this discount program.
- **Self-care.** Manage stress, improve your mood, sleep better, and more with the help of wellness apps, available to adult members. Visit **kp.org/selfcareapps**.
- **Health guides.** Stay informed on popular health subjects or discover something new through our healthy living guides. Visit **kp.org/livehealthy**.

The programs and resources described above are not covered under your health plan benefits and are not subject to the terms set forth in this *EOC* or other plan documents. Programs and resources are provided by third-party entities and may be discontinued at any time. If you would like additional information about these programs and resources, call Member Services.

Getting Assistance

We want you to be satisfied with your health care Services. If you have any questions or concerns about Services you received from Participating Providers or Participating Facilities, please discuss them with your Primary Care Provider or with other Participating Providers who are treating you.

Member Services representatives can answer questions you have about your benefits, available Services, and the facilities where you can receive Services. For example, they can explain your benefits, how to make your first medical appointment, what to do if you move, what to do if you need Services while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim, complaint, grievance, or appeal, as described in the "Grievances, Claims, Appeals, and External Review" section. Upon request Member Services can also provide you with written materials about your coverage.

Member Services representatives are available to assist you Monday through Friday (except holidays), from 8 a.m. to 6 p.m. PT.

All areas 1-800-813-2000

TTY for the hearing and speech impaired 711

Language interpretation services..... 1-800-324-8010

You may also e-mail us by registering on our website at **kp.org/register**.

Referrals

Referrals to Participating Providers and Participating Facilities

Primary Care Providers provide primary medical care, including pediatric care and obstetrics/gynecology care. Specialists provide specialty medical care in areas such as surgery, orthopedics, cardiology, oncology, urology, dermatology, and allergy/immunology. Your Primary Care Provider will refer you to a Specialist when appropriate. In most cases, you will need a referral to see a Specialist the first time. Please call Member Services for information about specialty Services that require a referral or discuss your concerns with your Primary Care Provider. In some cases, a standing referral may be allowed to a Specialist for a time period that is in accord with your individual medical needs as determined by the Participating Provider and Company.

Some outpatient specialty care is available in Participating Medical Offices without a referral. You do not need a referral for outpatient Services provided in the following departments at Participating Medical Offices owned and operated by Kaiser Permanente. Please call Member Services to schedule routine appointments in these departments:

- Audiology (routine hearing exams).
- Cancer Counseling.
- Behavioral Health Services.
- Obstetrics/Gynecology.
- Occupational Health.
- Optometry (eye exams).
- Social Services.
- Substance Use Disorder Services.

Referrals to Non-Participating Providers and Non-Participating Facilities

If your Participating Provider decides that you require Services not available from Participating Providers or Participating Facilities, they will recommend to Medical Group and Company that you be referred to a Non-Participating Provider or Non-Participating Facility. If the Medical Group's assigned Participating Provider determines that the Services are Medically Necessary and are not available from a Participating Provider or Participating Facility and Company determines that the Services are covered Services, Company will authorize your referral to a Non-Participating Provider or Non-Participating Facility for the covered Services. You pay the same Cost Share for authorized referral Services that you would pay if you received the Services from a Participating Provider or at a Participating Facility. You will need written authorization in advance in order for the Services to be covered. If Company authorizes the Services, you will receive a written "Authorization for Outside Medical Care" approved referral to the Non-Participating Provider or Non-Participating Facility, and only the Services and number of visits that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these Services.

Prior Authorization Review Requirements

When you need Services, you should talk with your Participating Provider about your medical needs or your request for Services. Your Participating Provider provides covered Services that are Medically Necessary.

Participating Providers will use their judgment to determine if Services are Medically Necessary. Some Services are subject to approval through Utilization Review, based on Utilization Review criteria developed by Medical Group or another organization utilized by the Medical Group and approved by Company. If you seek a specific Service, you should talk with your Participating Provider. Your Participating Provider will discuss your needs and recommend an appropriate course of treatment.

If you request Services that must be approved through Utilization Review and the Participating Provider believes they are Medically Necessary, the Participating Provider may submit the request for Utilization Review on your behalf.

If the request is denied, we will notify you and the requesting Participating Provider of the decision within two business days of the request. The decision letter will explain the reason for the determination along with instructions for filing an appeal.

If more information is needed to make a decision, we will notify you and the requesting Participating Provider in writing, of the specific additional information needed to make the determination, before the initial decision period ends.

We will make a decision and send notification within two business days after we receive the first piece of information (including documents) we requested.

If we do not receive any of the requested information, we will make a decision based on the information we have, 15 days after the date of the request for additional information.

Approved requests for prior authorization of a treatment, other than a prescription drug, are binding on us for a period ending on the later of the following:

- The reasonable duration of the treatment based on clinical standards; or
- Sixty (60) days after the date that the treatment begins following our approval of the prior authorization request.

You may request a copy of the complete Utilization Review criteria used to make the determination by calling Member Services.

If you disagree with the prior authorization review decision made by Company, you may appeal the decision, by following the course of grievances and appeals as outlined in the "Grievances, Claims, Appeals and External Review" section.

Your Participating Provider will request prior authorization when necessary. The following are examples of Services that require prior authorization:

- Bariatric surgery Services.
- Breast reduction surgery.
- Dental and orthodontic Services for the treatment of craniofacial anomalies.
- Drug formulary exceptions.
- Durable Medical Equipment.
- External Prosthetic Devices and Orthotic Devices.
- Gender Affirming Treatment.
- General anesthesia and associated hospital or ambulatory surgical facility Services provided in conjunction with non-covered dental Services.
- Habilitative Services.
- Hospice and home health Services.

- Inpatient hospital Services.
- Inpatient and residential Substance Use Disorder Services.
- Inpatient, residential, and Assertive Community Treatment (ACT) behavioral health Services.
- Non-emergency medical transportation.
- Open MRI.
- Plastic surgery.
- Referrals for any Non-Participating Facility Services or Non-Participating Provider Services.
- Referrals to Specialists who are not employees of Medical Group.
- Rehabilitative therapy Services.
- Routine foot Services.
- Skilled nursing facility Services.
- Transplant Services.
- Travel and lodging expenses.

For more information about Utilization Review, a copy of the complete Utilization Review criteria developed by Medical Group and approved by Company for a specific condition, or to talk to a Utilization Review staff person, please contact Member Services.

If you ask for Services that the Participating Provider believes are not Medically Necessary and does not submit a request on your behalf, you may ask for a second opinion from another Participating Provider. You should contact the manager in the area where the Participating Provider is located. Member Services can connect you with the correct manager, who will listen to your issues and discuss your options.

You may also choose to submit a request for Services that you have not yet received, as described under "Pre-service Claims and Appeals" in the "Grievances, Claims, Appeals, and External Review" section.

Except in the case of misrepresentation, prior authorization determinations that relate to your membership eligibility are binding on us if obtained no more than five business days before you receive the Service. Prior authorization determinations that relate to whether the Service is Medically Necessary or are covered under the Plan are binding on us if obtained no more than 60 days before you receive the Service. We may revoke or amend an authorization for Services you have not yet received if your membership terminates or your coverage changes or you lose your eligibility.

Participating Providers and Participating Facilities Contracts

Participating Providers and Participating Facilities may be paid in various ways, including salary, per diem rates, case rates, fee-for-service, incentive payments, and capitation payments. Capitation payments are based on a total number of Members (on a per-Member per-month basis), regardless of the amount of Services provided. Company may directly or indirectly make capitation payments to Participating Providers and Participating Facilities only for the professional Services they deliver, and not for Services provided by other physicians, hospitals, or facilities. Call Member Services if you would like to learn more about the ways Participating Providers and Participating Facilities are paid to provide or arrange medical and hospital Services for Members.

Our contracts with Participating Providers and Participating Facilities provide that you are not liable for any amounts we owe. You will be liable for the cost of non-covered Services that you receive from any providers or facilities, including Participating Providers and/or Participating Facilities.

Provider Whose Contract Terminates

You may be eligible to continue receiving covered Services from a Participating Provider for a limited period of time after our contract with the Participating Provider terminates.

This continuity of care provision applies when our contract with a Participating Provider terminates, or when a physician's employment with Medical Group terminates, except when the termination is because of quality of care issues or because the Participating Provider:

- Has retired.
- Has died.
- No longer holds an active license.
- Has moved outside our Service Area.
- Has gone on sabbatical.
- Is prevented from continuing to care for patients because of other circumstances.

If you satisfy all of the following requirements, you may qualify for this continuity of care:

- You are a Member on the date you receive the Services.
- You are undergoing an active course of treatment that is Medically Necessary and you and the Participating Provider agree that it is desirable to maintain continuity of care.
- We would have covered the Services if you had received them from a Participating Provider.
- The provider agrees to adhere to the conditions of the terminated contract between the provider and Company or its designee.

Except for the pregnancy situation described below, this extension will continue until the earlier of the following:

- The day following the completion of the active course of treatment giving rise to your exercising your continuity of care right; or
- The 120th day from the date we notify you about the contract termination.

If you are in the second trimester of pregnancy this extension will continue until the later of the following dates:

- The 45th day after the birth; or
- As long as you continue under an active course of treatment, but no later than the 120th day from the date we notify you about the contract termination.

Receiving Care in Another Kaiser Foundation Health Plan Service Area

You may receive covered Services from another Kaiser Foundation Health Plan, if the Services are provided, prescribed, or directed by that other plan, and if the Services would have been covered under this *EOC*. Covered Services are subject to the terms and conditions of this *EOC*, including prior authorization requirements, the applicable Cost Share shown in the "Benefit Summary," and the exclusions, limitations and reductions described in this *EOC*.

For more information about receiving care in other Kaiser Foundation Health Plan service areas, including availability of Services, and provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at **kp.org/travel**.

Out-of-Area Coverage for Dependents

This limited out-of-area benefit is available to Dependent children who are under the Dependent Limiting Age as shown in the "Benefit Summary" and who are outside any Kaiser Foundation Health Plan service area.

We cover certain Medically Necessary Services that a Dependent child receives from Non-Participating Providers inside the United States (which for the purpose of this benefit means the 50 states, the District of Columbia, and United States territories). These out-of-area benefits are limited to the following Services as otherwise covered under this *EOC*. Any other Services not specifically listed as covered are excluded under this out-of-area benefit.

- Office visits are limited to preventive care, primary care, specialty care, outpatient physical therapy visits, outpatient behavioral health and Substance Use Disorder Services, naturopathic medicine Services, and allergy injections – limited to ten visits combined per Year.
- Laboratory and diagnostic X-rays – limited to ten visits per Year. This benefit does not include special diagnostic procedures such as CT, MRI, or PET scans.
- Prescription drug fills – limited to ten fills per Year.

You pay the Cost Share as shown in the "Benefit Summary" under the "Out-of-Area Coverage for Dependents" section.

This out-of-area benefit cannot be combined with any other benefit, so we will not pay under this "Out-of-Area Coverage for Dependents" section for a Service we are covering under another section of this *EOC*, such as:

- "Receiving Care in Another Kaiser Foundation Health Plan Service Area."
- Services covered in the "Emergency, Post-Stabilization, and Urgent Care" section and under "Your Primary Care Provider" in the "How to Obtain Services" section.
- "Transplant Services."

POST-SERVICE CLAIMS – SERVICES ALREADY RECEIVED

In general, if you have a medical or pharmacy bill from a Non-Participating Provider, Non-Participating Facility, or non-participating pharmacy, our Claims Administration Department will handle the claim. Member Services can assist you with questions about specific claims or about the claim procedures in general.

If you receive Services from a Non-Participating Provider following an authorized referral from a Participating Provider, the Non-Participating Provider will send the bill to Claims Administration directly. You are not required to file a claim.

If you receive Services from a Non-Participating Provider or Non-Participating Facility without an authorized referral, or from a pharmacy that is not a Participating Pharmacy, and you believe Company should cover the Services, you need to send a completed medical claim form and the itemized bill to:

Kaiser Permanente
National Claims Administration - Northwest
PO Box 370050
Denver, CO 80237-9998

You can request a claim form from Member Services or download it from **kp.org**. When you submit the claim, please include a copy of your medical records from the Non-Participating Provider or Non-Participating Facility if you have them.

Company accepts CMS 1500 claim forms for professional Services and UB-04 forms for hospital claims. Even if the provider bills Company directly, you still need to submit the claim form.

You must submit a claim for a Service within 12 months after receiving that Service. If it is not reasonably possible to submit a claim within 12 months, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

We will reach a decision on the claim and pay those covered Charges within 30 calendar days from receipt unless additional information, not related to coordination of benefits, is required to make a decision. If the 30-day period must be extended, you will be notified in writing with an explanation about why. This written notice will explain how long the time period may be extended depending on the requirements of applicable state and federal laws, including ERISA.

You will receive written notification about the claim determination. This notification will provide an explanation for any unpaid amounts. It will also tell you how to appeal the determination if you are not satisfied with the outcome, along with other important disclosures required by state and federal laws.

If you have questions or concerns about a bill from Company, you may contact Member Services for an explanation. If you believe the Charges are not appropriate, Member Services will advise you on how to proceed.

EMERGENCY, POST-STABILIZATION, AND URGENT CARE

Emergency Services

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

You pay the emergency department visit Cost Share shown in the "Benefit Summary" under "Outpatient Services" for all Services received in the emergency department.

If you receive covered inpatient hospital Services, you pay the Cost Share shown in the "Benefit Summary" under "Inpatient Hospital Services," regardless of whether the Services also constitute Emergency Services or Post-Stabilization Care. If you visit an emergency department and are not admitted directly as an inpatient or to Kaiser Permanente at Home™, you pay the emergency department visit Cost Share shown in the "Benefit Summary" under "Outpatient Services" for all Services received in the emergency department.

If you have an Emergency Medical Condition, we cover the Services of an Emergency Medical Service (EMS) Provider and transportation to the nearest medical facility that meets your needs. Emergency transportation may be by air, ground, or water.

Emergency Services are available from Participating Hospital emergency departments 24 hours a day, seven days a week. Contact Member Services or see our *Medical Facility Directory* for locations of these emergency departments.

Post-Stabilization Care

We cover Post-Stabilization Care if one of the following is true:

- A Participating Provider or Participating Facility provides the Services.
- We authorize the Services from the Non-Participating Provider or Non-Participating Facility.
- Services are provided after you are Stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit during which screening and Stabilization Services have been furnished.

Coverage for Post-Stabilization Care from a Non-Participating Provider or Non-Participating Facility is limited to the Allowed Amount. In addition to the applicable Cost Share, you are responsible for paying any amount over the Allowed Amount, and any such payments do not count toward the Deductible or the Out-of-Pocket Maximum. You are not responsible for paying any amount over the Allowed Amount for Post-Stabilization Care from a Non-Participating Provider at a Participating Facility.

To request prior authorization for your receiving Post-Stabilization Care from a Non-Participating Provider or Non-Participating Facility, you or someone on your behalf must call us at 503-735-2596, or toll-free at 1-877-813-5993, before you receive the Services if it is reasonably possible to do so, but no later than 24 hours after any admission.

We understand that extraordinary circumstances can delay your ability to call us, for example if you are unconscious or if there is no parent or guardian with a young child. In these cases, you or someone on your behalf must call us as soon as reasonably possible. If you (or someone on your behalf) do not call us by the applicable deadline, we will not cover Post-Stabilization Care that you receive from a Non-Participating Provider or Non-Participating Facility.

After we are notified, we will discuss your condition with the Non-Participating Provider. If we decide that the Post-Stabilization Care is Medically Necessary and would be covered if you received it from a Participating Provider or Participating Facility, we will either authorize the Services from the Non-Participating Provider or Non-Participating Facility, or arrange to have a Participating Provider or Participating Facility provide the Services.

If we decide to arrange to have a Participating Provider or Participating Facility (or other designated provider or facility) provide the Services to you, we may authorize special transportation Services that are medically required to get you to the provider or facility. This may include transportation that is otherwise not covered.

When you receive Emergency Services from Non-Participating Providers, Post Stabilization Care may qualify as Emergency Services pursuant to federal law. We will not require prior authorization for such Post-Stabilization Care when your attending Non-Participating Provider determines that, after you are Stabilized, and taking into account your medical or Behavioral Health Condition, you are not able to travel to an available Participating Provider located within a reasonable travel distance, using non-medical transportation or non-emergency transportation.

Non-Participating Providers may provide notice and seek your consent to provide Post-Stabilization Care Services or other covered Services. Such Services will not be covered if you provide consent and do not obtain prior authorization as described in this section. You will be responsible for paying for the Services.

Urgent Care

Inside Our Service Area

You may receive covered Urgent Care Services from Participating Providers, including Kaiser Permanente Urgent Care. Visit **kp.org/getcare** or call Member Services to find the Kaiser Permanente Urgent Care locations nearest you.

Outside Our Service Area

You may receive covered Urgent Care Services from Participating Providers or Participating Facilities. Visit **kp.org/getcare** or call Member Services to find Urgent Care locations nearest you.

If you are temporarily outside our Service Area, we also cover Urgent Care you receive from a Non-Participating Provider or Non-Participating Facility, if we determine the Services were necessary to prevent serious deterioration of your health and that the Services could not be delayed until you returned to our Service Area.

WHAT YOU PAY

This section contains information to help you understand your health care costs. We also provide a cost estimator tool to assist you in planning for the estimated costs of Services. To access the secure cost estimator tool, log in to your **kp.org** member account and navigate to the cost estimates link on the "Coverage & Costs" tab. If you would like additional information about cost estimates, call Member Services.

Deductible

For each Year, most covered Services are subject to the Deductible amounts shown in the "Benefit Summary." The "Benefit Summary" indicates which Services are subject to the Deductible.

For Services that are subject to the Deductible, you must pay Charges for the Services when you receive them, until you meet your Deductible.

If you are the only Member in your Family, then you must meet the self-only Deductible. If there is at least one other Member in your Family, then you must each meet the individual Family Member Deductible, or your Family must meet the Family Deductible, whichever occurs first. Each individual Family Member Deductible amount counts toward the Family Deductible amount. Once the Family Deductible is satisfied, no further individual Family Member Deductible will be due for the remainder of the Year. The Deductible amounts are shown in the "Benefit Summary."

After you meet the Deductible, you pay the applicable Copayments and Coinsurance for covered Services for the remainder of the Year until you meet your Out-of-Pocket Maximum (see "Out-of-Pocket Maximum" in this "What You Pay" section).

For each Year, the following amounts count toward your Deductible:

- Charges you pay for covered Services you receive in that Year and that are subject to the Deductible.
- **Deductible take-over.** Payments that were counted toward your deductible under your prior group health coverage if all of the following requirements are met:
  - This group health coverage with Company replaces the Group's prior group health coverage.
  - Your prior group health coverage was not with Company or with any Kaiser Foundation Health Plan.
  - You were covered under Group's prior group health coverage on the day before the effective date of this *EOC*.
  - The payments were for Services you received during the period of 12 months or less that occurred between the plan year effective date under Group's prior group health coverage and your effective date of coverage under this *EOC*.
  - The payments were for Services that we would have covered under this *EOC* if you had received them as a Member during the term of this *EOC*.
  - We would have counted the payments toward your Deductible under this *EOC* if you had received the Services as a Member during the term of this *EOC*.

Note: If your Group has purchased benefits with a specific benefit Deductible, such as a prescription drug benefit, payments made for these benefits will be counted only to that specific benefit Deductible and will accumulate separately from the Deductible for covered Services shown in the "Benefit Summary."

Copayments and Coinsurance

The Copayment or Coinsurance for each covered Service is shown in the "Benefit Summary." Copayments or Coinsurance are due when you receive the Service. If we must bill you, an accounting fee may be added to offset handling costs.

Out-of-Pocket Maximum

There is a maximum to the total dollar amount of Deductible, Copayments, and Coinsurance that you must pay for covered Services that you receive within the same Year.

If you are the only Member in your Family, then you must meet the self-only Out-of-Pocket Maximum. If there is at least one other Member in your Family, then you must each meet the individual Family Member Out-of-Pocket Maximum, or your Family must meet the Family Out-of-Pocket Maximum, whichever occurs first. Each individual Family Member Out-of-Pocket Maximum amount counts toward the Family Out-of-Pocket Maximum amount. The Out-of-Pocket Maximum amounts are shown in the "Benefit Summary."

All Deductible, Copayments, and Coinsurance count toward the Out-of-Pocket Maximum, unless otherwise indicated. After you reach the Out-of-Pocket Maximum, you are not required to pay Copayments and Coinsurance for these Services for the remainder of the Year. Member Services can provide you with the amount you have paid toward your Out-of-Pocket Maximum.

The following amounts do not count toward the Out-of-Pocket Maximum and you will continue to be responsible for these amounts even after the Out-of-Pocket Maximum is satisfied:

- Payments for Services that are not covered under this *EOC*.
- Payments that you make because you exhausted (used up) your benefit allowance, or because we already covered the benefit maximum amount or the maximum number of days or visits for a Service.
- Payments for Services under the "Adult Vision Hardware and Optical Services Rider," if purchased by your Group.
- Payments for Services under the "Hearing Aid Rider," if purchased by your Group.
- Payments for enhanced benefit Services under the "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider," if purchased by your Group.
- Amounts recovered from a liability claim against another party subject to reimbursement under the "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section.

BENEFITS

The Services described in this "Benefits" section are covered only if all the following conditions are satisfied, and will not be retrospectively denied:

- You are a Member on the date you receive the Services.
- A Participating Provider determines that the Services are Medically Necessary.
- The Services are provided, prescribed, authorized, or directed by a Participating Provider except where specifically noted to the contrary in this *EOC*.
- You receive the Services from a Participating Provider, Participating Facility, or from a Participating Skilled Nursing Facility, except where specifically noted to the contrary in this *EOC*.
- You receive prior authorization for the Services, if required under "Prior Authorization Review Requirements" in the "How to Obtain Services" section.

All Services are subject to the coverage requirements described in this "Benefits" section. Some Services are subject to benefit-specific exclusions and/or limitations, which are listed, when applicable, in each benefit section. A broader list of exclusions and limitations that apply to all benefits is provided under the "Exclusions and Limitations" section.

All covered Services are subject to any applicable Cost Share as described in the "What You Pay" section and in the "Benefit Summary."

The benefits under this Plan are not subject to a pre-existing condition waiting period.

Preventive Care Services

We cover a variety of preventive care Services, which are Services to keep you healthy or to prevent illness, and are not intended to diagnose or treat a current or ongoing illness, injury, sign or symptom of a disease, or condition.

Preventive care Services include:

- Services recommended by, and rated A or B by, the U.S. Preventive Services Task Force (USPSTF). You can access the list of preventive care Services at **www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations**.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC.
- Preventive care and screenings for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
- Preventive care and screenings supported by HRSA. You can access the list of preventive care Services at **www.hrsa.gov/womens-guidelines/**.
- Any additional reproductive health preventive Services for all Members as required by applicable state law.

Services received for a current or ongoing illness, injury, sign or symptom of a disease, or condition during a preventive care examination or procedure may be subject to the applicable Cost Share.

Covered preventive care Services include, but are not limited to:

- Bone densitometry.
- Cervical cancer screening.
- Chlamydia test.
- Cholesterol tests (all types).
- Colorectal cancer screening for Members age 45 or older, or for younger Members who are at high risk, including:
  - Fecal occult blood test yearly plus one flexible sigmoidoscopy every four years, or more frequently as recommended by your Participating Provider.
  - Colonoscopy every ten years, or double contrast barium enema every five years, or more frequently as recommended by your Participating Provider.
  - Follow-up colonoscopy for screening to be achieved following abnormal findings identified by flexible sigmoidoscopy or CT colonography screening.
  - Required specialist consultation prior to the screening procedure.
  - Bowel preparation medications prescribed for the screening procedure.
  - Anesthesia Services performed in connection with the screening procedure.
  - Polyp removal performed during the screening procedure.
  - Any pathology exam on a polyp biopsy performed as part of the screening procedure.
- Contraceptive Services and supplies, including insertion/removal of IUD or implanted birth control drugs and devices.

- Diabetic retinopathy screening.
- Fasting glucose test.
- Healthy diet counseling and counseling for obesity and weight management.
- Immunizations.
- Mammography.
- Prostate screening examinations once every two years for men 50 years of age or older or for younger Members who are at high risk, and more frequently if your Participating Provider recommends it because you are at high risk for prostate cancer or disease.
- Routine preventive physical exam (adult, well-child, and well-baby).
- Screening prostate-specific antigen (PSA) test (not including monitoring or ultrasensitive tests).
- Transabdominal and transcervical sterilization procedures.

When a Participating Provider determines that a recommended Service is medically appropriate for an individual and the individual satisfies the criteria for the Service or treatment, we will provide coverage for the recommended Service regardless of sex assigned at birth, gender identity, or gender of the individual otherwise recorded by us.

If you would like additional information about covered preventive care Services, call Member Services. Information is also available online at **kp.org/prevention**.

Benefits for Outpatient Services

We cover the following outpatient Services for diagnosis, treatment, and preventive medicine upon payment of any applicable Cost Share shown in the "Benefit Summary" in the "Outpatient Services" section. Additional types of outpatient Services are covered as described under other headings in this "Benefits" section.

- Allergy testing and treatment materials.
- Biofeedback.
- Cardiac rehabilitative therapy visits.
- Chemotherapy and radiation therapy Services.
- Child abuse medical assessment including Services provided by an Oregon children's advocacy center that reports to the Child Abuse Multidisciplinary Intervention Program. Services may include, but are not limited to, a physical exam, forensic interview and behavioral health treatment.
- Diagnostic Services and scope insertion procedures, such as colonoscopy, endoscopy, and laparoscopy.
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits, subject to the drug formulary and exclusions described under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Emergency department visits.
- Eye exams, including refraction exams.
- Gender Affirming Treatment.
- Internally implanted devices, including bilateral cochlear implants and bone-anchored hearing aids, except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- Interrupted pregnancy surgery performed in an outpatient setting.

- Nurse treatment room visits to receive injections, including allergy injections.
- Outpatient surgery and other outpatient procedures.
- Primary care visits for internal medicine, gynecology, family medicine, and pediatrics.
- Respiratory therapy.
- Routine hearing exams.
- Specialty care visits.
- Treatment for temporomandibular joint (TMJ) disorder.
- Urgent Care visits.
- Vasectomy.

Benefits for Inpatient Hospital Services

We cover the following Services when you are admitted as an inpatient in a Participating Hospital. Additional types of inpatient Services are covered as described under other headings in this "Benefits" section.

- Anesthesia.
- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Chemotherapy and radiation therapy Services.
- Dialysis Services (this benefit is subject to the benefit limitations described under "Dialysis Services" in this "Benefits" section).
- Drugs and radioactive materials used for therapeutic purposes, except for the types of drugs excluded under the "Limited Outpatient Prescription Drugs and Supplies" section.
- Durable Medical Equipment and medical supplies.
- Emergency detoxification.
- Gender Affirming Treatment.
- General and special nursing care Services.
- Internally implanted devices, except for internally implanted insulin pumps, artificial hearts, and artificial larynx.
- Interrupted pregnancy surgery when performed in an inpatient setting.
- Laboratory, X-rays and other imaging, and special diagnostic procedures.
- Medical foods and formulas if Medically Necessary.
- Medical social Services and discharge planning.
- Operating and recovery rooms.
- Orthognathic surgery and supplies for treatment of temporomandibular joint (TMJ) disorder or injury, sleep apnea or congenital anomaly.
- Palliative care.
- Participating Provider's Services, including consultation and treatment by Specialists.
- Prescription drugs, including injections.
- Respiratory therapy.

- Room and board, including a private room if Medically Necessary.
- Specialized care and critical care units.
- Temporomandibular joint (TMJ) surgery for the treatment of TMJ disorders subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.
- Vasectomy.

Kaiser Permanente at Home™

Kaiser Permanente at Home is a personalized, patient-centered program that provides care in your home (or a place of temporary or permanent residence used as your home) as an alternative to receiving acute care in a hospital.

Kaiser Permanente at Home Services must be associated with an acute medical condition, such as, but not limited to, congestive heart failure, pneumonia, cellulitis or upper urinary tract infection, and are subject to prior authorization from Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.

To receive Kaiser Permanente at Home Services:

- You must be referred into the program by a Participating Provider.
- Your condition must meet criteria for Medically Necessary hospitalization.
- A Medical Group physician determines that it is feasible to maintain effective supervision and control of your care in the home, and that based on your health status, treatment plan, and home setting, you can be treated safely and effectively in the home.
- You must consent to receiving Kaiser Permanente at Home Services because you prefer to receive the care described in your treatment plan in your home.
- The care location must be within 30 minutes of a 911 response.
- The care location must have cell service.

Services are provided or arranged by Kaiser Permanente and the Participating Providers we contract with to provide Services under this program, including:

- Telemedical visits and in-person home visits by a care team of specialized health care providers including physicians, nurse practitioners, physician associates, RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionists, home health aides, and other healthcare professionals providing Services in accord with your Kaiser Permanente at Home treatment plan and the provider's scope of practice and license.
- A medical command center staffed by physicians and nurses who monitor your care and coordinate your care team. The medical command center provides 24/7 telemedical monitoring and access to your care team.
- Equipment temporarily installed in your home to monitor your vital signs, such as temperature, pulse, blood pressure, oxygen levels, and weight. This information is sent automatically to the medical command center and is available to any member of your care team.
- Communication devices such as a tablet computer for video visits, a "pick up the handset" phone with direct connection to the medical command center, and a wearable personal emergency response system (PERS) call button to allow you to contact the medical command center 24 hours a day, 7 days a week if you are unable to get to a phone. This includes communication technology to support reliable communication, backup power supply, and backup internet.

- Equipment necessary to ensure that you are monitored appropriately in your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer.
- Laboratory tests, mobile imaging (X-rays, ultrasounds), and EKGs.
- Safety items when Medically Necessary, such as shower stools, raised toilet seats, grabbers, long handled shoehorns, and sock aids.
- Meals when Medically Necessary while you are receiving acute care in the home.

The Cost Shares for the following covered Services, described elsewhere in this *EOC*, will not apply when the Services are prescribed as part of your Kaiser Permanente at Home treatment plan:

- Durable Medical Equipment.
- Medical supplies.
- Ambulance transportation to and from Participating Facilities when ambulance transport is Medically Necessary.
- Physician associate and nurse practitioner house calls.
- Emergency Department visits associated with this program.

The Cost Shares for covered Services described elsewhere in this *EOC* will apply to any Services that are not part of your Kaiser Permanente at Home treatment plan (for example, DME not specified in your Kaiser Permanente at Home treatment plan).

For outpatient prescription drug coverage and Cost Share information, please refer to the "Limited Outpatient Prescription Drugs and Supplies" section in the *EOC* and "Benefit Summary," and the "Outpatient Prescription Drug Rider," if purchased by your Group.

Kaiser Permanente at Home Exclusions

- Housekeeping or meal services that are not part of your Kaiser Permanente at Home treatment plan.
- Any care provided by or for a family member.
- Any other Services rendered in the home which are not specified in your Kaiser Permanente at Home treatment plan.

Ambulance Services

We cover licensed ambulance Services:

- For Emergency Medical Services Transport, or
- If we give prior authorization for an ambulance to transport you to or from a location where you receive covered Services.

Covered Emergency Medical Services Transport includes air, ground and water transportation.

Ambulance Services Exclusions

- Ambulance Services for personal comfort or convenience.

Bariatric Surgery Services

We cover inpatient and outpatient bariatric surgery procedures and related pre-surgery and post-surgery Services for clinically severe obesity in adults, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

You may request Utilization Review criteria, and a list of the approved surgical procedures we cover when criteria is met, by calling Member Services.

In addition to Utilization Review, you must meet one of the following requirements:

- You fully comply with the Kaiser Permanente Severe Obesity Evaluation and Management Program's contract for participation approved by Company; or,
- You receive the Service at a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

Behavioral Health Services

We cover Services to treat Behavioral Health Conditions as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association, including Medically Necessary applied behavior analysis (ABA) for autism spectrum disorder, and Medically Necessary treatment for pervasive developmental disorder (PDD).

Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request the criteria by calling Member Services.

The benefits described in this "Behavioral Health Services" section comply with the Mental Health Parity and Addiction Equity Act.

Outpatient Services

We cover individual office visits, group therapy visits, intensive outpatient visits, partial hospitalization, and Assertive Community Treatment (ACT) Services for behavioral health treatment. ACT Services are designed to provide comprehensive outpatient treatment and support to Members who are diagnosed with a severe mental illness and whose symptoms of mental illness lead to serious dysfunction in daily living.

Inpatient Hospital Services

We cover inpatient hospital Services for behavioral health treatment, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the inpatient facility. Prior authorization is not required for Members who are involuntarily committed and subsequently treated in a state hospital.

Residential Services

We cover residential Services in a residential facility, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the residential facility.

Psychological Testing

If, in the professional judgment of a Participating Provider you require psychological testing as part of diagnostic evaluation, prescribed tests are covered in accord with this "Behavioral Health Services" section. We do not cover court-ordered testing or testing for ability, aptitude, intelligence, or interest unless Medically Necessary.

Dialysis Services

We cover two types of dialysis: hemodialysis and peritoneal dialysis. You pay the Cost Share shown in the "Benefit Summary" under "Dialysis Services." We cover dialysis Services for acute renal failure and end-stage renal disease subject to Utilization Review criteria developed by Medical Group and approved by Company.

We cover treatment at outpatient dialysis facilities.

We also cover home dialysis. Coverage includes necessary equipment, training, and medical supplies.

If you receive dialysis Services as part of an inpatient hospital stay or at a Participating Skilled Nursing Facility, the Services will be covered according to your inpatient hospital or skilled nursing facility benefit.

External Prosthetic Devices and Orthotic Devices

We cover External Prosthetic Devices and Orthotic Devices, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company, when the following are true:

- The device is Medically Necessary to restore or maintain your ability to complete activities of daily living or essential job-related activities and is not solely for comfort or convenience.
- The device is required to replace all or part of an organ or extremity designated by CMS in the "L codes" of the Healthcare Common Procedure Coding System.

This coverage includes Services and supplies that are Medically Necessary for the effective use of an External Prosthetic Device or Orthotic Device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, patient instruction in the use of the device, and repair and replacement of the Medically Necessary device.

Internally implanted prosthetic and Orthotic Devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, are not covered under this "External Prosthetic Devices and Orthotic Devices" benefit, but may be covered if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

Covered External Prosthetic Devices and Orthotic Devices include, but are not limited to:

- Compression garments for burns.
- Diabetic foot care appliances and therapeutic shoes and inserts to prevent and treat diabetes-related complications.
- External prostheses after a Medically Necessary mastectomy, including prostheses when Medically Necessary, and up to four brassieres required to hold a prosthesis every 12 months.
- Fitting and adjustments.
- Halo vests.
- Lymphedema wraps and garments.
- Maxillofacial prosthetic devices: coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Provider. We cover maxillofacial prosthetic devices if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of:
  - Controlling or eliminating infection;
  - Controlling or eliminating pain; or
  - Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.
- Ocular prosthesis.
- Prosthetic devices for treatment of temporomandibular joint (TMJ) conditions.
- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity. This includes but is not limited to ostomy and urological supplies.
- Rigid and semi-rigid Orthotic Devices required to support or correct a defective body part.
- Tracheotomy equipment.

We periodically update the list of approved External Prosthetic Devices and Orthotic Devices to keep pace with changes in medical technology and clinical practice. To find out if a particular prosthetic or orthotic device is on our approved list for your condition, please call Member Services.

Coverage is limited to the standard External Prosthetic Device or Orthotic Device that adequately meets your medical needs. Our guidelines allow you to obtain non-standard devices (those not on our approved list for your condition) if we determine that the device meets all other coverage requirements, and Medical Group or a designated physician determines that the device is Medically Necessary and that there is no standard alternative that will meet your medical needs.

External Prosthetic Devices and Orthotic Devices Exclusions

- Artificial hearts.
- Artificial larynx.
- Comfort, convenience, or luxury equipment or features.
- Dental appliances and dentures.
- Internally implanted insulin pumps.

Fertility Services

Covered fertility Services include:

- Consultation and evaluation of fertility status.
- Diagnostic imaging and laboratory tests, such as tests to rule out sexually transmitted diseases, hormone level tests, and semen analysis.
- Diagnostic laparoscopy or hysteroscopy.
- Other Medically Necessary diagnostic Services to determine if there is an underlying medical condition that may affect fertility.

Diagnostic Services may include both the individual and their partner; however, Services are covered only for the person who is the Member.

You may have additional coverage if your Group has purchased a "Fertility Treatment Services Rider."

Fertility Services Exclusions

- Fertility preservation.
- Inpatient and outpatient fertility treatment Services.
- Oral and injectable drugs prescribed for fertility treatment.
- Services related to conception by artificial means, such as intrauterine insemination (IUI), in vitro fertilization (IVF), ovum transplants, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and artificial insemination.
- Services to reverse voluntary, surgically induced infertility.

Habilitative Services

We cover inpatient and outpatient habilitative Services subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. Coverage includes the range of Medically Necessary Services or health care devices designed to help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected

age. These Services may include physical, occupational, and speech therapy, and other Services for people with disabilities, and that:

- Takes into account the unique needs of the individual.
- Targets measurable, specific treatment goals appropriate for the person's age, and physical and mental condition.

We cover these habilitative Services at the Cost Share shown in the "Benefit Summary." The "Benefit Summary" also shows a visit maximum for habilitative Services. That visit maximum will be exhausted (used up) for a Year when the number of visits that we covered during the Year under this *EOC*, plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year. Visit maximums do not apply to habilitative Services to treat Behavioral Health Conditions covered under this *EOC*.

Habilitative Services Exclusions

- Daycare.
- Exercise programs for healthy individuals (unless Medically Necessary within an applied behavior analysis (ABA) treatment plan).
- Housing.
- Recreational activities (unless Medically Necessary within an applied behavior analysis (ABA) treatment plan).
- Respite care.
- Services and devices delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements.
- Services solely for palliative purposes.
- Social services.
- Specialized job testing.

Health Education Services

We cover a variety of health education Services to help you take an active role in improving and maintaining your health. These Services include:

- Diabetic counseling.
- Diabetic and other outpatient self-management training and education.
- Medical nutritional therapy for diabetes.
- Post coronary counseling and nutritional counseling.
- Tobacco use cessation. For the purposes of this *EOC*, tobacco use is defined as the use of tobacco on average four or more times per week within no longer than the past six months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco.

If you receive health education Services during a primary care visit, you pay the primary care Cost Share shown in the "Benefit Summary." If you receive health education Services during a specialty care visit, you pay the specialty care Cost Share shown in the "Benefit Summary."

Some Health Education Services may also be covered under the "Preventive Care Services" section.

There are fees for some health education classes. For more information about in-person and online health education programs, see our *Healthy Living* catalog, call Member Services, or visit **kp.org** and select Health & Wellness. To register by phone, call 503-286-6816 or 1-866-301-3866 (toll-free) and select option 1.

Hearing Aids and Other Hearing Devices

We cover Medically Necessary Services for the treatment of hearing loss as described in this "Hearing Aids and Other Hearing Devices" section when prescribed by a Participating Provider and obtained from a Participating Provider. You pay the Cost Share shown in the "Benefit Summary." These Services are limited to Members who are under the Dependent Limiting Age shown in the "Benefit Summary." You may have additional coverage if your Group has purchased a "Hearing Aid Rider."

Hearing Exam

We cover exams to determine the need for hearing correction, diagnostic hearing tests appropriate to the Member's age or developmental need, and aided testing. Medically Necessary diagnostic and treatment exams are covered at least twice per Year for Members who are younger than four years of age, and at least once per Year for Members who are four years of age or older. In addition, we cover visits to determine the appropriate hearing aid or hearing device model, visits to verify that the hearing aid or device conforms to the prescription, and visits for fitting, adjustment, cleaning, inspection, counseling, programming, and reprogramming of the hearing device.

Hearing Aids

We cover one hearing aid per impaired ear for the treatment of hearing loss, as shown in the "Benefit Summary", or more frequently if modifications to an existing hearing aid will not meet the needs of the Member. Coverage includes the cost of repair or replacement parts if they are not covered by a warranty and are necessary for the device to function correctly for the Member. Ear molds and replacement ear molds are covered as Medically Necessary and at least four times per Year for Members who are seven years of age or younger, and at least once per Year for Members eight years of age or older.

A hearing aid is any non-disposable, wearable electronic instrument or device designed to aid or compensate for impaired human hearing and any necessary ear molds, parts, attachments, batteries, components, or accessories necessary to the function of the hearing aid, except cords.

The date we cover a hearing aid is the date on which you are fitted for the device. Therefore, if you are fitted for a device while you are covered under this *EOC*, and if we would otherwise cover the device, we will provide the device even if you do not receive it until after you are no longer covered under this *EOC*.

Other Hearing Devices

Assistive Listening Devices

We cover assistive listening devices and bone conduction sound processors for the treatment of hearing loss, as shown in the "Benefit Summary". Coverage includes the cost of repair or replacement parts if they are not covered by a warranty and are necessary for the device to function correctly for the Member.

An assistive listening device is a device used with or without hearing aids or cochlear implants to provide access to sound or improve the ability of a user with hearing loss to hear in various listening situations, such as being located a distance from a speaker, in an environment with competing background noise, or in a room with poor acoustics or reverberation.

The date we cover an assistive listening device is the date on which you are fitted for the device. Therefore, if you are fitted for a device while you are covered under this *EOC*, and if we would otherwise cover the device, we will provide the device even if you do not receive it until after you are no longer covered under this *EOC*.

Internally Implanted Hearing Devices

We cover cochlear implants and other implantable hearing devices for one or both ears if Medically Necessary for the treatment of hearing loss, including fitting, programming, reprogramming, and repair and replacement parts necessary for the device to function correctly for the Member. Devices such as bone-anchored hearing aids, cochlear implants, and other implantable hearing devices that are internally implanted during a surgical procedure are covered under the benefits for the surgical procedure. Please refer to internally implanted devices in the "Benefits for Outpatient Services" section. Internally implanted hearing devices are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Hearing Aids and Other Hearing Devices Limitations

- Hearing aids are limited to one of the following digital models from a specified collection of hearing aids: (i) in the ear; (ii) behind the ear; (iii) on the body (Body Aid Model); or (iv) canal/CIC aids.
- Replacement batteries are limited to one box per Year for each hearing aid.

Hearing Aids and Other Hearing Devices Exclusions

- Non-prescription hearing aids or hearing aid components, except as described in this "Hearing Aids and Other Hearing Devices" section.
- Replacement of lost hearing aids and devices.

Home Health Services

Home health Services are Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, speech, and respiratory therapists. We cover home health Services only if all of the following are true:

- You are substantially confined to your home (or to a place of temporary or permanent residence used as your home) or the care is provided in lieu of Medically Necessary hospitalization.
- A Medical Group 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.
- You receive prior authorization from Company in accordance with Utilization Review criteria developed by Medical Group and approved by Company.
- Services are provided through a licensed Home Health Agency.

The "Benefit Summary" shows a visit maximum for home health Services. That visit maximum will be exhausted (used up) for a Year when the number of visits that we covered during the Year under this *EOC*, plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year.

The following types of Services are covered in the home only as described under these headings in this "Benefits" section:

- "Dialysis Services."
- "Outpatient Durable Medical Equipment (DME)."
- "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."

Home Health Services Exclusions

- "Meals on Wheels" or similar food services.
- Nonmedical, custodial, homemaker or housekeeping type services except by home health aides as ordered in the approved plan of treatment.

- Nutritional guidance.
- Private duty or continuous nursing Services.
- Services designed to maintain optimal health in the absence of symptoms.
- Services not included in an approved plan of treatment.
- Services of a person who normally lives in the home or who is a member of the family.
- Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. These Services are excluded even if we would cover the Services if they were provided by a qualified medical professional in a hospital or skilled nursing facility.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners, and similar appliances and devices.

Hospice Services

Hospice is a specialized form of interdisciplinary care designed to provide palliative care to help alleviate your physical, emotional, and spiritual discomfort through the last phases of life due to a terminal illness. It also provides support to your primary caregiver and your family. When you choose hospice, you are choosing to receive palliative (comfort) care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice Services at any time. You pay the Cost Share shown in the "Benefit Summary" under "Hospice Services."

We cover hospice Services if all of the following requirements are met:

- A Medical Group physician has diagnosed you with a terminal illness and determines that your life expectancy is six months or less.
- The Services are provided in your home (or a place of temporary or permanent residence used as your home).
- The Services are provided by a licensed hospice agency approved by Kaiser Foundation Hospitals.
- The Services are necessary for the palliation and management of your terminal illness and related conditions.
- The Services meet Utilization Review by Company using criteria developed by Medical Group and approved by Company.

We cover the following hospice Services:

- Counseling and bereavement Services for up to one year.
- Durable Medical Equipment (DME).
- Home health aide Services.
- Medical social Services.
- Medication and medical supplies and appliances.
- Participating Provider Services.
- Rehabilitative therapy Services for purposes of symptom control or to enable you to maintain activities of daily living.
- Services of volunteers.
- Short-term inpatient Services including respite care and care for pain control and acute and chronic symptom management.

- Skilled nursing Services, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers.

Limited Dental Services

We do not cover dental Services except as described below. Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request these criteria by calling Member Services.

Covered Dental Services

We cover dental Services only as described below:

- Dental and orthodontic Services for the treatment of craniofacial anomalies if the Services are Medically Necessary to improve or restore function.
- Dental Services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment, limited to (a) emergency dental Services, or (b) extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.
- Dental Services for Members who are potential transplant recipients and require Medically Necessary pre-transplant dental evaluation and clearance before being placed on the waiting list for a covered transplant. Covered Services are routine dental Services necessary to ensure the oral cavity is clear of infection, and may include oral examination, dental x-rays, prophylaxis (dental cleaning), fluoride treatment, fillings, and dental extractions. In the case of urgent transplantation, we will cover these Services when performed post-transplant.
- General anesthesia and associated hospital or ambulatory surgical facility Services in conjunction with non-covered dental Services when Medically Necessary for Members who:
    - have a medical condition that your Participating Provider determines would place you at undue risk if the dental procedure were performed in a dental office; or
    - are physically or developmentally disabled.

Covered Services may be provided by a licensed dentist or other person who is regulated under state law to practice dental or dental-related Services or otherwise practicing dental care Services consistent with state law, including an expanded practice dental hygienist, denturist, dental therapist, or pediatric dental assistant. You pay the Cost Share you would pay if the Services were not related to a covered dental Service.

Limited Dental Services Exclusions

The following dental Services are not covered, except where specifically noted to the contrary in this *EOC*:

- Dental appliances and dentures.
- Dental implants.
- Extraction of teeth, except as described above in the "Covered Dental Services" section.
- Hospital Services for dental care, except as described above in the "Covered Dental Services" section.
- Orthodontics, except as described above in the "Covered Dental Services" section.
- Routine or preventive dental Services.
- Services to correct malocclusion.

Limited Outpatient Prescription Drugs and Supplies

We cover limited outpatient prescription drugs and supplies as described in this "Limited Outpatient Prescription Drugs and Supplies" section. You may have additional coverage if your Group has purchased an "Outpatient Prescription Drug Rider."

Covered drugs or supplies must be prescribed by a Participating Provider or any licensed dentist in accordance with our drug formulary guidelines.

You must obtain drugs or supplies at a Participating Pharmacy (including our Mail-Order Pharmacy). You may obtain a first fill of a drug or supply at any Participating Pharmacy. All refills must be obtained through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy), or at another Participating Pharmacy that we designate for covered refills. See your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Covered Drugs and Supplies

Items covered under this "Limited Outpatient Prescription Drugs and Supplies" benefit include:

- Certain preventive medications (including, but not limited to, aspirin, fluoride, folic acid supplements, liquid iron for infants, and tobacco use cessation drugs) according to, and as recommended by, the USPSTF, when obtained with a prescription order.
- Certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as IV or intraspinal-infusion) for up to a 30-day supply, including the supplies and equipment required for their administration.
- Contraceptive drugs and devices approved by the U.S. Food and Drug Administration (FDA), including injectable contraceptives and internally implanted time-release contraceptive drugs, emergency contraceptives, and contraceptive devices such as intrauterine devices, diaphragms, and cervical caps. Over-the-counter contraceptive drugs, devices, and products approved by the FDA do not require a prescription in order to be covered. You may receive a three-month supply for a first dispensing of a contraceptive drug and a 12-month supply of a subsequent dispensing of the same contraceptive drug, unless you request a smaller supply. You pay the Cost Share as shown in the "Benefit Summary."
- Drugs, injectables, and radioactive materials used for therapeutic or diagnostic purposes, if they are administered to you in a Participating Medical Office or during home visits. We cover these items upon payment of the administered medications Cost Share shown under "Outpatient Services" in the "Benefit Summary."
- Glucagon emergency kits, insulin, ketone test strips for urine-testing, blood glucose test strips, and disposable needles and syringes when prescribed for the treatment of diabetes. We cover additional diabetic equipment and supplies, including lancets and injection aids, under the "Outpatient Durable Medical Equipment (DME)" section and the "External Prosthetic Devices and Orthotic Devices" section.
- Self-administered chemotherapy medications used for the treatment of cancer.

These limited drugs and supplies are available to you even if your Group has not purchased additional drug coverage. If your Group has purchased additional drug coverage, the limited drugs and supplies listed in this "Limited Outpatient Prescription Drugs and Supplies" section are not covered under it.

Day Supply Limit

The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-day (or any other number of days) supply for you. When you pay the applicable Cost Share shown in the "Benefit Summary," you will receive the prescribed supply up to the day supply limit. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantity that exceeds the day supply limit.

You may receive a three-month supply for a first dispensing of a contraceptive drug and a 12-month supply of a subsequent dispensing of the same contraceptive drug, unless you request a smaller supply.

How to Get Covered Drugs or Supplies

Participating Pharmacies are located in many Participating Facilities. To find a Participating Pharmacy please see your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Participating Pharmacies include our Mail-Order Pharmacy. This pharmacy offers postage-paid delivery to residents of Oregon and Washington. Some drugs and supplies are not available through our Mail-Order Pharmacy, for example drugs that require special handling or refrigeration, or are high cost. Drugs and supplies available through our Mail-Order Pharmacy are subject to change at any time without notice.

If you would like to use our Mail-Order Pharmacy, call 1-800-548-9809 or order online at **kp.org/refill**.

About Our Drug Formulary

Our drug formulary is a list of drugs that our Regional Formulary and Therapeutics Committee has reviewed and approved for our Members and includes drugs covered under this *EOC*. Drugs on the formulary have been approved by the FDA.

Our Regional Formulary and Therapeutics Committee is made up of Participating Physicians, other Participating Providers, and administrative staff. The committee chooses drugs for the formulary based on several factors, including safety and effectiveness as determined from a review of the scientific literature. They may not approve a drug if there is not enough scientific evidence that it is clinically effective. They may also exclude a drug if it does not have a clinical or cost advantage over comparable formulary drugs.

The Regional Formulary and Therapeutics Committee meets to review new drugs and reconsider drugs currently on the market. After this review, they may add drugs to the formulary or remove drugs from it. If a drug is removed from the formulary, you will need to switch to another comparable drug that is on the drug formulary, unless your old drug meets exception criteria. Refer to the "Drug Formulary Exception Process" in this "Limited Outpatient Prescription Drugs and Supplies" section for more information.

If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your Participating Provider or another member of your health care team.

To see if a drug or supply is on our drug formulary, go online to **kp.org/formulary**. You may also call our Formulary Application Services Team (FAST) at 503-261-7900. If you would like a copy of our drug formulary or additional information about the formulary process, please call Member Services. The presence of a drug on our drug formulary does not necessarily mean that your Participating Provider will prescribe it for a particular medical condition.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider or any licensed dentist prescribes a drug or supply that our drug formulary does not list for your condition, if the law requires the item to bear the legend "Rx only." The exception process is not available for drugs and supplies that the law does not require to bear this legend, or for any drug or supply prescribed by someone other than a Participating Provider or any licensed dentist.

A Participating Provider or any licensed dentist may request an exception if they determine that the non-formulary drug or supply is Medically Necessary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests. We will approve the exception if all of the following requirements are met:

- We determine that the drug or supply meets all other coverage requirements except for the fact that our drug formulary does not list it for your condition.

- Medical Group or a designated physician makes the following determinations:
  - The drug or supply is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs or supplies that our drug formulary lists for your condition.
  - Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug or supply. For this drug or supply, the Participating Pharmacy can provide a copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

If we approve an exception through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the "Benefit Summary."

If we do not approve the formulary exception request, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

Limited Outpatient Prescription Drugs and Supplies Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Drugs prescribed for an indication if the FDA has determined that use of the drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Evidence Review Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs and supplies that are available without a prescription, even if the non-prescription item is in a different form or different strength (or both), except that this exclusion does not apply to non-prescription drugs or supplies described in the "Covered Drugs and Supplies" section.
- Drugs, biological products, and devices that the FDA has not approved.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Injectable drugs that are self-administered (except insulin).
- Mail-order drugs for anyone who is not a resident of Oregon or Washington.
- Nutritional supplements.
- Replacement of drugs and supplies due to loss, damage, or carelessness. This exclusion does not apply to drugs used to treat Substance Use Disorder.
- The following are excluded, but you may have coverage for them if your Group purchased an "Outpatient Prescription Drug Rider":
  - Prescription drugs and supplies that are dispensed on an outpatient basis, except those listed under "Covered Drugs and Supplies" of this "Limited Outpatient Prescription Drugs and Supplies" section.
  - Drugs prescribed for fertility treatment.
  - Drugs and supplies to treat sexual dysfunction are excluded except for drugs that are FDA-approved to treat behavioral health symptoms of sexual dysfunction.

- Drugs used in weight management.

Maternity and Newborn Care

We cover the following maternity and newborn care Services:

- Prenatal care visits and postpartum visits.
- Maternal diabetes management, including medication and supplies (Medically Necessary Services beginning with conception and ending through six weeks postpartum).
- Maternity hospital care for mother and baby, including Services for complications of pregnancy.
- Obstetrical care and delivery (including cesarean section).
- Newborn medical Services following birth and initial physical exam.
- Newborn nurse home visiting Services for Dependent children up to six months of age, if available in your area.
- Newborn PKU test.

We will not limit the length of a maternity hospital stay for a mother and baby to less than 48 hours for vaginal delivery and 96 hours for a cesarean section delivery. The length of inpatient stay is determined by an attending Participating Provider, in consultation with the mother. Our policy complies with the federal Newborns' and Mothers' Health Protection Act of 1996 (NMHPA).

Newborns are covered from the moment of birth for the first 31 days of life and are subject to their own Cost Share. In order for coverage to continue beyond this 31-day period, you must follow the rules for adding Dependents as described under "Adding New Dependents to an Existing Account" in the "When You Can Enroll and When Coverage Begins" section.

Certain maternity Services, such as screening for gestational diabetes and breastfeeding equipment, supplies, counseling, and support, are covered under the "Preventive Care Services" section. Outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures are covered under the "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" section.

Maternity and Newborn Care Exclusions

- Birthing center Services.
- Home birth Services.

Medical Foods and Formula

We cover the following Medically Necessary medical foods and formula subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company:

- Elemental formula for the treatment of eosinophilic gastrointestinal associated disorder.
- Enteral formula for home treatment of severe intestinal malabsorption when the formula comprises the sole or essential source of nutrition.
- Medical foods and formula necessary for the treatment of phenylketonuria (PKU), specified inborn errors of metabolism, or other metabolic disorders.

Naturopathic Medicine

We cover outpatient visits for naturopathic medicine Services when provided by a Participating Provider in the Participating Provider's office. You do not need a referral or prior authorization.

Naturopathic medicine is a natural approach to health and healing which emphasizes a holistic approach to the diagnosis, treatment and prevention of illness. Naturopathic physicians diagnose and treat patients by using natural modalities such as clinical nutrition, herbal medicine, and homeopathy.

Covered Services include:

- Evaluation and management.
- Health condition related treatments.
- Physical therapy modalities such as hot and cold packs.

To locate a Participating Provider, visit **www.chpgroup.com**. The CHP Group is a Participating Provider we contract with to provide naturopathic medicine Services. If you need assistance searching for a Participating Provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

Outpatient Durable Medical Equipment (DME)

We cover outpatient Durable Medical Equipment (DME) subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

DME must be for use in your home (or a place of temporary or permanent residence used as your home).

When you receive DME in a home health setting in lieu of hospitalization, DME is covered at the same level as if it were received in an inpatient hospital care setting.

We decide whether to rent or purchase the DME, and we select the vendor. We also decide whether to repair, adjust, or replace the DME item when necessary.

Covered DME includes, but is not limited to:

- Bilirubin lights.
- CADD (continuous ambulatory drug delivery) pumps.
- Diabetic equipment and supplies including external insulin pumps, infusion devices, blood glucose monitors, continuous glucose monitors, lancets, and injection aids.
- Enteral pumps and supplies.
- Home ultraviolet light therapy equipment for treatment of certain skin conditions such as cutaneous lymphoma, eczema, psoriasis, and scleroderma.
- Osteogenic bone stimulators.
- Osteogenic spine stimulators.
- Oxygen and oxygen supplies.
- Peak flow meters.
- Ventilators.
- Wheelchairs.
- Wigs following chemotherapy or radiation therapy, limited to one synthetic wig per Year.

We periodically update the list of approved DME items to keep pace with changes in medical technology and clinical practice. To find out if a particular DME item is on our approved list for your condition, please call Member Services.

Coverage is limited to the standard DME item that adequately meets your medical needs. Our guidelines allow you to obtain non-standard DME items (those not on our approved list for your condition) if we

determine that the item meets all other coverage requirements, and Medical Group or a designated physician determines that the item is Medically Necessary and that there is no standard alternative that will meet your medical needs.

Outpatient Durable Medical Equipment (DME) Exclusions

- Comfort, convenience, or luxury equipment or features.
- Devices for testing blood or other body substances unless specifically listed as covered in this "Outpatient Durable Medical Equipment (DME)" section.
- Exercise or hygiene equipment.
- Modifications to your home or car.
- More than one corrective appliance or artificial aid or item of DME, serving the same function or the same part of the body, except for necessary repairs, adjustments and replacements as specified under this "Outpatient Durable Medical Equipment (DME)" section.
- Non-medical items, such as sauna baths or elevators.
- Repair or replacement of DME items due to loss or misuse.
- Spare or duplicate use DME.

Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures

We cover outpatient Services for laboratory, X-ray, imaging, and special diagnostic procedures. Some Services, such as preventive screenings and routine mammograms, are not covered under this "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" benefit but may be covered under the "Preventive Care Services" section.

Laboratory, X-ray, and Imaging

We cover outpatient laboratory, X-ray, and imaging Services. Covered outpatient laboratory, X-ray, and imaging Services include, but are not limited to:

- Bone densitometry.
- Cardiovascular testing.
- Cultures.
- Diagnostic and supplemental breast imaging, including diagnostic mammography, breast MRI, or breast ultrasound that is used to:
  - Evaluate an abnormality.
  - Screen for breast cancer when there is no abnormality seen or suspected, and is based on personal or family medical history, or additional factors that may increase the individual's risk of breast cancer.
- Glucose tolerance.
- X-ray.
- Ultrasound imaging.
- Urinalysis.

Special Diagnostic Procedures

Special diagnostic procedures may or may not involve radiology or imaging technology. Some special diagnostic Services may be subject to a higher Cost Share, as shown in the "Benefit Summary." Covered special diagnostic procedures include, but are not limited to:

- CT scans.
- MRI.
- Nerve conduction studies.
- PET scans.
- Pulmonary function studies.
- Sleep studies.

You must receive prior authorization by Company for MRI, CT scans, PET scans, and bone density/DXA scans. (See "Prior Authorization Review Requirements" in the "How to Obtain Services" section.)

Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures Limitations

Covered genetic testing Services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when Medically Necessary. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Reconstructive Surgery Services

We cover inpatient and outpatient reconstructive surgery Services as indicated below, when prescribed by a Participating Provider. Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

- To correct disfigurement resulting from an injury or from Medically Necessary surgery.
- To correct a congenital defect, disease, or anomaly in order to produce improvement in physical function.
- To treat congenital hemangioma known as port wine stains on the face.

With respect to maxillofacial prosthetic services, coverage is limited to the least costly clinically appropriate treatment as determined by a Participating Provider. We cover maxillofacial prosthetic Services if they are necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and are defective because of disease, trauma, or birth and developmental deformities when this restoration and management are performed for the purpose of any of the following:

- Controlling or eliminating infection.
- Controlling or eliminating pain.
- Restoring facial configuration or functions such as speech, swallowing, or chewing, but not including cosmetic procedures rendered to improve the normal range of conditions.

Members who have undergone mastectomy are entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). "Mastectomy" means the surgical removal of breast tissue and breast lumps due to malignancy or suspected malignancy. We cover:

- All stages of reconstruction of the breast on which a mastectomy was performed, including but not limited to nipple reconstruction, skin grafts, and stippling of the nipple and areola.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Mastectomy-related prostheses.
- Treatment of physical complications of the mastectomy, including lymphedemas.
- Inpatient care related to the mastectomy and post-mastectomy Services.

Mastectomy-related prosthetics and Orthotic Devices are covered under and subject to the "External Prosthetic Devices and Orthotic Devices" section.

Rehabilitative Therapy Services

We cover inpatient and outpatient physical, occupational, and speech therapy Services, when prescribed by a Participating Provider, subject to the benefit descriptions and limitations contained in this "Rehabilitative Therapy Services" section. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Outpatient Rehabilitative Therapy Services

We cover outpatient rehabilitative therapy Services for the treatment of conditions which, in the judgment of the Participating Provider, will show sustainable, objective, measurable improvement as a result of the prescribed therapy. Prescribed outpatient therapy Services must receive prior authorization as described under "Prior Authorization Review Requirements" in the "How to Obtain Services" section.

The "Benefit Summary" shows a visit maximum for outpatient rehabilitative therapy Services. That visit maximum will be exhausted (used up) for the Year when the number of visits that we covered during the Year under this *EOC*, plus any visits we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the visit maximum. After you reach the visit maximum, we will not cover any more visits for the remainder of the Year. This limitation does not apply to inpatient hospital Services or to outpatient rehabilitative therapy Services to treat Behavioral Health Conditions covered under this *EOC*.

Outpatient Rehabilitative Therapy Services Limitations

- Physical therapy Services and occupational therapy Services are covered as Medically Necessary to restore or improve functional abilities when physical and/or sensory perceptual impairment exists due to injury, illness, stroke, or surgery.
- Speech therapy Services are covered as Medically Necessary for speech impairments of specific organic origin such as cleft palate, or when speech, language, or the swallowing function is lost due to injury, illness, stroke, or surgery.

Inpatient Rehabilitative Therapy Services

We cover inpatient rehabilitative therapy Services for the treatment of conditions which, in the judgment of a Participating Provider, will show sustainable, objective, measurable improvement as a result of the prescribed therapy. Prescribed inpatient therapy Services must receive prior authorization as described under "Prior Authorization Review Requirements" in the "How to Obtain Services" section.

Rehabilitative Therapy Services Exclusions

- Services designed to maintain optimal health in the absence of symptoms.

Services Provided in Connection with Clinical Trials

We cover routine costs of Medically Necessary conventional Services you receive in connection with a clinical trial if all of the following conditions are met:

- We would have covered the Services if they were not related to a clinical trial.
- You are eligible to participate in the clinical trial according to the trial protocol, as determined in one of the following ways:
  - A Participating Provider makes this determination.
  - You provide us with medical and scientific information establishing this determination.
  - If any Participating Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Participating Provider unless the clinical trial is outside the state where you live.

- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial, and it meets one of the following requirements:
  - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA).
  - The study or investigation is a drug trial that is exempt from having an investigational new drug application.
  - The study or investigation is approved or funded by at least one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
      - It is comparable to the National Institutes of Health system of peer review of studies and investigations.
      - It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Inpatient Hospital Services" in the "Benefit Summary" for the Cost Share that applies to hospital inpatient care.

Services Provided in Connection with Clinical Trials Exclusions

- The investigational Service.
- Services provided solely for data collection and analysis and that are not used in your direct clinical management.
- Services required solely for the clinically appropriate monitoring of the Service being tested in the clinical trial.
- Services customarily provided by a clinical trial sponsor free of charge to any participant in the clinical trial.
- Services that would not be covered outside of the clinical trial.

Skilled Nursing Facility Services

We cover skilled inpatient Services in a licensed Participating Skilled Nursing Facility, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the facility. The skilled inpatient Services must be those customarily provided by Participating Skilled Nursing Facilities. These Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

When your benefit has a day maximum, the "Benefit Summary" shows a day maximum for skilled nursing facility Services. That day maximum will be exhausted (used up) for a Year when the number of days that we covered during the Year under this *EOC*, plus any days we covered during the Year under any other evidence of coverage with the same group number printed on this *EOC*, add up to the day maximum. After you reach the day maximum, we will not cover any more days for the remainder of the Year.

We cover the following:

- Blood, blood products, blood storage, and their administration, including the Services and supplies of a blood bank.
- Dialysis Services.
- DME Services.
- Habilitative Services.
- Medical and biological supplies.
- Medical social Services.
- Nursing Services.
- Rehabilitative therapy Services.
- Room and board.

Substance Use Disorder Services

We cover Substance Use Disorder Services as found in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, published by the American Psychiatric Association, including medical treatment for withdrawal symptoms. Emergency detoxification for medical conditions associated with acute alcohol, drug, or other substance abuse is covered without prior authorization.

Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request the criteria by calling Member Services.

The benefits described in this "Substance Use Disorder Services" section comply with the Mental Health Parity and Addiction Equity Act.

Outpatient Services for Substance Use Disorder

Covered Services include:

- Individual office visits.
- Group therapy visits.
- Court-ordered screening interviews or treatment programs for a Member convicted of driving under the influence of intoxicants (DUII).

Inpatient Hospital Services for Substance Use Disorder

We cover inpatient hospital Services for Substance Use Disorder, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the inpatient facility.

Residential Services

We cover residential Services in a residential program, including drugs that are prescribed as part of your plan of care and administered to you by medical personnel in the residential facility.

Day Treatment Services

We cover day treatment Services in a day treatment program.

Telemedicine Services

Telemedicine is a means of delivering health care Services using information and telecommunication technologies to provide consultation and education, or to facilitate diagnosis, treatment, care management or self-management of your health care.

We cover telemedicine Services at the applicable "Telemedicine Services" Cost Share shown in your "Benefit Summary" if:

- The Service is otherwise covered under this EOC if received in person;
- The Service is Medically Necessary;
- The Service is determined to be safely and effectively provided using telemedicine, according to generally accepted health care practices and standards; and
- The application and technology used to provide the Service meets all standards required by state and federal laws governing the privacy and security of protected health information.

During a state of emergency, we will cover telemedicine provided to Members residing in the geographic area specified in the declaration of the state of emergency, if the telemedicine Service is delivered using any commonly available technology, regardless of whether the technology meets all standards required by state and federal laws governing the privacy and security of protected health information.

Covered telemedicine applications and technologies may include:

- Landlines, wireless communications, internet and telephone networks; and
- Synchronous or asynchronous transmission using audio only, video only, audio and video and transmission of data from remote monitoring devices.

You may choose to receive a covered health Service in person or via telemedicine. You are not required to have an established patient-provider relationship with a Participating Provider to receive telemedicine Services from the provider.

Telephone and Video Visits

We cover scheduled telephone visits and video visits.

If you have a minor condition that does not require an in-person medical exam, you have the option to schedule a telephone visit. If you prefer to meet face-to-face with a provider online by computer, smartphone or tablet, you may set up a video visit just as you would with an in-person appointment.

Telephone visits and video visits are appropriate for routine care such as medication management and test results; and urgent care such as cough, cold, flu, bug bite, fever, earache, minor sprain, urinary tract infection, wounds or burns. Video visits are also appropriate for specialty care such as post-op follow-up, behavioral health appointments, dermatology and speech therapy.

To schedule a telephone visit or video visit, sign on to **kp.org** or the Kaiser Permanente app, then select "Appointments" or call Member Services.

E-Visits

We cover e-visits for common conditions such as cough/cold, nausea/vomiting, pink eye, urinary tract infection, sore throat, sinus problems, constipation or diarrhea. To access an e-visit, log in to your **kp.org** member account on your desktop, laptop, or tablet and fill out a questionnaire about your symptoms. A nurse will get back to you with a care plan, usually within six hours. If needed, a prescription may be sent to your pharmacy. E-visits may include secure chat instant messaging.

To learn more about telephone, video and e-visits, including a short instructional video and troubleshooting tips, visit **kp.org/telehealth/northwest**.

Transplant Services

We cover inpatient and outpatient Services for the transplants listed in this "Transplant Services" section. These Services are covered only when received from Participating Providers and Participating Facilities, and only at National Transplant Network facilities we designate. Services are subject to Utilization Review criteria developed by Medical Group and approved by Company.

You pay the applicable Cost Share you would pay if the Services were not related to a transplant. Inpatient Services associated with a covered transplant are covered at the "Inpatient Hospital Services" Cost Share shown on your "Benefit Summary." Outpatient Services associated with a covered transplant are covered at the applicable Cost Share shown on your "Benefit Summary" for the corresponding benefit, for example, "Outpatient Services," "Outpatient Durable Medical Equipment," and "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures."

A National Transplant Network facility is a transplant facility that meets all of the following requirements:

- It is licensed in the state where it operates.
- It is certified by Medicare as a transplant facility for the specific transplant.
- It is designated by Company as a transplant facility for the specific transplant.
- It is able to meet reasonable access standards for organ transplants based on Regional Organ Procurement Agency statistics for the facility location (a Regional Organ Procurement Agency is the geographic area designated by a state-licensed organ procurement organization for transplants in the state of Oregon).

We cover only the following transplants at National Transplant Network facilities:

- Bone marrow.
- Cornea.
- Heart.
- Heart-lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Pancreas after kidney.
- Simultaneous kidney-pancreas.
- Small bowel.
- Small bowel/liver.
- Stem cell.

Transplant Services Limitations

After the referral to a transplant facility, the following apply:

- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made.
- Company, Participating Hospitals, Medical Group, and Participating Providers are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor.

- We provide or pay for certain donation-related Services for a donor, or an individual identified by Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for coverage of Services for living transplant donors are available by calling Member Services.
- If we refer you for or preauthorize transplant Services at a distant location (farther away than the normal community patterns of care) and you choose to obtain your transplant at this distant location, we cover appropriate travel and lodging expenses for you and a caregiver. Your transplant coordinator can provide information about covered expenses.

Transplant Services Exclusions

- Non-human and artificial organs and tissues, and their implantation.

EXCLUSIONS AND LIMITATIONS

The Services listed in this "Exclusions and Limitations" section are either completely excluded from coverage or partially limited under this *EOC*. These exclusions and limitations apply to all Services that would otherwise be covered under this *EOC* and are in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in this *EOC*.

Acupuncture. Services for acupuncture are excluded unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred acupuncture Services.

Certain Exams and Services. Physical examinations and other Services are excluded when: (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or governmental licensing, or (c) court ordered or required for parole or probation. This exclusion does not apply to Medically Necessary court-ordered Services that are covered under "Substance Use Disorder Services" or "Behavioral Health Services" in the "Benefits" section.

Chiropractic Services. Chiropractic and related Services are excluded, unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred chiropractic Services.

Cosmetic Services. Services that are intended primarily to change or maintain your appearance and will not result in significant improvement of the condition being treated. This exclusion does not apply to Medically Necessary Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section, Gender Affirming Treatment, or any other Services that are Medically Necessary.

Custodial Care. Assistance with activities of daily living (such as walking, getting in and out of a bed or chair, bathing, dressing, eating, using the toilet, and taking medicine) or personal care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure, certification, or the presence of a supervising licensed nurse.

Dental Services. This exclusion does not apply to Services that are covered under "Limited Dental Services" in the "Benefits" section.

Designated Blood Donations. Collection, processing, and storage of blood donated by donors whom you designate, and procurement and storage of cord blood is covered only when Medically Necessary for the imminent use at the time of collection for a designated recipient.

Employer Responsibility. We do not reimburse the employer for any Services that the law requires an employer to provide. When we cover any of these Services we may recover the Charges for the Services from the employer.

Experimental or Investigational Services. Services are excluded if any of the following is true about the Service:

- They cannot be legally marketed in the United States without the approval of the U.S. Food and Drug Administration (FDA), and the FDA has not granted this approval.
- They are the subject of a current new drug or new device application on file with the FDA.
- They are provided as part of a Phase I, Phase II, or Phase IV clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Services.
- They are provided pursuant to a written protocol or other document that lists an evaluation of the Services' safety, toxicity, or efficacy as among its objectives.
- They are subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of Services.
- They are provided pursuant to informed consent documents that describe the Services as experimental or investigational, or in other terms that indicate that the Services are being evaluated for their safety, toxicity, or efficacy.
- The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:
  - Use of the Services should be substantially confined to research settings, or
  - Further research is necessary to determine the safety, toxicity, or efficacy of the Services.

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

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

We consult Medical Group and then use the criteria described above to decide if a particular Service is experimental or investigational.

This exclusion does not apply to Services that we cover under "Services Provided in Connection with Clinical Trials" in the "Benefits" section of this *EOC*.

Eye Surgery. Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.

Family Services. Services provided by a member of your immediate family.

Genetic Testing. Genetic testing and related Services are excluded except as described under "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" in the "Benefits" section.

Government Agency Responsibility. We do not reimburse the government agency for any Services that the law requires be provided only by or received only from a government agency. When we cover any of these

Services, we may recover the Charges for the Services from the government agency. However, this exclusion does not apply to Medicaid.

Hearing Aids. Hearing aids, tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid are excluded, unless your Group has purchased the "Hearing Aid Rider." This exclusion does not apply to Services that are covered under "Hearing Aids and Other Hearing Devices" in the "Benefits" section.

Hypnotherapy. All Services related to hypnotherapy.

Intermediate Services. Services in an intermediate care facility are excluded.

Low-Vision Aids. Low-vision aids are excluded, unless your employer Group has purchased the "Pediatric Vision Hardware and Optical Services Rider" or "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider."

Massage Therapy Services. Massage therapy and related Services are excluded, unless your employer Group has purchased an "Alternative Care Services Rider" that includes coverage for self-referred massage therapy Services.

Non-Medically Necessary Services. Services that are not Medically Necessary.

Nonreusable Medical Supplies. Nonreusable medical supplies, such as splints, slings, and wound dressing, including bandages and ace wrap bandages, are limited to those supplied and applied by a licensed health care provider, while providing a covered Service. Nonreusable medical supplies that a Member purchases or obtains from another source are excluded.

Optometric Vision Therapy and Orthoptics (Eye Exercises). Services related to optometric vision therapy and orthoptics (eye exercises) are excluded.

Professional Services for Evaluation, Fitting, and Follow-Up Care for Contact Lenses. This exclusion does not apply to Services that are covered under the "Pediatric Vision Hardware and Optical Services Rider" or "Adult Vision Hardware and Optical Services Rider," if purchased by your Group.

Services Related to a Non-Covered Service. When a Service is not covered, all Services related to the non-covered Service are also excluded. However, this exclusion does not apply to Services we would otherwise cover if they are to treat complications which arise from the non-covered Service and to Medically Necessary Services for a Member enrolled in and participating in a qualifying clinical trial if we would typically cover those Services absent a clinical trial.

Services That are Not Health Care Services, Supplies, or Items. This exclusion does not apply to Medically Necessary applied behavior analysis (ABA) Services. For example, we do not cover:

- Teaching manners and etiquette.
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning.
- Items and services that increase academic knowledge or skills.
- Teaching and support services to increase intelligence.
- Academic coaching or tutoring for skills such as grammar, math, and time management.
- Teaching you how to read, whether or not you have dyslexia.
- Educational testing.
- Teaching art, dance, horse riding, music, play or swimming.
- Teaching skills for employment or vocational purposes.

- Vocational training or teaching vocational skills.
- Professional growth courses.
- Training for a specific job or employment counseling.
- Aquatic therapy and other water therapy.

Supportive Care and Other Services. Supportive care primarily to maintain the level of correction already achieved; care primarily for the convenience of the Member; and care on a non-acute, symptomatic basis are excluded.

Surrogacy. Services for anyone in connection with a Surrogacy Arrangement, whether traditional or gestational, except for otherwise-covered Services provided to a Member who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. See "Surrogacy Arrangements – Traditional and Gestational Carriers" in the "Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and Lodging. Transportation or living expenses for any person, including the patient, are limited to travel and lodging expenses needed for Member to receive covered Services at Non-Participating Facilities, subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company.

Travel Immunizations. Travel-related immunizations for yellow fever, typhoid, and Japanese encephalitis, unless your Group has purchased a "Travel Immunizations Rider."

Vision Hardware and Optical Services. Corrective lenses, eyeglasses, and contact lenses are excluded, unless your Group has purchased an "Adult Vision Hardware and Optical Services Rider" and/or "Pediatric Vision Hardware and Optical Services Rider" or "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider."

REDUCTIONS

Coordination of Benefits

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100 percent of the total Allowable expense.

Definitions

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   (1) Plan includes: group and individual health insurance contracts, health maintenance organization (HMO) contracts, group or individual closed panel Plans, other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts, such as skilled nursing care; Medicare or any other federal governmental Plan, as permitted by law;

and group and individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care.

(2) Plan does not include: independent, non-coordinated hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of group long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100 percent of the total Allowable expense.

D. Allowable expense is a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of Services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary Plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan

provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel Plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, subscriber or retiree is the Secondary Plan and the other Plan is the Primary plan.

(2) Dependent child covered under more than one Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

(i) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

(ii) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

(ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Plan covering the Custodial parent;
2. The Plan covering the spouse of the Custodial parent;
3. The Plan covering the non-custodial parent; and then
4. The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(d) For a dependent child:

(i) Who has coverage under either or both parents' plans and also has coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.

(ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent and the dependent's spouse.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid-off nor retired, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more Closed panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel Plan, COB shall not apply between that Plan and other Closed panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable.

Facility of Payment

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

Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Questions About Coordination of Benefits?
Contact Your State Insurance Department

Hospitalization on Your Effective Date

If you are an inpatient in a hospital on your membership effective date but had other Group coverage on the day before your membership effective date, your other Group coverage will be responsible for covering the Services you receive until you are released from the hospital, or until you have exhausted your benefit with the other Group coverage and the benefits available under this Plan will be reduced accordingly.

Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance

This "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section applies if you receive covered Services for an injury or illness alleged to be any of the following:

- Caused by another party's act or omission.
- Received on the premises of another party.
- Covered by a no-fault insurance provision.

For purposes of this section, "no-fault insurance" means a type of insurance policy that covers your medical expenses for injury or illness due to an accident, regardless of who caused the accident.

Subject to applicable law, if you obtain a settlement, award, or judgment from or on behalf of another party or insurer, or a payment under a no-fault insurance provision, you must ensure we are reimbursed for covered Services that you receive for the injury or illness.

This "Injuries or Illnesses Alleged to be Caused by Other Parties or Covered by No-Fault Insurance" section does not affect your obligation to pay any applicable Cost Share for these covered Services. The amount of reimbursement due to the Plan is not limited by or subject to the Out-of-Pocket Maximum provision.

If you do not recover anything from or on behalf of the other party, or no-fault insurance, then you are responsible only for any applicable Cost Share.

To the extent permitted by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party, or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by another party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total Charges for the relevant covered Services.

To secure our rights, we will have a lien on the proceeds of any judgment, award, or settlement you or we (when we subrogate) obtain against another party, or any other insurer, regardless of how those proceeds may be characterized or designated. Subject to applicable law, the proceeds of any judgment, award, or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against another party, or any insurer, you must send written notice of the claim or legal action to us at:

The Phia Group, LLC
40 Pequot Way
Canton, MA 02021
Fax: 781-848-1154

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

You must provide us written notice before you settle a claim or obtain a judgment or award, or if it appears you will make a recovery of any kind. Subject to applicable law, if you recover any amounts from another party or any other insurer based on your injury or illness, you must pay us after you are reimbursed the total amount of the actual losses and damages you incurred. Sufficient funds to satisfy our claims must be held in a specifically identifiable account until our claims are resolved. Pending final resolution of our claims, you must retain control over the recovered amounts to which we may assert a right.

If reasonable collections costs have been incurred by your attorney in connection with obtaining recovery, we will reduce the amount of our claim by the amount of an equitable apportionment of the collection costs between us and you. This reduction will be made only if:

- We receive a list of the fees and associated costs before settlement, and
- Your attorney's actions were directly related to securing a recovery for you.

In addition to the rights set forth above, we shall also be entitled to all of the remedies, benefits, and other rights of sections 742.520 – 742.544, Oregon Revised Statutes.

If your estate, parent, guardian, or conservator asserts a claim against another party or any insurer based on your injury or illness, any settlement or judgment recovered shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

Surrogacy Arrangements – Traditional and Gestational Carriers

If you enter into a Surrogacy Arrangement, whether traditional or gestational, you must ensure we are reimbursed for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount we collect will not exceed the payments or other compensation you and any other payee are entitled to receive under the Surrogacy Arrangement. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate.

This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and includes both traditional surrogacy and gestational carriers. Note: This "Surrogacy Arrangements – Traditional and Gestational Carriers" section does not affect your obligation to pay any applicable Cost Share, or other amounts you are required to pay for these Services. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

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

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

You must send this information to:

Surrogacy Other Party Liability Supervisor
Equian
P.O. Box 36380
Louisville, KY 40233-6380
Fax: 1-502-214-1137
Phone: 1-800-552-8314

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

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement, award, or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against that party. We may assign our rights to enforce our liens and other rights.

Workers' Compensation or Employer's Liability

If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services even if it is unclear whether you are entitled to a payment or settlement under the law. You have an obligation to reimburse us to the extent of a payment or any other benefit, including any amount you receive as a settlement under the law.

In addition, we or our Participating Providers will be permitted to seek reimbursement for these Services directly from the responsible employer or the government agency that administers the law.

GRIEVANCES, CLAIMS, APPEALS, AND EXTERNAL REVIEW

Important Information for Members Whose Benefit Plans are Subject to ERISA.

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that regulates employee benefits, including the claim and appeal procedures for benefit plans offered by certain employers. If an employer's benefit plan is subject to ERISA, each time you request Services that must be approved before the Service is provided, you are filing a "pre-service claim" for benefits. You are filing a "post-service claim" when you ask us to pay for or cover Services that have already been received. You must follow our procedure for filing claims, and we must follow certain rules established by ERISA for responding to claims.

Terms We Use in This Section

The following terms have the following meanings when used in this "Grievances, Claims, Appeals, and External Review" section:

- A claim is a request for us to:
  - Provide or pay for a Service that you have not received (pre-service claim);
  - Continue to provide or pay for a Service that you are currently receiving (concurrent care claim); or
  - Pay for a Service that you have already received (post-service claim).
- An adverse benefit determination is our decision to deny, reduce or terminate a Service, or failure or refusal to provide or to make a payment in whole or in part for a Service that is based on:
  - Denial or termination of enrollment of an individual in a health benefit plan;

- Rescission or cancellation of a policy;
- Imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, annual benefit limit or other limitation on otherwise covered Services;
- Determination that a Service is experimental or investigational or not Medically Necessary or appropriate; or
- Determination that a course or plan of treatment that a Member is undergoing is an active course of treatment for purposes of continuity of care; or
- Denial, in whole or in part, of a request for prior authorization, a request for an exception to step therapy or a request for coverage of a treatment, drug, device or diagnostic or laboratory test that is subject to Utilization Review requirements.

- A grievance is communication expressing dissatisfaction with an adverse benefit determination, without specifically declining any right to appeal or review, that is:
  - In writing, for an internal appeal or an external review;
  - In writing or orally for an expedited response or an expedited external review; or
  - A complaint regarding the:
    - Availability, delivery, or quality of a Service;
    - Claims payment, handling or reimbursement for Services and, unless a request for an appeal has not been submitted, the complaint is not disputing an adverse benefit determination; or
    - Matters pertaining to the contractual relationship between the Member and Company.
- An internal appeal is a request for us to review our initial adverse benefit determination.

Member Satisfaction Procedure

We want you to be satisfied with the Services you receive from Kaiser Permanente. We encourage you to discuss any questions or concerns about your care with your provider or another member of your health care team. If you are not satisfied with your provider, you may request another. Contact Member Services for assistance. You always have the right to a second opinion from a qualified provider at the applicable Cost Share.

If you are not satisfied with the Services received at a particular medical office, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by following one of the procedures listed below:

- Call Member Services; or
- Send your written complaint to Member Relations at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 NE Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

All complaints are handled in a confidential manner.

After you notify us of a complaint, this is what happens:

- A representative reviews the complaint and conducts an investigation, verifying all the relevant facts.

- The representative or a physician evaluates the facts and makes a recommendation for corrective action, if any.
- When you file a complaint, we will respond within 30 calendar days.

We want you to be satisfied with our facilities, Services, and providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know.

Language and Translation Assistance

If we send you grievance or adverse benefit determination correspondence, we will include a notice of language assistance (oral translation). You may request language assistance with your claim and/or appeal by calling 1-800-324-8010. The notice of language assistance "Help in Your Language" is also included in this *EOC*.

Appointing a Representative

If you would like someone to act on your behalf regarding your claim, you may appoint an authorized representative, an individual who by law or by your consent may act on your behalf. You must make this appointment in writing. Contact Member Services for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

While you are encouraged to use our appeal procedures, you have the right to file a complaint or seek other assistance from the Consumer Advocacy Section of the Division of Financial Regulation. Contact them by mail, email, telephone, fax, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
Email: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll-Free: 1-888-877-4894
Fax: 503-378-4351
https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx

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 (including complete medical necessity criteria, benefit provisions, guidelines, or protocols) used to make a denial determination. 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 Member Services.

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 mail or fax all additional information to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

To arrange to give testimony by telephone, you should contact Member Services.

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

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue another 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.

Internal Claims and Appeals Procedures

Company will review claims and appeals, and we may use medical experts to help us review them.

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this "Internal Claims and Appeals Procedures" section:

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

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will they be the subordinate of someone who did participate in our original decision.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur (urgent pre-service appeal and urgent concurrent appeal), you must exhaust the internal claims and appeals procedures described below before initiating an external review.

Pre-service Claims and Appeals

Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive authorization before receiving a Service that must be authorized in order to be a covered benefit may be the basis for our denial of your pre-service claim or a post-service claim for payment. If you receive any of

the 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 contact Member Services.

Here are the procedures for filing a non-urgent pre-service claim, an urgent pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

Non-Urgent Pre-service Claim

- You may request a pre-service benefit determination on your own behalf. Tell us in writing that you want to make a claim for us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You may email your request to us at **https://healthy.kaiserpermanente.org/oregon-washington/support**, mail or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Attn: Utilization Management
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-877-899-4972

- 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. 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 or health, the life or health of a fetus, or your ability to regain maximum function; (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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

- 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 no later than two business days after we receive your claim.

  We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial decision period.

  If more information is needed to make a decision, we will ask you for the information in writing within two business days after we receive your claim, and we will give you 15 calendar days to send the information.

  We will make a decision and send notification within two business 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 15 calendar days after we send our request, we will make a decision based on the information we have no later than 15 calendar days following the date the additional information was requested.

  If we notify you of our decision orally, we will send you written confirmation no later than two business days after the oral notification.

- We will send written notice of our decision to you and, if applicable, to your provider.

Urgent Pre-service Claim

- 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 no later than two business days after we receive your claim.
- We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you prior to the expiration of the initial decision period.
- If more information is needed to make a decision, we will ask you for the information in writing within 2 business days after we receive your claim, and we will give you 15 calendar days to send the information.
- We will make a decision and send notification within two business 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 15 calendar days after we send our request, we will make a decision based on the information we have no later than 15 calendar days following the date the additional information was requested.

  If we notify you of our decision orally, we will send you written confirmation no later than two business days after the oral notification.
- If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Pre-service Appeal

- Within 180 calendar 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 health 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 determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must mail or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239
- We will acknowledge your appeal in writing within five calendar days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 30 calendar days after we receive your appeal.

- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, which may be available to you.

Urgent Pre-service Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your pre-service claim. Please include the following:

  (1) Your name and health 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 determination; and

  (5) All supporting documents.

  Your request and the supporting documents constitute your appeal. You must call Member Services, mail, or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

- When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section), if our internal appeal decision is not in your favor.
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function; (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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and give you oral or written notice of our decision 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 three calendar days after the oral notification.
- 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, which may be available to you.

Concurrent Care Claims and Appeals

Concurrent care claims are requests that Company continues to provide, or pay for, an ongoing course of covered treatment to be provided over a period of time or number of treatments, when the course of treatment already being received is scheduled to end. If you have any general questions about concurrent care claims or appeals, please call Member Services.

Unless you are appealing an urgent care claim, 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 Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then you will have to pay for the Services that we decide are not covered.

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

Non-Urgent Concurrent Care Claim

- Tell us 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 call Member Services, mail, or fax your claim to us at:

  Kaiser Foundation Health Plan of the Northwest
  Attn: Utilization Management
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-877-899-4972

- If you want us to consider your claim on an urgent basis and you contact us at least 24 hours before your authorized care ends, you may request that we review your concurrent care claim on an urgent basis. We will decide whether your claim is urgent or non-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 or health, the life or health of a fetus, or your ability to regain maximum function; (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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

- 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 authorized 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 no later than 15 calendar days after we receive your claim.

  We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we send you notice before the initial decision period ends.

  If more information is needed to make a decision, we will ask you for the information in writing before the initial decision period ends, and we will give you until your care is ending or, if your care has ended, 45 calendar days to send us the information.

We will make our decision as soon as possible if your care has not ended, or within 15 calendar 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 45 calendar days after we send our request, we will make a decision based on the information we have within the appropriate timeframe, not to exceed 15 calendar 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.

Urgent Concurrent Care Claim

- If we consider your concurrent care claim on an urgent basis, we will notify you of our decision orally or in writing as soon as your clinical condition requires, but no later than 24 hours after we receive your claim. If we notify you of our decision orally, we will send you written confirmation within three calendar days after the oral notification.
- If more information is needed to make a decision, we will give you seven calendar days to send the information.
- We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision.

  We will notify you of our decision within 48 hours of receiving the first piece of requested information or by the deadline for receiving the information, whichever is sooner.
- If we deny your claim (if we do not agree to provide or pay for extending the ongoing course of treatment), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Non-Urgent Concurrent Care Appeal

- Within 180 calendar 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 health record number;

  (2) Your medical condition or relevant symptoms;

  (3) The ongoing course of covered treatment that you want to continue or extend;

  (4) All of the reasons why you disagree with our adverse benefit determination; and

  (5) All supporting documents.

  Your request and all supporting documents constitute your appeal. You must mail or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision as soon as possible if your care has not ended but no later than 30 calendar days after we receive your appeal.

- If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, which may be available to you.

Urgent Concurrent Care Appeal

- Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent care claim. Please include the following:

  (1) Your name and health record number;

  (2) Your medical condition or relevant 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 call Member Services, mail, or fax your appeal to us at:

  Kaiser Foundation Health Plan of the Northwest
  Member Relations Department
  500 N.E. Multnomah St., Suite 100
  Portland, OR 97232-2099
  Fax: 1-855-347-7239

- When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Grievances, Claims, Appeals, and External Review" section).
- We will decide whether your appeal is urgent or non-urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function; (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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- 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 three calendar days after the oral notification.
- If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

Post-service Claims and Appeals

Post-service claims are requests that we pay for Services you already received, including claims for out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call Member Services.

Here are the procedures for filing a post-service claim and a post-service appeal:

Post-service Claim

- Within 12 months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following:

  (1) The date you received the Services;

  (2) Where you received them;

  (3) Who provided them;

  (4) Why you think we should pay for the Services; and

  (5) A copy of the bill and any supporting documents, including medical records.

  Your letter and the related documents constitute your claim. You may contact Member Services to obtain a claim form. You must mail your claim to the Claims Department at:

  Kaiser Foundation Health Plan of the Northwest
  National Claims Administration – Northwest
  PO Box 370050
  Denver, CO 80237-9998

- We will not accept or pay for claims received from you after 12 months from the date of Service, 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 calendar days after we receive your claim.

  We may extend the time for making a decision for an additional 15 calendar days if circumstances beyond our control delay our decision, if we notify you within 30 calendar days after we receive your claim.

  If more information is needed to make a decision, we will ask you for the information before the initial decision period ends, and we will give you 45 calendar days to send us the information.

  We will make a decision within 15 calendar 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 calendar days after we send our request, we will make a decision based on the information we have within 15 calendar days following the end of the 45 calendar-day period.

- If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

Post-service Appeal

- Within 180 calendar 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 health record number;

(2) Your medical condition or relevant symptoms;

(3) The specific 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 or fax your appeal to us at:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 N.E. Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

- We will acknowledge your appeal in writing within five calendar days after we receive it.
- We will fully and fairly review all available information relevant to your appeal without deferring to prior decisions.
- We will review your appeal and send you a written decision within 30 calendar days after we receive your appeal.
- If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

External Review

If you are dissatisfied with our final adverse benefit determination, you have a right to request an external review. An external review is a request for an independent review organization (IRO) to determine whether our internal appeal decision is correct. For example, you have the right to request external review of an adverse decision that is based on any of the following:

- Relies on medical judgment, including but not limited to, medical necessity, appropriateness, health care setting, level of care, or that the requested Service is not efficacious or otherwise unjustified under evidence-based medical criteria.
- Concludes that a treatment is experimental or investigational.
- Whether a course or plan of treatment is an active course of treatment for purposes of continuity of care when a Participating Provider's contract with us is terminated.
- Whether an exception to the prescription drug formulary or step therapy prescribing criteria should be granted.
- Concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or Substance Use Disorder) benefits.
- Involves consideration of whether we are complying with federal law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130).
- Involves a decision related to rescission of your coverage.

You must exhaust our internal claims and appeals procedure for your claim before you may request external review unless one of the following is true:

- External review is permitted to occur simultaneously with your urgent pre-service appeal or urgent concurrent care appeal;
- Your request qualifies for expedited external review;
- We have failed to comply with federal requirements regarding our claims and appeals procedures.

You are not responsible for the costs of the external review, and you may name someone else to file the request for external review for you if you give permission in writing and include that with your request for external review. Company will be bound by and act in accordance with the decision of the independent review organization (IRO) notwithstanding the definition of Medically Necessary care. If we do not follow a decision of an IRO, you have the right to sue us.

Within 180 calendar days after the date of our appeal denial letter you must send your request for external review to Member Relations in writing (via mail, fax, or online through our website at **kp.org**). If you wish to mail or fax your request, you may send it to us at:

Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 1-855-347-7239

You may be required to provide us with a signed waiver form that enables us to disclose your protected health information, including pertinent medical records, to the IRO that will evaluate your request. The "Authorization for Use or Disclosure of Protected Health Information" form is also available at **info.kaiserpermanente.org/northwest/roi/forms.html**.

The appeal denial letter that we send to you explains the external review process and includes the waiver form. Member Relations will forward your request to the director of the Oregon Department of Consumer and Business Services (DCBS), Division of Financial Regulation (DFR), within two business days after receiving your request. Your request for external review will be assigned to one of the nationally accredited IROs contracted by DCBS no later than the next business day after the director receives your request for external review from us.

Within two business days of receiving notice of your request, DCBS will send you a written description of the IRO they selected along with more information about the process. They will also notify us of the IRO they selected, and within five business days after receiving notification from DCBS, we will send the IRO any documents and information we considered in making our adverse benefit determination.

You will have five business days to submit to the IRO, in writing, any additional information that the IRO must consider when conducting the external review. The IRO will forward to us any additional information you submit within one business day of receipt. We may also forward additional information directly to the IRO. The IRO will have one business day after receiving the additional information to forward that information to you.

Unless your external review is expedited, the IRO will issue a decision within 30 calendar days after the date when we receive your request for external review. The IRO will notify you and us of its decision no later than five calendar days after the decision is issued.

You may also contact DCBS directly to request an external review. If DCBS receives a request for external review directly from you, they will notify us of your request no later than the next business day. Upon receipt

of your request from DCBS, we will follow the process described above. You may contact the Oregon DCBS by mail, e-mail, telephone, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
E-mail: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll-Free: 1-888-877-4894
https://dfr.oregon.gov/help/Pages/index.aspx

Expedited External Review

We shall expedite the external review if:

- The adverse benefit determination concerns an admission, the availability of care, a continued stay or a health care Service for a medical condition for which you received Emergency Services and you have not been discharged from a health care facility; or
- A provider you have an established relationship with certifies in writing and provides supporting documentation that the ordinary time period for external review would (a) seriously jeopardize your life or health, the life or health of a fetus, or your ability to regain maximum function; (b) 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; (c) your attending provider requests that your claim be treated as urgent; or (d) involves a request concerning admissions, continued stay, or other health care Services if you have received Emergency Services but have not been discharged from a facility.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures. 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.

TERMINATION OF *AGREEMENT*

If the *Agreement* terminates and Group does not replace this coverage with another Plan, Company will give Group written notice of termination no later than 10 working days after the termination date and will explain the rights of Members regarding continuation of coverage as provided by federal and state law.

TERMINATION OF MEMBERSHIP

If your membership terminates, all rights to benefits end at 11:59 p.m. PT on the termination date. In addition, Dependents' memberships end at the same time the Subscribers' membership ends.

You will be billed as a non-member for any Services you receive after your membership terminates. Company and Participating Providers and Participating Facilities have no further liability or responsibility under this *EOC* after your membership terminates.

Termination During Confinement in a Hospital

If you are hospitalized on the date when your membership terminates, we will continue to cover otherwise covered Services in that hospital if all of the following conditions are met:

- The coverage under this *EOC* is being immediately replaced by another insured group health insurance policy.
- You are an inpatient receiving covered Services on the date your membership ends.
- You must continue to pay any applicable Cost Share.

Your coverage under this provision continues until the earlier of:

- Your discharge from the hospital or
- Your exhaustion of hospital benefits under this *EOC*.

Termination Due to Loss of Eligibility

You and your Dependents must remain eligible to maintain your Group coverage. You must immediately report to your Group any changes in eligibility status, such as a Spouse's loss of eligibility due to divorce or a Dependent child who has reached the Dependent Limiting Age. If you no longer meet the eligibility requirements described in this *EOC*, please confirm with your Group's benefits administrator when your membership will end.

Termination for Cause

If you or any other Member in your Family knowingly commits fraud in connection with membership, Company, or a Participating Provider, we may terminate your membership under this employer's *Agreement* by sending written notice, including the specific reason for termination with supporting evidence to the Subscriber at least 31 days before the membership termination date. Some examples of fraud include:

- Misrepresenting eligibility information about yourself or a Dependent.
- Presenting an invalid prescription or physician order for Services.
- Intentionally misusing a Company ID card (or letting someone else use your ID card to obtain Services pretending to be you).
- Giving us incorrect or incomplete material information.
- Failing to notify us of changes in Family status or Medicare coverage that may affect your eligibility or benefits.

We may report fraud and other illegal acts to the authorities for prosecution.

If we terminate your membership for cause, we will:

- Refund any amounts we owe your Group for Premium paid for the period after the termination date.
- Pay you any amounts we have determined that we owe you for claims during your membership.

We may deduct any amounts you owe Company, Participating Providers, or Participating Facilities from any payment we make to you.

If your coverage is terminated for any of the above reasons, you have the right to file an appeal. For more information, please contact Member Services.

Termination of Your Group's *Agreement* with Us

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. We require the Group to notify Subscribers in writing if the *Agreement* with us terminates.

Termination of Certain Types of Health Benefit Plans by Us

We may terminate a particular Plan or all Plans offered in the group market as permitted by law. If we discontinue offering a particular Plan in the group market, we will terminate the particular Plan upon 90 days prior written notice to you. If we discontinue offering all Plans in the group market, we may terminate the *Agreement* upon 180 days prior written notice to you.

CONTINUATION OF MEMBERSHIP

Strike, Lock-Out, or Other Labor Disputes

If your compensation is suspended directly or indirectly as a result of a strike, lock-out, or other labor dispute, you may continue membership under this *EOC* by paying Premium for yourself and eligible Dependents directly to the Group for up to six months. If the Group's coverage is terminated by Company, reinstatement with Company is subject to all terms and conditions of your Group's *Agreement* with Company. When your Group continuation coverage under this *EOC* stops, you and your Dependents may be eligible to purchase an individual plan offered by Company.

Illness, Temporary Plant Shut Down, or Leave of Absence

If you are off work due to illness, temporary plant shutdown, or other leave of absence authorized by your Group, you may make arrangements to make monthly payments through your Group for up to 12 weeks. The 12-week period may be extended by advance arrangements confirmed in writing by Company. Once the 12-week period is exhausted, you may also be eligible to convert to an individual plan. (See the "Conversion to an Individual Plan" section.)

Continuation of Group Coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to most employees (and most of their covered dependents) of most employers with 20 or more employees (however, it does not apply to church plans as defined by federal law). Please contact your Group for details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group for the coverage.

Federal or State-Mandated Continuation of Coverage

Termination of coverage will be postponed if the Member is on a leave of absence and continuation of coverage is required by the federal or state-mandated family or medical leave act or law, as amended.

State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or Older

If your Group has 20 or more employees, you and your Dependents may be able to continue your coverage under this *EOC* through your Group if you meet all of the following criteria:

- You are the Subscriber's Spouse.
- You are age 55 or older.
- The Subscriber died, or you divorced or are legally separated from the Subscriber.
- You are not eligible for Medicare.

To continue coverage, you must notify Member Services in writing within 60 days after legal separation or divorce, or the Group must notify us in writing within 30 days after the death of the Subscriber. Within 14 days after we receive the notice, we will send you an election form, payment information, and instructions for

electing continuation coverage. You must return the completed election form no later than 60 days after the date we mailed it to you.

The first Premium payment must be paid within 45 days of your coverage election date. Your right to continue coverage as a surviving, separated, or divorced Spouse will end upon the earliest of the following events:

- You fail to pay your Premium.
- The Group's *Agreement* with us terminates.
- You become covered under another group health coverage.
- You, as a separated or divorced Spouse, remarry.
- You become eligible for Medicare.

State Continuation Coverage for Non-COBRA Groups

You may be able to continue coverage under this *EOC* for up to nine months if all of the following requirements are met:

- Your Group is not subject to COBRA law.
- The Subscriber in your Family was covered continuously under this *EOC* during the three-month period ending on the date of the qualifying event.
- You were covered under this *EOC* on the day before the qualifying event, or you are a child born to or adopted by the Subscriber while the Subscriber has continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section and you would have been covered under this *EOC* if you had been born or adopted on the day before the qualifying event. For the purposes of this "State Continuation Coverage for Non-COBRA Groups" section, "qualifying event" means the loss of membership under this *EOC* caused by one of the following:
  - Voluntary or involuntary termination of the employment of the Subscriber.
  - A reduction in hours worked by the Subscriber.
  - The Subscriber's becoming eligible for Medicare.
  - A Dependent's losing Dependent child status under this *EOC*.
  - Termination of membership in your Group resulting in loss of eligibility under the Group's evidence of coverage.
  - The death of the Subscriber.
- You are not eligible for Medicare, and you are not eligible for coverage under any other hospital or medical coverage or program that was not covering you on the day before the qualifying event.

To request continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section, you must send us a written request for this continuation coverage no later than 15 days after the later of the following:

- The date of your qualifying event.
- The date on which we sent you notice of your right to continue coverage under this *EOC*.

You must mail or fax your written request to us at:

Consolidated Service Center (CSC)
PO Box 23127
San Diego, CA 92193
Fax: 866-311-5974

Your Premium will be 100 percent of the applicable Premium. You must pay your first Premium payment to your Group within 31 days after the date of your qualifying event. Subsequent Premium payments are due on the last day of the month preceding the month of membership.

Continuation coverage under this "State Continuation Coverage for Non-COBRA Groups" section ends on the earliest of the following dates:

- The date that is nine months after your qualifying event.
- The end of the period for which we received your last timely Premium payment.
- The Premium due date coinciding with or next following the date that you become eligible for Medicare or for coverage under any other hospital or medical coverage or program that was not covering you on the day before the qualifying event.
- The date on which your Group's *Agreement* with us terminates.

If you are a surviving, divorced, or separated Spouse and are not eligible for continuation coverage under the "State Continuation Coverage for Surviving, Divorced, or Separated Spouses 55 or Older" section you may continue coverage for yourself and your Dependents under this "State Continuation Coverage for Non-COBRA Groups" section under the same terms as the Subscriber.

If you are a Subscriber who is laid off and then rehired by the same employer within nine months and you were eligible for coverage at the time of the layoff, you may not be subjected to any waiting period even if you chose not to continue coverage under this "State Continuation Coverage for Non-COBRA Groups" section.

If your Group coverage was under another evidence of coverage on the date of your qualifying event and you later became covered under this *EOC*, you may be able to continue coverage under this *EOC* if you otherwise meet the eligibility requirements in this "State Continuation Coverage for Non-COBRA Groups" section. The period of state continuation coverage includes the number of months you were covered under the previous evidence of coverage plus the number of months of coverage under this *EOC*, not to exceed nine months.

State Continuation Coverage after Workers' Compensation Claim

If you are a Subscriber and you file a workers' compensation claim for an injury or illness, you may be able to continue coverage under this *EOC* for up to six months after you would otherwise lose eligibility. Please contact your Group for details such as how to elect coverage and how much you must pay your Group for the coverage.

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 *EOC* for a limited time after you would otherwise lose eligibility, if required by federal law (USERRA).

You must submit an USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage and how much you must pay your Group for the coverage.

Conversion to an Individual Plan

After your Group notifies us to terminate your membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Member. You may contact Member Services if you have questions.

Moving to Another Kaiser Foundation Health Plan Service Area

If you move to another Kaiser Foundation Health Plan service area, you should contact your Group's benefits administrator to learn about your Group health care options. You may be eligible to enroll in a plan in the other Kaiser Foundation Health Plan service area. Eligibility requirements, benefits, premium, deductible, copayments, and coinsurance may not be the same in the other service area.

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

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

Agreement Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to make revised materials available to you.

Annual Summaries and Additional Information

Additional information that we have filed with the Oregon Department of Consumer and Business Services (DCBS) is available to you upon request. You may contact the Oregon DCBS to request the following:

- Our annual summary of grievances and appeals.
- Our annual summary of the utilization management program.
- Our annual summary of quality assurance activities.
- The results of publicly available accreditation surveys of our health plan.
- Our annual summary of health-promotion and disease-prevention activities.
- An annual summary of scope of network and accessibility of Services.

Contact the Oregon DCBS by mail, e-mail, telephone, or online at:

Department of Consumer and Business Services
Division of Financial Regulation
Consumer Advocacy Section
P.O. Box 14480
Salem, OR 97309-0405
E-mail: DFR.InsuranceHelp@oregon.gov
Phone: 503-947-7984
Toll-Free: 1-888-877-4894
https://dfr.oregon.gov/help/Pages/index.aspx

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*. In the absence of fraud, all statements made by an applicant, Group, or Subscriber shall be deemed representations and not warranties. No statement made for the purpose of effecting coverage shall void coverage or reduce benefits unless contained in a written instrument signed by the Group or Subscriber, a copy of which has been furnished to the Group or Subscriber.

Assignment

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

Attorney Fees and Expenses

In any dispute between a Member and Company or Medical Group or Kaiser Foundation Hospitals, each party will bear its own attorney fees and other expenses, except as otherwise required by law.

Exercise of Conscience

We recognize the right to exercise religious beliefs and conscience. If a Participating Provider or Participating Facility declines to provide a covered Service for reasons of conscience or religion, we will make arrangements to provide the covered Services.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with Oregon law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Company whether or not set forth in this *EOC*.

Group and Members not Company Agents

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

Information about New Technology

When a new medical technology or procedure needs review, our Inter-regional New Technology Committee examines and evaluates data from government agencies, medical experts, medical journals, and medical specialty societies. Recommendations from this inter-regional committee then are passed onto the local committee. The committee reviews the national recommendations to see how they apply to local medical practices. Once this review takes place, the committee makes recommendations for the new technology or procedure to become a covered benefit. In addition, the committee communicates practice guidelines to network providers and related health care providers. If the committee's recommendation is accepted, the new technology is added to the covered benefits, either immediately or when this contract renews.

No Waiver

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

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of race, ethnicity, nationality, actual or perceived gender, age, physical or mental disability, marital status, sexual orientation, genetic information, or religion.

Notices

We will send our notices to you to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives an overpayment, or from any person or organization obligated to pay for the Services.

Privacy Practices

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

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

You have the right to request that Kaiser Permanente send your PHI directly to you, and not to the Subscriber of your Plan. You have the right to tell us where you want us to redirect communications containing your PHI, including a different mailing address, email address or telephone number. To make a request for confidential communication, please call Member Services and ask for a "Confidential Communication Request" form. It may take up to 30 days from the date of receipt of the form for us to process your request.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices,* which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, please call Member Services. You can also find the notice on our website at **kp.org**.

Unusual Circumstances

In the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, labor disputes, disability of a large share of personnel at Participating Facilities, and complete or partial destruction of Participating Facilities, we will make a good faith effort to provide or arrange for covered Services within the limitations of available personnel and facilities. Kaiser Permanente shall have no other liability or obligation if covered Services are delayed or unavailable due to unusual circumstances.

NONDISCRIMINATION STATEMENT AND NOTICE OF LANGUAGE ASSISTANCE

Nondiscrimination Notice

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex,

gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at:

Member Relations Department
Attention: Kaiser Civil Rights Coordinator
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: **1-855-347-7239**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, DC 20201
Phone: **1-800-368-1019**
TDD: **1-800-537-7697**

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Help in Your Language

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-813-2000** (TTY: **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-813-2000** (TTY: **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-813-2000** (TTY: **711**).

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電**1-800-813-2000**（TTY：**711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-813-2000** (TTY: **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-813-2000** (TTY: **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-813-2000** (TTY: **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-813-2000**（TTY: **711**）まで、お電話にてご連絡ください。

ខ្មែរ (Khmer) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-813-2000** (TTY: **711**)។

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-813-2000** (TTY: **711**) 번으로 전화해 주십시오.

ລາວ (Laotian) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-800-813-2000** (TTY: **711**).

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-813-2000** (TTY: **711**).

ਪੰਜਾਬੀ (Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-800-813-2000** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Română (Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-800-813-2000** (TTY: **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-813-2000** (TTY: **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-813-2000** (TTY: **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-813-2000** (TTY: **711**).

ไทย (Thai) เรียน: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-813-2000** (TTY: **711**).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-800-813-2000** (TTY: **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-813-2000** (TTY: **711**).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network and/or your plan does not cover out-of-network services.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than your in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit. Your health plan coverage may not cover out-of-network services when you agree (consent) to receive services from the out-of-network providers.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service. Providers and facilities are not balance billing you when they seek to collect cost sharing or another amount that you agreed to pay or are required to pay under your plan for the services that they provided.

You are protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, or when an in-network provider is not available. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers and facilities.
  - Base what you owe the provider or facility (your cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or non-emergency services provided by certain out-of-network providers at an in-network facility toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed by a provider or facility, contact the federal government at **www.cms.gov/nosurprises/consumers** or by calling **1-800-985-3059**; or the Division of Financial Regulation, Department of Consumer and Business Services at **https://dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx** or call **1-888-877-4894**.

Visit **www.cms.gov/nosurprises/consumers** for more information about your rights under federal law.

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST ALTERNATIVE CARE SERVICES RIDER

This rider is part of the *Evidence of Coverage (EOC)* to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Alternative Care Services Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*, unless otherwise indicated.

Alternative Care Services

We cover the self-referred alternative care Services described in this "Alternative Care Services Rider" when Services are received from a Participating Provider and provided as outpatient Services in the provider's office.

To locate a Participating Provider, visit **www.chpgroup.com**. The CHP Group is a Participating Provider we contract with to provide alternative care Services. If you need assistance searching for a Participating Provider, or to verify the current participation status of a provider, or if you do not have access to the online directory, please contact Member Services.

Benefits are subject to visit limits and applicable Cost Shares shown in the "Alternative Care Services Rider Benefit Summary."

Acupuncture Services

Acupuncturists influence the health of the body by the insertion of very fine needles. Acupuncture treatment is primarily used to relieve pain, reduce inflammation, and promote healing. Covered Services include:

- Evaluation and management.
- Acupuncture.
- Electro acupuncture.

Chiropractic Services

Chiropractic and manual manipulation of the spine, joints or soft tissue focuses on reducing pain and improving the function and structure of the body. It is a system of therapy that involves non-invasive care promoting science-based approaches to a variety of ailments. Covered Services include:

- Evaluation and management.
- Musculoskeletal treatments.
- Physical therapy modalities such as hot and cold packs.

When prescribed, X-ray procedures are covered as described in the "Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures" section in the "Benefits" section of the *EOC*.

Alternative Care Services Exclusions

- Dermal friction technique.
- East Asian massage and tui na.
- Laserpuncture.
- Nambudripad allergy elimination technique (NAET).
- Point injection therapy.
- Qi gong.

- Services designed to maintain optimal health in the absence of symptoms.
- Sonopuncture.

Alternative Care Services Rider Benefit Summary

	You Pay
Acupuncture Services (up to 20 visits per Year)	$25 per visit
Chiropractic Services (up to 20 visits per Year)	$25 per visit

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST OUTPATIENT PRESCRIPTION DRUG RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. This rider becomes part of the *EOC* "Benefits" section, except for the "Outpatient Prescription Drug Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." The provisions of the *EOC* apply to this entire rider.

Note: We also cover some outpatient drugs and supplies in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.

Covered Drugs and Supplies

We cover outpatient prescription drugs and supplies as described in this "Outpatient Prescription Drug Rider."

Covered drugs and supplies must be prescribed by a Participating Provider or any licensed dentist in accordance with our drug formulary guidelines.

You must obtain drugs and supplies at a Participating Pharmacy (including our Mail-Order Pharmacy). You may obtain a first fill of a drug or supply at any Participating Pharmacy. All refills must be obtained through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy), or at another Participating Pharmacy that we designate for covered refills. See your *Medical Facility Directory*, visit **kp.org**, or contact Member Services.

Cost Share for Covered Drugs and Supplies

When you get a prescription from a Participating Pharmacy, or order a prescription from our Mail-Order Pharmacy, you pay the applicable Cost Share as shown in the "Outpatient Prescription Drug Rider Benefit Summary." This applies for each prescription consisting of up to the day supply shown in the "Outpatient Prescription Drug Rider Benefit Summary."

Outpatient prescription drugs and supplies are subject to the applicable Cost Share until the medical Out-of-Pocket Maximum is met.

If Charges for the drug or supply are less than your Copayment, you pay the lesser amount.

When you obtain your prescription through a pharmacy owned and operated by Kaiser Permanente (including our Mail-Order Pharmacy) you may be able to use an approved drug manufacturer coupon as payment for your prescription Cost Share. If the coupon does not cover the entire amount of your Cost Share, you are responsible for the additional amount up to the applicable Cost Share as shown in the "Benefit Summary." When you use an approved coupon for payment of your Cost Share, the coupon amount will count toward the Out-of-Pocket Maximum. For more information about the Kaiser Permanente coupon program rules and limitations, please call Member Services or go to **kp.org/rxcoupons**.

Day Supply Limit

The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a Medically Necessary 30-day (or any other number of days) supply for you. When you pay the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary," you will receive the prescribed supply up to the day supply limit. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantity that exceeds the day supply limit.

Medication Synchronization

Medication synchronization is the coordination of medication refills, if you are taking two or more medications for a chronic condition, so that your medications are refilled on the same schedule. You may request medication synchronization for a new prescription from the prescribing provider or a Participating Pharmacy who will determine the appropriateness of medication synchronization for the drugs being dispensed and inform you of the decision.

How to Get Covered Drugs or Supplies

Participating Pharmacies are located in many Participating Facilities. To find a Participating Pharmacy, please see your *Medical Facility Directory*, visit **kp.org/directory/nw**, or contact Member Services.

Participating Pharmacies include our Mail-Order Pharmacy. This pharmacy offers postage-paid delivery to addresses in Oregon and Washington. Some drugs and supplies are not available through our Mail-Order Pharmacy, for example drugs that require special handling or refrigeration, or are high cost. Drugs and supplies available through our Mail-Order Pharmacy are subject to change at any time without notice.

If you would like to use our Mail-Order Pharmacy, call 1-800-548-9809 or order online at **kp.org/refill**.

Definitions

The following terms, when capitalized and used in this "Outpatient Prescription Drug Rider," mean:

- **Brand-Name Drug.** The first approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Cost Share.** The Prescription Drug Deductible, Copayment, or Coinsurance you must pay for covered Services.
- **Generic Drug.** A drug that contains the same active ingredient as a Brand-Name Drug and is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent and having the same active ingredients(s) as the Brand-Name Drug. Generally, Generic Drugs cost less than Brand-Name Drugs, and must be identical in strength, safety, purity, and effectiveness.
- **Non-Preferred Brand-Name Drug.** A Brand-Name drug or supply that is not approved by Company's Regional Formulary and Therapeutics Committee and requires prior authorization for coverage.
- **Preferred Brand-Name Drug.** A Brand-Name drug or supply that Company's Regional Formulary and Therapeutics Committee has approved. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Prescription Drug Deductible.** The amount you must pay for certain prescription drugs and supplies you receive in a Year before we will cover those prescription drugs and supplies, subject to any applicable Copayment or Coinsurance, in that Year. Prescription Drug Deductible amounts count toward the medical Out-of-Pocket Maximum.
- **Preventive Drug.** A drug on our "Supplemental Tier for Preventive Drugs (non-ACA)" list. This Preventive Drug tier list includes formulary drugs that have been identified as preventive for certain conditions and complications from those conditions, such as asthma, high cholesterol, diabetes, high blood pressure, osteoporosis, and stroke prevention. This category does not include those preventive drugs required under the Patient Protection and Affordable Care Act (PPACA). If you would like a copy of the current list of eligible Preventive Drugs, please call Member Services.
- **Specialty Drug.** A drug or supply, including many self-injectables as well as other medications, often used to treat complex chronic health conditions, is generally high cost, and is approved by the U.S. Food and Drug Administration (FDA). Specialty drug treatments often require specialized delivery, handling, monitoring, and administration.

About Our Drug Formulary

Our drug formulary is a list of drugs that our Regional Formulary and Therapeutics Committee has reviewed and approved for our Members and includes drugs covered under this rider. Drugs on the formulary have been approved by the FDA.

Our Regional Formulary and Therapeutics Committee is made up of Participating Physicians, other Participating Providers, and administrative staff. The committee chooses drugs for the formulary based on several factors, including safety and effectiveness as determined from a review of the scientific literature. They may not approve a drug if there is not enough scientific evidence that it is clinically effective. They may also exclude a drug if it does not have a clinical or cost advantage over comparable formulary drugs.

The Regional Formulary and Therapeutics Committee meets to review new drugs and reconsider drugs currently on the market. After this review, they may add drugs to the formulary or remove drugs from it. If a drug is removed from the formulary, you will need to switch to another comparable drug that is on the drug formulary, unless your old drug meets exception criteria. Refer to the "Drug Formulary Exception Process" in this rider for more information.

If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your Participating Provider or another member of your health care team.

Drugs on our formulary may move to a different drug tier during the Year. For example, a drug could move from the Non-Preferred Brand-Name Drug list to the Preferred Brand-Name Drug list. If a drug you are taking is moved to a different drug tier, this could change the Cost Share you pay for that drug.

To see if a drug or supply is on our drug formulary, or to find out what drug tier the drug is in, go online to **kp.org/formulary**. You may also call our Formulary Application Services Team (FAST) at 503-261-7900 or toll-free at 1-888-572-7231. If you would like a copy of our drug formulary or additional information about the formulary process, please call Member Services. The presence of a drug on our drug formulary does not necessarily mean that your Participating Provider will prescribe it for a particular medical condition.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a Participating Provider or any licensed dentist prescribes a drug or supply that our drug formulary does not list for your condition, if the law requires the item to bear the legend "Rx only." The exception process is not available for drugs and supplies that the law does not require to bear this legend, or for any drug or supply prescribed by someone other than a Participating Provider or any licensed dentist.

A Participating Provider or any licensed dentist may request an exception if they determine that the non-formulary drug or supply is Medically Necessary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests.

We will approve the exception if all of the following requirements are met:

- We determine that the drug or supply meets all other coverage requirements except for the fact that our drug formulary does not list it for your condition.
- Medical Group or a designated physician makes the following determinations:
    - The drug or supply is Medically Necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs or supplies that our drug formulary lists for your condition.
    - Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug or supply. For this drug or supply, the Participating Pharmacy can provide a copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

If we approve an exception through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary."

If we do not approve the formulary exception request, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

Prior Authorization and Step Therapy Prescribing Criteria

Prior authorization is required when you are prescribed certain drugs or supplies before they can be covered. A Participating Provider may request prior authorization if they determine that the drug or supply is Medically Necessary. Prescribing Participating Providers must supply to Company the medical information necessary for Company to make the prior authorization determination. Coverage for a prescribed drug or supply that is approved for prior authorization begins on the date Company approves the request.

Approved requests for prior authorization are binding on us for one year from the date that the treatment begins following our approval if the drug:

- Is prescribed as a maintenance therapy that is expected to last at least 12 months based on medical or scientific evidence;
- Continues to be prescribed throughout the 12-month period; and
- Is prescribed for a condition that is within the scope of use for the drug as approved by the FDA, or has been proven to be a safe and effective form of treatment for your medical condition based on clinical practice guidelines developed from peer-reviewed medical literature.

A list of those drugs and supplies that require prior authorization and the Utilization Review criteria we use are available online at **kp.org/formulary** or you may contact Member Services.

We apply step therapy prescribing criteria, developed by Medical Group and approved by Company, to certain drugs and supplies. The step therapy prescribing criteria require that you try a therapeutically similar drug (step 1) for a specified length of time before we will cover another drug (step 2) prescribed for the same condition. A list of drugs and supplies subject to step therapy prescribing criteria, and the requirements for moving to the next step drug, are available online at **kp.org/formulary** or you may contact Member Services.

Prior Authorization Exception Process

We have a process for you or your prescribing Participating Provider to request a review of a prior authorization determination that a drug or supply is not covered. This exception process is not available for drugs and supplies that the law does not require to bear the legend "Rx only."

Your prescribing Participating Provider may request an exception if they determine that the drug or supply is Medically Necessary. Prescribing Participating Providers must supply to the Participating Pharmacy the medical information necessary to review the request for exception. A coverage determination will be made within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests.

If the exception request is approved through this exception process, then we will cover the drug or supply at the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary."

If the exception request is not approved, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter and under "External Review" in the "Grievances, Claims, Appeals, and External Review" section.

Emergency Fill

For purposes of this section, "emergency fill" means a limited dispensed amount of the prescribed drug that allows time for the processing of a prior authorization request. You may have the right to receive an emergency fill of a prescription drug that requires prior authorization under the following circumstances:

- The Participating Pharmacy is unable to reach the Company's prior authorization department by phone, as it is outside the department's business hours; or
- The Participating Pharmacy is unable to reach the prescribing Participating Provider for full consultation, and
- Delay in treatment would result in imminent emergency care, hospital admission or might seriously jeopardize the life or health of the patient or others in contact with the patient.

An emergency fill must be received at a Participating Pharmacy and is subject to the applicable Cost Share shown in the "Outpatient Prescription Drug Rider Benefit Summary." An emergency fill is limited to no more than a seven-day supply or the minimum packaging size available.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy Services. You also have the right to know what drugs are covered under this Plan and the limits that apply. If you have a question or a concern about your prescription drug benefits, please contact Member Services or visit us online at **kp.org**.

Medication Management Program

The Medication Management Program is available at no extra cost to Members who use Participating Pharmacies. The program's primary focus is on reducing cardiovascular risk by controlling lipid levels and high blood pressure. Providers, including pharmacists, nurse care managers, and other staff, work with Members to educate, monitor, and adjust medication doses.

Outpatient Prescription Drug Rider Limitations

- If your prescription allows refills, there are limits to how early you can receive a refill. In most cases, we will refill your prescription when you have used at least 70 percent of the quantity. Prescriptions for most controlled substances cannot be refilled early. Please ask your pharmacy if you have questions about when you can get a covered refill.
- The Participating Pharmacy may reduce the day supply dispensed at the applicable Cost Share to a 30-day supply in any 30-day period if it determines that the drug or supply is in limited supply in the market or for certain other items. Your Participating Pharmacy can tell you if a drug or supply you use is one of these items.
- For certain drugs or supplies we may limit the amount of a drug or supply that is covered for a specified time frame. Quantity limits are in place to ensure safe and appropriate use of a drug or supply. Drugs and supplies subject to quantity limits are indicated on our drug formulary, available at **kp.org/formulary**. You may also contact Member Services for more information.
- Not all drugs are available through mail order. Examples of drugs that cannot be mailed include controlled substances as determined by state and/or federal regulations, drugs that require special handling, and drugs affected by temperature.

Outpatient Prescription Drug Rider Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Brand-Name Drugs for which a Generic Drug is available, unless approved. Refer to the "Prior Authorization and Step Therapy Prescribing Criteria" section.
- Drugs prescribed for an indication if the FDA has determined that use of that drug for that indication is contraindicated.

- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if the Oregon Health Evidence Review Commission or our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs and supplies ordered from the Mail-Order Pharmacy to addresses outside of Oregon or Washington.
- Drugs and supplies that are available without a prescription, even if the non-prescription item is in a different form or different strength (or both), except that this exclusion does not apply to non-prescription drugs or supplies described under "Covered Drugs and Supplies" in the "Limited Outpatient Prescription Drugs and Supplies" section of the *EOC*.
- Drugs, biological products, and devices that the FDA has not approved.
- Drugs and supplies to treat sexual dysfunction are excluded except for drugs that are FDA-approved to treat behavioral health symptoms of sexual dysfunction.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Internally implanted time-release drugs, except that internally implanted time-release contraceptive drugs are covered.
- Nutritional supplements.
- Outpatient drugs that require professional administration by medical personnel or observation by medical personnel during self-administration (refer instead to the "Limited Outpatient Prescription Drugs and Supplies" section).
- Replacement of drugs and supplies due to loss, damage, or carelessness. This exclusion does not apply to drugs used to treat Substance Use Disorder.

Outpatient Prescription Drug Rider Benefit Summary

Outpatient Prescription Drugs and Supplies	**Participating Pharmacies** **You Pay**
Prescription Drug Deductible (per Member per Year)	$250
Generic Drugs	$10 for up to a 30-day supply after Prescription Drug Deductible
Generic Drugs from our Mail-Order Pharmacy	$10 for up to a 30-day supply after Prescription Drug Deductible $20 for a 31- to 90-day supply after Prescription Drug Deductible
Preferred Brand-Name Drugs or supplies	30% Coinsurance up to $100 maximum for up to a 30-day supply after Prescription Drug Deductible
Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	30% Coinsurance up to $100 maximum for up to a 30-day supply after Prescription Drug Deductible 30% Coinsurance up to $200 maximum for a 31- to 90-day supply after Prescription Drug Deductible

Outpatient Prescription Drugs and Supplies	Participating Pharmacies You Pay
Non-Preferred Brand-Name Drugs or supplies	40% Coinsurance up to $350 maximum for up to a 30-day supply after Prescription Drug Deductible
Non-Preferred Brand-Name Drugs or supplies from our Mail-Order Pharmacy	40% Coinsurance up to $350 maximum for up to a 30-day supply after Prescription Drug Deductible 40% Coinsurance up to $700 maximum for a 31- to 90-day supply after Prescription Drug Deductible
Specialty Drugs or supplies	30% Coinsurance up to $250 maximum for up to a 30-day supply after Prescription Drug Deductible
Preventive Drugs or supplies (non-ACA)	$0 for up to a 30-day supply
Preventive Drugs or supplies (non-ACA) from our Mail-Order Pharmacy	$0 for up to a 30-day supply $0 for a 31- to 90-day supply
Blood glucose test strips	Subject to the applicable drug tier Copayment or Coinsurance
HIV post-exposure prophylaxis (PEP) drugs	$0
Self-administered chemotherapy medications used for the treatment of cancer	20% Coinsurance or subject to the applicable drug tier Cost Share, whichever is less
Fertility drugs up to a $10,000 lifetime benefit maximum	20% Coinsurance for up to a 30-day supply after Prescription Drug Deductible

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST HEARING AID RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Hearing Aid Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*. The hearing aid exclusion in the *EOC* "Exclusions and Limitations" section does not apply to Services we cover under this rider.

Hearing aid Services covered under this "Hearing Aid Rider" are only for Members who are the Dependent Limiting Age and older, as shown in the "Benefit Summary." Dependents who are under the Dependent Limiting Age are not covered under this "Hearing Aid Rider," but are covered instead as described under "Hearing Aids and Other Hearing Devices" in the "Benefits" section of the *EOC*.

Hearing Aids

We cover prescription hearing aids, visits to determine the appropriate hearing aid model, visits to verify that the hearing aid conforms to the prescription, and visits for fitting, counseling, adjustment, cleaning, and inspection. These Services are covered only when received from Participating Providers.

Hearing exams to determine the need for hearing correction and to provide a prescription for hearing aids are not covered under this "Hearing Aid Rider" (see the "Benefits" section of the *EOC*).

We provide an allowance for each ear toward the price of a hearing aid. The allowance is shown in the "Hearing Aid Rider Benefit Summary." You do not have to use the allowances for both ears at the same time, but we will not provide the allowance for an ear if we have previously covered a hearing aid for that ear within the same benefit period shown in the "Hearing Aid Rider Benefit Summary," under this or any other evidence of coverage (including riders) with the same group number printed on this *EOC*.

The date we cover a hearing aid is the date on which you are fitted for the hearing aid. Therefore, if you are fitted for a hearing aid while you are covered under this *EOC*, and if we would otherwise cover the hearing aid, we will cover the hearing aid even if you do not receive the hearing aid until after you are no longer covered under this *EOC*.

Covered hearing aids are electronic devices worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold, if necessary, and are limited to one of the following digital models: (i) in-the-ear; (ii) behind-the-ear; (iii) on-the-body (Body Aid Model); or (iv) canal/CIC aids.

Hearing Aid Exclusions

- Bone anchored hearing aids.
- Cleaners, moisture guards, and assistive listening devices (for example, FM systems, cell phone or telephone amplifiers, and personal amplifiers designed to improve your ability to hear in a specific listening situation).
- Hearing aids that were fitted before you were covered under this *EOC* (for example, a hearing aid that was fitted during the previous contract year will not be covered under this *EOC*, though it might be covered under your evidence of coverage for the previous contract year).
- Internally implanted hearing aids.
- Non-prescription hearing aids.
- Repair of hearing aids beyond the warranty period.
- Replacement of lost or broken hearing aids, if you have exhausted (used up) your allowance.

- Replacement parts and batteries.

Hearing Aid Rider Benefit Summary

Hearing Aid Services	You Pay
Visits for hearing aid Services	$40
Hearing aids $2,000 allowance for each hearing aid per ear every three years	Any amount by which price exceeds allowance

KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST FERTILITY TREATMENT SERVICES RIDER

This rider is part of the *Evidence of Coverage* (*EOC*) to which it is attached. All provisions of this rider become part of the *EOC* "Benefits" section, except for the "Fertility Treatment Services Rider Benefit Summary," which becomes part of the *EOC* "Benefit Summary." This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*. The "Fertility Services Exclusions" section in the *EOC* does not apply to Services we cover under this rider.

The following section is added to the *EOC* "Benefits" section:

Fertility Treatment Services

We cover fertility treatment Services, including Services related to conception by artificial means, such as artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT). Services are subject to Utilization Review by Company using criteria developed by Medical Group and approved by Company. You may request Utilization Review criteria by calling Member Services. These Services are covered only when received from Participating Providers.

Diagnostic Services for fertility are covered as described under the "Fertility Services" section in the "Benefits" section of the *EOC*.

This benefit has a Lifetime Benefit Maximum. For purposes of this rider, a Lifetime Benefit Maximum means we will not cover more than the amount shown in the "Fertility Treatment Services Rider Benefit Summary" for all covered fertility treatment Services during your lifetime. Your Lifetime Benefit Maximum is calculated by adding up the Charges for all Services we covered for treatment of fertility and subtracting any Cost Share you paid for those Services.

Fertility Treatment Services Exclusions

- The cost of donor semen, donor eggs, and Services related to their procurement and storage (such as cryopreservation).
- Oral and injectable drugs prescribed for fertility treatment unless your Group has purchased an "Outpatient Prescription Drug Rider" that includes coverage for fertility drugs.
- Services to reverse voluntary, surgically induced infertility.

Fertility Treatment Services Rider Benefit Summary

	You Pay
Fertility treatment Services up to a $20,000 Lifetime Benefit Maximum	20% Coinsurance after Deductible

NOTES

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. This EOC is for your Group's 2025 contract year.

In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

The health care coverage described in this EOC has been designed to be a High Deductible Health Plan (HDHP) compatible for use with a Health Savings Account (HSA). An HSA is a tax-exempt account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions to such an account are tax deductible but in order to qualify for and make contributions to an HSA, you must be enrolled in a qualified High Deductible Health Plan.

Please note that the tax references contained in this document relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

kp.org

KAISER PERMANENTE®

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no-cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-632-9700** (TTY **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the heading in the "Benefits/Coverage (What Is Covered)" section and to the “Limitations/Exclusions (What Is Not Covered)” section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and Advanced Imaging Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits; Emergency Services; urgent care; and outpatient surgery.

Here is some ***important information*** to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service ***must be*** Medically Necessary (refer to the “Definitions” section in this EOC); ***and***
   b. The Service ***must be*** provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service ***must be*** described in this EOC as covered. Refer to the “Benefits/Coverage (What is Covered)” section.
2. The Charges for your Services are ***not*** always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.
11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies.

For covered Services that are subject to the medical Deductible, any amounts you pay over eligible Charges will not apply toward the medical Deductible.

A. For covered Services that **ARE** subject to the medical Deductible:

1. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.
2. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").
3. Your applicable Copayment and Coinsurance may apply to your annual OPM (see "II. Annual Out-of-Pocket Maximums").

B. For covered Services that **ARE NOT** subject to the medical Deductible:

1. Only services that apply to the medical Deductible are specified in "III. Copayments and Coinsurance." Covered Services that ARE NOT subject to the medical deductible will not be specified in "III. Copayments and Coinsurance."
2. Your Copayment or Coinsurance will apply, as listed in "III. Copayments and Coinsurance

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply toward the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply toward the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. Your medical Deductible applies toward the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** toward the OPM:

1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM. Copayments or Coinsurances ***apply*** toward the OPM unless otherwise specified in "III. Copayments and Coinsurance".
2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** toward the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** toward the OPM:

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** toward the OPM for the rest of the Accumulation Period.

Tracking Deductible(s) and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your Deductible(s) and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Medical Deductible

Note: Covered Services do not apply to the medical Deductible unless otherwise specified.

Aggregate	$1,750/Individual per Accumulation Period $3,500/Family per Accumulation Period
Medical Deductible An Aggregate Medical Deductible means: • If you are the only person covered on your plan, the individual Medical Deductible amount applies. After the individual medical Deductible is met, the Member will begin paying payments or Coinsurance for most covered Services for the rest of the Accumulation Period. • If there are two or more family Members on your plan, the individual Medical Deductible amount does not apply. The entire family Medical Deductible must be met before Copayment or Coinsurance is applied for any individual family Member. No one in the family is considered to have met the Deductible until the entire family Deductible is met.	

Out-of-Pocket Maximum

Note: Covered services apply to the Out-of-Pocket Maximum unless otherwise specified.

Aggregate Out-of-Pocket Maximum An Aggregate OPM means: • If you are the only person covered on your plan, the individual OPM amount applies. After the individual OPM is met, the Member will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • If there are two or more family Members on your plan, the individual OPM amount does not apply. The family OPM amount applies to the entire family as a whole. The entire family medical OPM amount must be met before any covered family Member will no longer pay Copayments or Coinsurance for covered Services. No one in the family is considered to have met the OPM until the entire family OPM is met.	$3,425/Individual per Accumulation Period $6,850/Family per Accumulation Period

Covered services are not subject to the medical Deductible unless otherwise specified. Covered services apply to the Out-of-Pocket Maximum unless otherwise specified.	
Office Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Primary care visits	Visit: 20% Coinsurance after Deductible
Specialty care visits	Visit: 20% Coinsurance after Deductible
Consultations with clinical pharmacists	Visit: 20% Coinsurance after Deductible
Allergy evaluation and testing	
• Primary care visits	Visit: 20% Coinsurance after Deductible
• Specialty care visits	Visit: 20% Coinsurance after Deductible
Allergy injections	Visit: 20% Coinsurance after Deductible An additional charge may apply for allergy serum.
Gynecology care visits	Visit: 20% Coinsurance after Deductible
Routine prenatal and postpartum visits	20% Coinsurance after Deductible
Office administered drugs	30% Coinsurance after Deductible
• Travel immunizations	Not Covered
Virtual Care Services	
• Chat with a provider online	
○ Primary care visits	No Charge after Deductible
○ Specialty care visits	No Charge after Deductible
• Email	
○ Primary care visits	No Charge after Deductible
○ Specialty care visits	No Charge after Deductible
• E-visits	
○ Primary care visits	No Charge after Deductible
○ Specialty care visits	No Charge after Deductible
• Telephone visits	
○ Primary care visits	No Charge after Deductible
○ Specialty care visits	No Charge after Deductible

• Video visits	
○ Primary care visits	No Charge after Deductible
○ Specialty care visits	No Charge after Deductible
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility	20% Coinsurance after Deductible

Outpatient Hospital and Surgical Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities	Ambulatory surgical center: 20% Coinsurance after Deductible Outpatient hospital: 20% Coinsurance after Deductible
Outpatient hospital Services, including direct admission to observation care	20% Coinsurance after Deductible

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.)	20% Coinsurance after Deductible
Inpatient professional Services	20% Coinsurance after Deductible

Alternative Medicine	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Chiropractic Care	
• Evaluation and/or Manipulation	20% Coinsurance after Deductible Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or X-rays required for chiropractic care	See "X-ray, Laboratory, and Advanced Imaging Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services	20% Coinsurance after Deductible Acupuncture limited to 20 visits per Accumulation Period See Additional Provisions

Ambulance Services	**You Pay**
Ambulance Services	20% Coinsurance after Deductible

Bariatric Surgery	**You Pay**
Bariatric Surgery	20% Coinsurance after Deductible

Dental Services following Accidental Injury	**You Pay**
Dental Services following Accidental Injury	Not Covered

Dialysis Care	You Pay
Dialysis Care	20% Coinsurance after Deductible

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment	20% Coinsurance after Deductible
• Milk pumps (also known as breast pumps)	No Charge
Prosthetic devices	
• Internally implanted prosthetic devices	See “Outpatient Hospital and Surgical Services” and “Hospital Inpatient Care” for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg	20% Coinsurance after Deductible
• All other prosthetic devices	20% Coinsurance after Deductible
Orthotic devices	20% Coinsurance after Deductible
Oxygen	20% Coinsurance after Deductible
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and Out-of-Plan emergency department visits and related covered Services unless otherwise noted (covered 24 hours a day)	20% Coinsurance after Deductible For advanced imaging procedures, see “X-ray, Laboratory, and Advanced Imaging Procedures” for applicable Copayment or Coinsurance.
Plan and Out-of-Plan emergency department observation care	20% Coinsurance after Deductible Emergency department Copayment is waived if you receive emergency care and then are transferred to observation care. If the above amount is a Coinsurance, the Coinsurance is applied to both the emergency department care and the observation care. If you are directly admitted to observation care, see “Outpatient hospital Services” for applicable Copayment or Coinsurance.

Urgent Care	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and Out-of-Plan urgent care	20% Coinsurance after Deductible

Family Planning and Sterilization Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Family planning counseling	See “Office Services” for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures	See “Office Services” or “Outpatient Hospital and Surgical Services” for applicable Copayment or Coinsurance.
Procedure for the interruption of pregnancy (abortion)	Any exclusions listed below also apply to interruption of pregnancy (abortion) drugs.
• Elective interruption of pregnancy	No Charge after Deductible
• Therapeutic interruption of pregnancy	No Charge after Deductible
Vasectomies	No Charge after Deductible

Health Education Services	You Pay
Training in self-care and preventive care	See “Office Services” for applicable Copayment or Coinsurance.

Hearing Services	You Pay
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist	20% Coinsurance after Deductible
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist	Exam: 20% Coinsurance after Deductible
Hearing aids for Members up to age 18	20% Coinsurance after Deductible
• Fitting and recheck visits	20% Coinsurance after Deductible
Hearing aids for Members age 18 and over	$2,000 Credit per ear every 36 months See Additional Provisions Subject to medical Deductible
• Fitting and recheck visits	No Charge after Deductible

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider	20% Coinsurance after Deductible Up to 120 visits per Accumulation Period

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care	20% Coinsurance after Deductible
Hospice care for terminally ill patients	20% Coinsurance after Deductible

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	20% Coinsurance after Deductible
Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization	20% Coinsurance after Deductible
Individual office visits	Visit: 20% Coinsurance after Deductible
Group office visits	Visit: 20% Coinsurance after Deductible
Intensive outpatient therapy or partial hospitalization	Visit: 20% Coinsurance after Deductible

Out-Of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area.	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)*	Visit limit: Limited to 10 visits per Accumulation Period Visit: $20 Copayment each visit after Deductible Other Services received during an office visit: Not Covered Preventive immunizations:No Charge
Diagnostic X-ray Services	Diagnostic X-ray limit:Limited to 10 diagnostic X-rays per Accumulation Period 20% Coinsurance after Deductible
Outpatient physical, occupational, and speech therapy visits	Therapy visit limit:Limited to 10 therapy visits (any combination) per Accumulation Period Visit: $20 Copayment each visit after Deductible
Outpatient prescription drugs	Prescription drug fills: Limited to 12 prescription drug fills (any combination) per Accumulation Period
• Copayment/Coinsurance (except as listed below)	50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty all after Deductible
• Prescribed diabetic supplies	20% Coinsurance
• Preventive drugs	
○ Contraceptive drugs	No Charge
○ Over the counter (OTC) items *(Federally mandated over the counter items)*	No Charge
○ Tobacco cessation drugs	No Charge

Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Inpatient treatment in a designated rehabilitation facility	20% Coinsurance after Deductible Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits	

• Habilitative Services	Visit limits are combined between in-person visits and video visits.
○ In-person visits	20% Coinsurance after Deductible Limited to 60 visits combined therapies per Accumulation Period
○ Video visits	No Charge after Deductible
• Rehabilitative Services	Visit limits are combined between in-person visits and video visits.
○ In-person visits	20% Coinsurance after Deductible Limited to 60 visits combined therapies per Accumulation Period
○ Video visits	No Charge after Deductible
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder	20% Coinsurance after Deductible
Outpatient physical, occupational, and speech therapy video visits to treat Autism Spectrum Disorder	No Charge after Deductible
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) to treat Autism Spectrum Disorder	20% Coinsurance after Deductible
• Applied Behavior Analysis (ABA) video visits to treat Autism Spectrum Disorder	No Charge after Deductible
Cardiac rehabilitation	20% Coinsurance after Deductible
Cardiac rehabilitation video visits	No Charge after Deductible
Pulmonary rehabilitation	20% Coinsurance after Deductible
Pulmonary rehabilitation video visits	No Charge after Deductible

Prescription Drugs, Supplies, and Supplements	**You Pay**
See Additional Provisions if your Group has purchased coverage for outpatient prescription drugs.	
Note: Coverage is subject to the drug formulary restrictions and guidelines.	
Outpatient prescription drugs	Prescriptions are subject to the medical Deductible and are subject to the pharmacy Deductible unless otherwise listed in this “Prescription Drugs, Supplies, and Supplements” section.
• Pharmacy Deductible	Not Applicable

• Copayment/Coinsurance (except as listed below)	$10 after Deductible Generic Preferred/40% Coinsurance Generic Non-Preferred with $350 maximum Generic Non-Preferred/30% Coinsurance with $100 maximum Brand Preferred/30% Coinsurance with $350 maximum Brand Non-Preferred Weight loss drugs: $10 after Deductible Generic Preferred/40% Coinsurance Generic Non-Preferred with $350 maximum Generic Non-Preferred/30% Coinsurance with $100 maximum Brand Preferred/30% Coinsurance with $350 maximum Brand Non-Preferred Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs	See applicable Outpatient prescription drug Copayment or Coinsurance
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply of all prescription insulin drugs.
○ Diabetic supplies (When obtained from sources designated by Kaiser Permanente)	20% Coinsurance
• Interruption of pregnancy (abortion) drugs	See “Family Planning and Sterilization Services” for any applicable exclusions.
	No Charge after Deductible
• Preventive drugs	
○ Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente Pharmacy.)*	No Charge (Not subject to medical or pharmacy Deductible)
○ Prescription contraceptives *(Supply limit according to applicable law)*	No Charge
○ Tobacco cessation drugs	No Charge (Not subject to medical or pharmacy Deductible)
• Preventive maintenance drugs	No Charge
• Sexual dysfunction drugs	Not Covered
• Sexual transmitted infection (STI) drugs	No Charge after Deductible
• Specialty drugs	30% Coinsurance after Deductible with $250 maximum
• Supply limit	30 days
Mail-order	
• Copayment/Coinsurance	$20 after Deductible Generic Preferred/40% Coinsurance Generic Non-Preferred with $700 maximum/30% Coinsurance Brand Preferred with $200 maximum/30% Coinsurance Brand Non-Preferred with $700 maximum See Additional Provisions
• Supply Limit	Up to 90 days

Preventive Care Services	You Pay
Preventive care visits • Adult preventive care exams and screenings • Mental health wellness examination • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings • Colonoscopies • Flexible sigmoidoscopies	 No Charge No Charge
Preventive Virtual Care Services • Chat with a provider online • Email • E-visits • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance.

Reconstructive Surgery	You Pay
Reconstructive Surgery	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility	See “Office Services”, “Prescription Drugs, Supplies, and Supplements”, “X-ray, Laboratory, and Advanced Imaging Procedures”, or appropriate section for applicable Copayment or Coinsurance.
Intrauterine insemination (IUI)	20% Coinsurance after Deductible
In Vitro Fertilization (IVF)	20% Coinsurance after Deductible
Gamete Intrafallopian Transfer (GIFT)	20% Coinsurance after Deductible
Zygote Intrafallopian Transfer (ZIFT)	20% Coinsurance after Deductible
Standard fertility preservation Services **Note**: There is a limit of one (1) year of storage for gametes and embryos unless specified under “You Pay”.	20% Coinsurance after Deductible

Skilled Nursing Facility Care	You Pay
Skilled Nursing Facility Care	20% Coinsurance after Deductible Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification	20% Coinsurance after Deductible
Inpatient professional Services for medical detoxification	20% Coinsurance after Deductible
Individual office visits	Visit: 20% Coinsurance after Deductible
Group office visits	Visit: 20% Coinsurance after Deductible
Intensive outpatient therapy or partial hospitalization	Visit: 20% Coinsurance after Deductible
Residential rehabilitation	20% Coinsurance after Deductible per inpatient admission

Transplant Services	You Pay
Transplant Services	See appropriate section in this Schedule of Benefits for applicable Copayment or Coinsurance.

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See “Office Services” for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist • Up to the end of the calendar year the Member turns age 19	Visit: 20% Coinsurance after Deductible Refraction Test: 20% Coinsurance after Deductible
• Members age 19 and over	Visit: 20% Coinsurance after Deductible Refraction Test: 20% Coinsurance after Deductible
Routine eye exam when performed by an Ophthalmologist • Up to the end of the calendar year the Member turns age 19	Visit:20% Coinsurance after Deductible Refraction Test:20% Coinsurance after Deductible
• Members age 19 and over	Visit: 20% Coinsurance after Deductible Refraction Test:20% Coinsurance after Deductible
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility	20% Coinsurance after Deductible
Optical hardware • Up to the end of the calendar year the Member turns age 19	Not Covered
• Members age 19 and over	Not Covered

X-ray, Laboratory, and Advanced Imaging Procedures	You Pay
Diagnostic laboratory Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals)	20% Coinsurance after Deductible
Diagnostic laboratory Services received in the outpatient department of a Plan Hospital	20% Coinsurance after Deductible
Diagnostic X-ray Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals)	20% Coinsurance after Deductible
Diagnostic X-ray Services received in the outpatient department of a Plan Hospital	20% Coinsurance after Deductible
Therapeutic X-ray Services received during an office visit, in a Plan Medical Office, in a contracted free-standing facility, or a Plan Hospital	20% Coinsurance after Deductible
Advanced imaging procedures including but not limited to CT, PET, MRI, nuclear medicine • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office administered drugs".)*	20% Coinsurance after Deductible

Plus Benefit	You Pay
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider	Not Covered
• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, e-visits, online chat, telephone visits, and video visits.	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, e-visits, online chat, telephone visits, and video visits.	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives	Not Covered
Prescription drug fill maximum per Accumulation Period	Not Applicable

• Outpatient prescription drugs filled at an out-of-Plan Pharmacy	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy	Not Covered

Eligibility Amendments

- Dependent Limiting Age

  The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. If the Member continues to meet all other eligibility requirements, a Dependent child will continue to be eligible until the Dependent child reaches this age. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the “Eligibility” section in the EOC.

- Domestic Partner

  Your Group coverage includes health benefits for both same- and opposite-sex domestic partners and their Dependents. To be covered they must meet:
  1. The eligibility requirements as described in the “Eligibility” section of this EOC; and
  2. The conditions for domestic partnership as described in the Affidavit of Domestic Partnership.

  You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group’s benefit administrator for details.

- Grandchildren

  Under your Group contract, a grandchild of you or your Spouse can be enrolled as your Dependent in this health benefit plan. This includes an adopted or foster grandchild. The grandchild must meet all Group and Health Plan eligibility requirements.

Group-Specific Coverage

- Eligible Organization

  This plan covers federally mandated over-the-counter non-prescription female contraceptive drugs and devices.

Additional Provisions

Please see “Additional Provisions” for any supplemental information that applies to your coverage

CONTACT US

Advice Nurses (Medical Advice) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Clinical Contact Center (to schedule an appointment)

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For Members seeking Behavioral Health Services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services – Available Monday through Friday, 8 a.m. to 6 p.m., except major holidays

CALL	Toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **Waterpark I** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Utilization Management

CALL	Toll free **1-800-632-9700** (Member Services)
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-529-0934**
WRITE	**Utilization Management** **Kaiser Foundation Health Plan of Colorado** **Waterpark I** **2500 South Parker Road** **Aurora, CO 80014-1622**

Member Relations (to file an appeal)

CALL	Toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Member Relations** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 23127** **San Diego, CA 92193**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

c. Other dependent persons (but not including foster children) who meet all of the following requirements:
   i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
   ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
   i. They are dependent on you or your Spouse; and
   ii. You give us proof of the Dependent's disability and dependency annually if we request it.

e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

If your plan has different eligibility requirements, please see the "Eligibility Amendments" section of the "Schedule of Benefits (Who Pays What)" and/or the "Additional Provisions."

4. Health Savings Account Eligibility

Enrollment in a High Deductible Health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to an HSA. Other requirements include that you must not be: (a) covered by another health coverage plan (for example, through your spouse's employer) that is not also an HSA-compatible health plan, with certain exceptions; (b) enrolled in Medicare; or (c) able to be claimed as a Dependent on another person's tax return. Consult your tax advisor for more information about your eligibility for an HSA.

B. Enrollment and Effective Date of Coverage

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

1. New Employees and their Dependents

If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents
   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.
      For existing Subscribers:
      i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.
      ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

   b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.
      For existing Subscribers:
      i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.
      ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

   c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment."

4. Special Enrollment
   You or your Dependent may experience a qualifying event that allows a change in your enrollment. Examples of qualifying events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The qualifying event results in a special enrollment period that usually (but not always) starts on the date of the qualifying event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's qualifying event. To learn more about qualifying events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, contact your Group. If your Group coverage is ending, call **Member Services** or go to kp.org/specialenrollment.

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

6. Persons Barred from Enrolling
   You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

- "Urgent Care" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive Emergency or non-Emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-Emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have their own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call the **Clinical Contact Center** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call the **Clinical Contact Center** to change your PCP. You may also change your PCP online or when visiting a Kaiser Permanente Medical Office Building. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, they will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, they will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid. An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions

Upon request and subject to payment of any applicable Deductible, Copayments, and/or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**

Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency department or Independent Freestanding Emergency Department.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. There may be instances when you need to receive urgent care outside our Service Area. The Copayment or Coinsurance for urgent care listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization; Deductible; Copayment; Coinsurance; limitations and exclusions, as further described online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Medical Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Medical Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) Emergency Services, Urgent Care, certain Post Stabilization Care Services that qualify as Emergency Services (under applicable federal law and state law), and Ancillary Services for which you have prior Authorization in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate. When you receive covered Services for which you do not have prior Authorization or that you receive from Out-of-Plan Providers or from Out-of-Plan Facilities that have not been approved by us in advance, we will not pay for them except when they are Emergency Services or urgent care.

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments, and/or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment, and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You will also be required to pay any amount in excess of eligible Charges and any amount for Services provided by an Out-of-Plan Provider when you consent to their provision of Services. You are responsible for any applicable Deductible, Copayment, or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits; Emergency Services; urgent care; and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office Services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. Member may receive Services from a certified nurse midwife. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.

14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or Coinsurance shown in the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.
    - Drugs (including Biologics and Biosimilars) and injectables;
    - Radioactive materials used for therapeutic purposes;
    - Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
    - Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).

   Note: Services provided during post-surgical office visits may have a cost-share.

2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram; sleep study; stress test; pulmonary function test; any treatment room; or direct admission to any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. All charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions
   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.
   b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**
   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown in the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.

b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and
3. The facility is certified by Medicare and is a Plan Facility; and
4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps, insulin pump supplies, and continuous glucose monitors are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.
   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.
2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.
      v. Additional prosthetic device or devices if the treating physician determines that the additional prosthetic device or devices are necessary to enable the covered person to engage in physical recreational activities.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."

b. Prosthetic Devices Exclusions
   i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.
   ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are subject to the Deductible and apply toward the Out-of-Pocket Maximum. EIS are not subject to any Copayments or Coinsurance.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department or Independent Freestanding Emergency Department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Emergency Services would be covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Emergency Services are provided by a Plan Provider or an Out-of-Plan Provider. Even if you receive Emergency Services from a Plan Provider, you must still obtain prior Authorization from us before you receive Post Stabilization Care from such Plan Provider. We may direct that you receive covered Post Stabilization Care at a particular Plan Hospital or other Plan Facility (such as a Skilled Nursing Facility) so that we may better coordinate your care using Plan Providers and our electronic medical record system. We will pay for Post Stabilization Care only at the Plan Provider authorized by us. If you or your treating providers do not obtain prior Authorization from us for Post Stabilization Care Services that require prior Authorization, we will not pay any amount for those Services and you may be liable to pay for these Services, in addition to any amounts such as Deductibles, Copayments, or Coinsurance.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC. Coverage for Services that are not Emergency Services, Post Stabilization Care, or Urgent Care Services as described in this "Emergency Services and Urgent Care" section will be covered as described under other sections of this EOC. Please refer to the "Schedule of Benefits" for Copayment and Coinsurance information. If you are admitted to a hospital from its emergency department because your condition is not stabilized, the Copayment or Coinsurance shown under "Hospital Inpatient Care" in the "Schedule of Benefits" applies.

a. **Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)**
"Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan

Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency department of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

When you receive Emergency Services from Out-of-Plan Providers, Post Stabilization Care may qualify as Emergency Services pursuant to federal law and state law. We will not require prior Authorization for such Post Stabilization Care at a non-Plan Hospital when your attending Out-of-Plan Provider determines that, after you receive Emergency (screening and stabilization) Services, you are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider located within a reasonable travel distance taking into account your medical condition.

Out-of-Plan Providers may provide notice and seek your consent to provide Post Stabilization Care Services or other covered Services. Such Services will not be covered when you do not obtain prior Authorization as described herein. If you (or your authorized representative) consent to the furnishing of Services by Out-of-Plan Providers, then you will be responsible for paying for such Services in the absence of any prior Authorization. In addition, if you (or your authorized representative) consent to the provision of Services by an Out-of-Plan Provider, then we will not pay for such Services, and the amount you pay will not count toward satisfaction of the Deductible, if any, or the Out-of-Pocket Maximum(s).

Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

i. We cover out-of-Plan Emergency Services as follows:

A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the Emergency Medical Condition.

ii. Emergency Services Limitation for Out-of-Plan Providers

If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

When you receive Emergency Services in Colorado (and federal law and state law do not require us to consider the Post Stabilization Care as Emergency Services), we cover Post Stabilization Care only if we provide prior Authorization for the Post Stabilization Care. **Therefore, it is very important that you, your provider including your Out-of-Plan Provider, or someone else acting on your behalf, call us to notify us that you need Post Stabilization Care and to get prior Authorization from us before you receive the Post Stabilization Care.**

After we are notified, we will discuss your condition with your emergency care Out-of-Plan Provider. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for Post Stabilization Care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any Post Stabilization Care received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations

Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment

Our payment is reduced by:

i. any applicable Deductible, Copayment, and/or Coinsurance for Emergency Services and advanced imaging procedures performed in the emergency department. The emergency department and advanced imaging procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Deductible, Copayment, and/or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. any other payments you would have had to make if you received the same Services from our Plan Providers; and
v. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
vi. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

Note: If you receive Emergency Services or Post Stabilization Care from an Out-of-Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance transportation described under the "Ambulance Services and Other Transportation" section, you may have to pay the Out-of-Plan Provider and file a claim for reimbursement unless the Out-of-Plan Provider must refrain from billing you under applicable law or agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by an Out-of-Plan Provider as part of your Emergency Services or Post Stabilization Care even if you receive the services at a Plan Provider.

2. Urgent Care

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. There may be instances when you need to receive urgent care outside our Service Area. When urgent care Services are required, we cover urgent care Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the urgent care Services would be covered under your plan if you had received them inside our Service Area. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

Note: The procedure for receiving reimbursement for out-of-Plan urgent care Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage

a. Family planning counseling. This includes counseling and information on birth control.
b. Tubal ligations.
c. Vasectomies.
d. Interruption of pregnancy (abortion). Your group may exclude coverage for part or all interruption of pregnancy services. Please refer to the "Schedule of Benefits (Who Pays What)".

Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and Advanced Imaging Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions

Any and all Services to reverse voluntary, surgically induced sterilization.

K. Gender Affirming Health Services

We cover gender affirming health Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet Utilization Management Program Criteria to be eligible for coverage.

1. Coverage

Non-surgical Services:

a. Office visits and mental health visits.

b. Laboratory Services and X-ray Services.
c. Hormone therapy visits and administration.
d. Facial and body hair removal (assigned male at birth).
e. Outpatient prescription drugs, if covered by your plan.
f. Inpatient and outpatient hospital care.
g. Treatment for complications of surgery.

Surgical Services:
a. Pre-surgical and post-surgical consultations with surgeon.
b. Gender affirmation surgeries including:
   i. **Assigned female at birth**: hysterectomy; oophorectomy; metoidioplasty; phalloplasty; vaginectomy; scrotoplasty; erectile prosthesis; urethral extension; bilateral mastectomy with chest reconstruction; breast reduction; body contouring; gender affirming facial surgery.
   ii. **Assigned male at birth**: penectomy; vaginoplasty; clitoroplasty; labiaplasty; orchiectomy; breast augmentation; tracheal shave; body contouring; gender affirming facial surgery.
c. Inpatient and outpatient hospital care.
d. Treatment for complications of surgery.

You pay the applicable Copayment, Coinsurance, and/or Deductible shown in the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Gender Affirming Health Services Exclusions
   a. Any gender affirming health Service that is not Medically Necessary.
   b. Calf implants.
   c. Hairline advancement.
   d. Pectoral implants.
   e. Permanent hair implantation.
   f. Voice modification surgery, unless medically necessary.

L. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

M. Hearing Services

1. Members up to Age 18
   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to: the initial assessment; fitting; adjustments; and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Over
   a. Coverage
      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."
   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

N. Home Health Care

1. Coverage
   We cover skilled nursing care, home infusion therapy, physical therapy, occupational therapy, speech therapy, home health aide Services, and medical social Services:
   a. only on an Intermittent Care basis (as described below); and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

Intermittent Care basis means skilled nursing, therapy, social work, and home health aide Services, that are not custodial, and require a skilled professional, and are provided less than 8 hours (combined) each day and 28 or fewer hours each week.

Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

Note: X-ray, laboratory, and advanced imaging procedures are not covered under this section. See "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Home Health Care Exclusions
   a. Custodial care. Custodial care is care that helps with activities of daily living (like bathing, dressing, using the bathroom, and eating) or personal needs that could be done safely and reasonably without professional skills or training.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

O. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for Hospice Special Services. Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:
   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

P. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy
      i. We cover individual office visits and group office visits. Psychological testing as part of diagnostic evaluation is covered.
      ii. We cover partial hospitalization and intensive outpatient therapy.
      iii. We cover visits for the purpose of monitoring drug therapy.

   b. Inpatient Services

      We cover psychiatric hospitalization in a hospital or Residential Treatment Center designated by Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board;

psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

We cover mental health Services, whether they are voluntary or are court-ordered, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

We will not deny coverage for intentionally self-inflicted injuries, including attempted suicide.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Custodial Care, as defined in "Exclusions" under "Limitations/Exclusions (What is Not Covered)."

Q. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits; diagnostic X-rays; physical, occupational, and speech therapy; and prescription drug fills as covered under this EOC:
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).
   b. Diagnostic X-rays.
   c. Physical, occupational, and speech therapy visits.
   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures; laboratory tests; and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation; routine prenatal and postpartum visits; chiropractic care; acupuncture services; applied behavior analysis (ABA); hearing tests; hearing aids; home health visits; hospice services; and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. Advanced imaging procedures, including but not limited to: CT; PET; MRI; nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

R. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."
   b. Outpatient Care

We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."

c. Inpatient Rehabilitation Services
We will cover treatment while you are in a designated inpatient rehabilitation facility. See the "Schedule of Benefits (Who Pays What)."

d. Cardiac Rehabilitation
We cover treatment in a cardiac rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Pulmonary Rehabilitation
We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities. After your Deductible has been met, you pay the applicable physical, occupational and speech therapy Coinsurance.

f. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

g. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
   i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
   ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services Exclusions
   a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
   b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

S. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

In any Accumulation Period, you must pay full Charges for all drugs until you meet your Deductible. After you meet your Deductible, you pay the applicable Copayment or Coinsurance for these drugs for the rest of the Accumulation Period, subject to the annual Out-of-Pocket Maximum limits.

If your prescription drug has a Copayment shown in the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

For outpatient prescription drugs and/or items that are covered under the "Prescription Drugs, Supplies, and Supplements" section and obtained at a pharmacy owned and operated by Health Plan, you may be able to use approved manufacturer coupons as payment for the Copayment or Coinsurance that you owe, after you satisfy your plan's required Deductible, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire Copayment or Coinsurance for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information about the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.

1. Coverage
   a. Limited Drug Coverage Under Your Basic Drug Benefit
      If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown in the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

      If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

      Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

      i. We cover:
         (a) prescription contraceptives intended to last:
            (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
            (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
         (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

         Note: For non-grandfathered health plans, we cover twelve (12) months of a prescription contraceptive at one time.

         For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

      ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

   b. Outpatient Prescription Drugs
      Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

      i. Prescriptions by Mail
         If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

      ii. Specialty Drugs
         Prescribed specialty drugs, such as self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown in the "Schedule of Benefits (Who Pays What)."

c. Food Supplements
We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Diabetic Supplies and Accessories
Diabetic supplies and accessories, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:
i. home glucose monitoring supplies.
ii. disposable syringes for the administration of insulin.
iii. glucose test strips.
iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice. If you experience a severe adverse reaction from a covered countermeasure, please visit hrsa.gov/cicp.
b. Some drugs may require prior authorization.
c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
a. Drugs for which a prescription is not required by law.
b. Disposable supplies for home use such as: bandages; gauze; tape; antiseptics; dressings; and ace-type bandages.
c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
d. Any packaging except the dispensing pharmacy's standard packaging.
e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
f. Drugs or injections for the treatment of infertility, unless your Group has purchased outpatient prescription drug coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
g. Drugs to shorten the length of the common cold.
h. Drugs to enhance athletic performance.
i. Drugs for the treatment of weight control.
j. Drugs available over the counter and by prescription for the same strength.
k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
l. Unless approved by Health Plan, drugs not approved by the FDA.
m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
n. Prescription drugs necessary for Services excluded under this EOC.
o. Drugs administered during a medical office visit. See "Office Services."
p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics."

T. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

Preventive Services may help you stay healthy. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

U. Reconstructive Surgery

1. Coverage

We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

V. Reproductive Support Services

Note: If your Group is a religious purchaser, the coverage shown below may not apply to you. See the "Schedule of Benefits (Who Pays What)" to determine what coverage, if any, your Group has purchased.

1. Coverage
   We cover Services for the diagnosis and treatment of involuntary infertility, including Services for Members who may experience future impairment to their fertility due to medical treatment, or are unable to reproduce due to factors associated with their partner or lack of partner. The following Services are covered as shown in the "Schedule of Benefits (Who Pays What)":
   a. Office visits.
   b. Services including, but not limited to, X-ray and laboratory tests.
   c. Intrauterine insemination (IUI).
   d. In Vitro Fertilization (IVF).
   e. Gamete intrafallopian transfer (GIFT).
   f. Zygote intrafallopian transfer (ZIFT).
   g. Standard fertility preservation Services.
   h. Office administered drugs supplied and used during an office visit for IUI, IVF, GIFT, or ZIFT.

Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy.

2. Limitations
   a. There is a limit of three (3) completed oocyte retrievals with unlimited embryo transfers, using single embryo transfer when recommended and medically appropriate.
   b. There is a limit of one (1) year of storage for gametes and embryos.
   c. Services are covered only for the person who is the Member.

3. Reproductive Support Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Donor semen, eggs, and embryos.
   c. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   d. Prescription drugs received from a pharmacy for infertility services, unless prescription drug coverage is purchased.
   e. Any and all Services related to elective cryopreservation (e.g. elective egg freezing). This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, embryos, or other reproductive materials.

W. Skilled Nursing Facility Care

1. Coverage
   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:

   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Health Plan.

Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment (DME) and Prosthetics and Orthotics"; X-ray, laboratory, and advanced imaging procedures, see "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Skilled Nursing Facility Care Exclusion
   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

X. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services
   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation
   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   a. We cover individual office visits and group office visits.
   b. We cover partial hospitalization and intensive outpatient therapy.
   c. We cover visits for the purpose of monitoring drug therapy.
   d. We cover substance use disorder Services intended to reduce, eliminate, or avoid the use of opioids for persons with chronic pain conditions.

We cover substance use disorder Services, whether they are voluntary or are court-ordered, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

Y. Transplant Services

1. Coverage for Members who are transplant recipients
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.
   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.
   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.
   d. Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant.
   e. These Services must be directly related to a covered transplant for you

2. Coverage for Members who are living organ donors
   We cover Services related to living organ donation for a Member who is a living organ donor. We will not impose any Deductibles, Copayments, Coinsurance, benefit maximums, waiting periods, or other limitations on coverage for the living organ donation.

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Health Plan. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.
   b. Plan Providers must determine that you meet Utilization Management Program Criteria before you receive Services.
   c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Health Plan. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Health Plan selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.

d. After referral, if a Plan Provider or the medical staff of the referral facility determines you do not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants associated with high dose chemotherapy for solid tissue tumors (except bone marrow transplants covered under this EOC) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices**.

Z. Vision Services

1. Coverage

   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as: eyeglass holders; eyeglass cases; repair kits; contact lens cases; contact lens cleaning and wetting solution; and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and Advanced Imaging Procedures

1. Coverage
   a. Outpatient

      We cover the following Services:

      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. Advanced imaging procedures such as: MRI; CT; PET; and nuclear medicine.
      Note: For advanced imaging procedures, you will be billed for each individual procedure performed. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Deductible, Copayment, and/or Coinsurance for advanced imaging procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to: Emergency Services; urgent care; and outpatient surgery.

      Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

   b. Inpatient

      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including: diagnostic and therapeutic X-rays and isotopes; electrocardiograms; electroencephalograms; MRI; CT; PET; and nuclear medicine, are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and Advanced Imaging Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services;
   b. Naturopathy Services;
   c. Massage therapy;
   d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Certain Maternity Services that are not Medically Necessary.** Certain maternity Services that are not Medically Necessary, including but not limited to: home birth Services and doula Services.

4. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. Examples of this include cosmetic surgery related to bariatric surgery and hair prostheses due to hair loss. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

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

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma, or (c) Medically Necessary Services required for the direct treatment of a covered transplant procedure for a Member who is a transplant recipient. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages.
   b. Gauze.
   c. Tape.
   d. Antiseptics.
   e. Dressings.
   f. Ace-type bandages.
   g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;

b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
c. Teaching and support services to increase academic performance;
d. Academic coaching or tutoring for skills such as grammar, math, and time management;
e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of their license under Colorado law that is intended to address speech impediments;
f. Teaching you how to read, whether or not you have dyslexia;
g. Educational testing; testing for ability, aptitude, intelligence, or interest;
h. Teaching, or any other items or services associated with, recreational activities such as: art; dance; horse riding; music; swimming; or teaching you how to play.

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

11. **Excess Charges from Out-of-Plan Providers.** Charges from Out-of-Plan Providers that exceed eligible Charge(s).

12. **Experimental or Investigational Services**
    a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:

        i. has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
        ii. is the subject of a current new drug or new device application on file with the FDA; or
        iii. is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
        iv. is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
        v. is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
        vi. has not been recommended for coverage by the Interregional New Technology Committee, the Medical Technology Assessment Team, or any committees reviewing new technologies within Kaiser Permanente, based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
        vii. is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
        viii. is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

    b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:

        i. The Member's medical records; and
        ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
        iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
        iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
        v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
        vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

    c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

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

    Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

13. **Genetic Testing and Gene Therapy.** Genetic testing and gene therapy, unless determined to be: Medically Necessary; and you meet Utilization Management Program Criteria.

14. **Intermediate Care.** Care in an intermediate care facility.
15. **Residential Care.** Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Residential Treatment Center, a Skilled Nursing Facility, or inpatient respite care covered in the "Hospice Care" section.
16. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.
17. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or urgent care outside the Service Area.
18. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.
19. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.
20. **Services that Are the Subject of an Out-of-Plan Provider's Notice and Consent.** Amounts owed to Out-of-Plan Providers when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable state or federal law.
21. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.
22. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.
23. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.
24. **Weight Management Facilities.** Services received in a weight management facility.
25. **Workers' Compensation or Employer's Liability.** If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services obtained at a Kaiser facility. We will not cover any workers compensation services obtained at contracted or non-contracted providers. Any workers' compensation services provided or paid for by the health plan are subject to your obligation to reimburse us to the extent of a payment or any other benefit, including any amount received as a settlement that you receive under applicable law.

    In addition, we or our Participating Providers will be permitted to seek reimbursement for these Services directly from the responsible employer or the government agency that administers applicable law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot, civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:

   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.

   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.

   iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.

   iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another

Plan that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.

v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii, a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan** the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;

2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering the **non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY
If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

If you have any questions about COB, please call or write **Patient Financial Services.**

2. Injuries or Illnesses Alleged to be Caused by Other Parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under applicable law. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by applicable law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types.

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

The Phia Group, LLC.
40 Pequot Way
Canton, MA 02021
Fax: 781-848-1154

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us directly. You may not agree to waive, release, reduce or, in any other manner, take action that may affect our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights under applicable law to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Surrogacy Arrangements: Traditional or Gestational Carriers

In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which an individual agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Surrogacy Arrangements: Traditional or Gestational Carriers" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

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

- Names, addresses, and telephone numbers of the other parties to the arrangement

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

You must send this information to:

The Phia Group, LLC.
40 Pequot Way
Canton, MA 02021
Fax: 781-848-1154

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

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent under applicable law as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call Member Services.

Note: A baby born under a Surrogacy Arrangement does not have health coverage rights under the surrogate's health coverage. The intended parents of a child born under a Surrogacy Arrangement will need to arrange for health coverage for the newborn.

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, can be found in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care can be found in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

For Emergency Services (including Post Stabilization Care that federal law and state law define as Emergency Services) provided by an Out-of-Plan Provider, your Deductible, Copayment and/or Coinsurance, as applicable, will be the same amount or percentage, as applicable, as they would be for Emergency Services provided by a Plan Provider pursuant to applicable state law or, if state law is inapplicable, then federal law. In addition, in the event that an Out-of-Plan Provider provides Ancillary Services at a Plan Provider, then your Deductible, Copayment and/or Coinsurance shall be calculated as required by applicable state law or, if state law is inapplicable, then federal law. In addition, if you (or your authorized representative) consent to the provision of Services by an Out-of-Plan Provider, then we will not pay for such Services, and the amount you pay will not count toward satisfaction of the Deductible, if any, or the Out-of-Pocket Maximum(s).

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

You may file a claim (request for payment/reimbursement):

- by signing in to kp.org, completing an electronic form, and uploading supporting documentation;
- by mailing a paper form that can be obtained by visiting kp.org/formsandpubs or calling Member Services; or
- if you are unable to access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claims:
  1. Member/patient name and Medical Record Number
  2. The date you received the Services
  3. Where you received the Services
  4. Who provided the Services
  5. Why you think we should pay for the Services
  6. A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services.

  Mailing address to submit your claim:

  Kaiser Permanente
  National Claims Administration - Colorado
  P.O. Box 373150
  Denver, CO 80237-3150

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no charge to the Member.

C. Administration of Agreement

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

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation. Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

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

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

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

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments and/or Coinsurance, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

We may seek payment for any claims paid to Plan Providers for Services rendered after termination of your enrollment.

L. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which occurs at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit will be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be eligible for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department**. To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

M. Genetic Testing Information

In accordance with state law: (1) Information derived from genetic testing shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic testing information that identifies the person tested with the test results released requires specific written consent by the person tested. (2) Any entity that receives information derived from genetic testing may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of group disability insurance or long-term care insurance coverage.

N. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

O. Group and Members are not Health Plan's Agents

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

P. No Waiver

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

Q. Nondiscrimination

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

R. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

S. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

T. Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You generally may access and receive copies of your PHI, update or amend your PHI, and ask us for an accounting of certain disclosures of your PHI. You also may request delivery of confidential communications to a location other than your usual address or by alternate means.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Kaiser Permanente Medical Office Building or on our website, kp.org.

U. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

V. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination/Nonrenewal/Continuation" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

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

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent enrollment eligibility information or membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

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

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the “Eligibility” section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

   We may terminate your continuation coverage if payment is not received when due.

   If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA

   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days’ notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance

You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative

If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal

You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

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 may request our Authorization for Release of Appeal Information form by calling **Member Services**.

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 **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal

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, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to **Member Relations**. To arrange to give testimony by telephone, you should contact **Member Services**.

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

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next 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 next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will the reviewer be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the 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 **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Utilization Management**.

      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 if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; 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 may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

      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, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, 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 all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) 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 three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. 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 or fax your appeal to **Member Relations**.

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally, please contact **Member Services**. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. 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 may submit your appeal orally to **Member Services**, by mail or by fax to **Member Relations**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; 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 may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.
Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, 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 then appeal our decision (an adverse benefit determination), then during the time that we are considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

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

a. 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 or fax your claim to **Utilization Managment**.

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 if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; 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 may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

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 (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time 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 days end and explain why we need the extra time and when we expect to make a decision. 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 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent 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 three (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 or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. 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 either mail or fax your appeal to **Member Relations**.

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally, please contact **Member Services**. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally to **Member Services**, by mail or by fax to **Member Relations**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat 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 if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

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 three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services or urgent care Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

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 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. 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 Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to **Member Relations**.

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally, please contact Member Services. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal

Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)

We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Membership Administration**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination 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.

Appeals of Denial of Individual Plan Application

Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 23127
San Diego, CA 92193

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination 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.

External Review

Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision, if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that (1) is a denial of a preauthorization for a Service; (2) is a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; (3) is a denial of a request for Services on the ground that the Service is experimental or investigational; (4) concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or substance abuse) benefits; or, (5) involves consideration of whether we are complying with federal law and state law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130). If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Member Services** to request a copy of this form) to **Member Relations** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Member Services** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

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 (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, 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.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Relations**; or
   b. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A **Member Relations** Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The **Member Relations** Liaison or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Relations**. **Member Relations** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Ancillary Services: Services that are:
- Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner
- Items and services provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory services
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Plan Provider satisfies the notice and consent requirements under federal law and state law.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):
1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For Emergency Services received from Out-of-Plan Providers (including Post Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process; or
5. For all other Services received from Out-of-Plan Providers (including Post Stabilization Services that are not Emergency Services under federal law and Ancillary Services), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process, or (2) in the even that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Out-of-Plan Provider and us, or absent such an agreement, the usual, customary and reasonable rate for those services as determined by us based on objective criteria.
6. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

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

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

1. Serious jeopardy to the health of a person or, with respect to a pregnant individual, the health of the individual or their unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

- An appropriate medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act (section 1867 of the Social Security Act) ("EMTALA")) that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, 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, or Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA (or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department) to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
- Post Stabilization Care furnished by an Out-of-Plan Provider (including a nonparticipating emergency facility) is covered as Emergency Services when federal law and state law apply AND
    - Your attending Out-of-Plan Provider determines that you are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider within a reasonable travel distance, taking into account your medical condition; or,
    - You (or your authorized representative) are not in a condition to receive, and/or to provide consent to, the Out-of-Plan Provider's notice and consent form, in accordance with applicable state law pertaining to informed consent as determined by your attending Out-of-Plan Provider using appropriate medical judgment.

Note: Once your condition is stabilized, covered Services that you receive are Post Stabilization Care and not Emergency Services EXCEPT when you receive Emergency Services from Out-of-Plan Providers AND federal law and state law require coverage of your Post Stabilization Care as Emergency Services. Post Stabilization Care is subject to all of the terms and conditions of this EOC including but not limited to prior Authorization requirements unless federal law and state law applies and defines such Post Stabilization Care as Emergency Services.

Family Unit: A Subscriber and all of their Dependents.

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

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Health Savings Account (HSA): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law requirements. Kaiser Permanente does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

High Deductible Health Plan (HDHP): A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The health care coverage under this EOC has been designed to be a High Deductible Health Plan compatible for use with a Health Savings Account.

Independent Freestanding Emergency Department: A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:
- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

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

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

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Post Stabilization Care: Means Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Stabilized. We cover Post Stabilization Care only when (1) it is considered to be Emergency Services under federal law and state law (without prior Authorization) or, (2) we determine that such Services are Medically Necessary pursuant to a request for prior Authorization for the Service.

Premiums: Periodic membership charges paid by Group.

Residential Treatment Center: A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment. The term Residential Treatment Center does not include a provider, or that part of a provider, used mainly for:
1. Nursing care.
2. Rest care.
3. Convalescent care.
4. Care of the aged.
5. Custodial Care.
6. Educational care.

Service Area: Our Service Area consists of certain geographic areas in Colorado which we designate by county, where appropriate. Our Service Area may change. Contact Member Services for a complete listing of our Service Area counties.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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CHIR0AA

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown in the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: Physical therapy, see "Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services"; X-ray and laboratory tests, see "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CMPL0AA

ACUPUNCTURE SERVICES

1. Coverage

   Acupuncture Services are covered as shown in the "Schedule of Benefits (Who Pays What)" when provided by contracted acupuncturists and if clinically appropriate.

   Coverage includes treatment for:
   a. Neuromusculoskeletal pain due to an injury or illness; or
   b. Allergy, asthma, nausea, or vomiting.

   Services include:
   a. Acupuncture by manual stimulation.
   b. Electro-acupuncture applied to inserted needles and acupressure.

   Cupping or moxibustion are only covered in lieu of electrical stimulation.

   You may self-refer for visits to contracted acupuncturists.

2. Acupuncture Services Exclusions
   a. Rental or purchase of durable medical equipment (DME).
   b. Air purifiers, therapeutic mattresses, supplies or similar devices, appliances, or equipment. Their use or installation does not have to be for therapy or easy access.
   c. Radiology and lab tests.
   d. Prescription drugs, vitamins, herbs or food supplements. It does not matter if they are prescribed or recommended by a contracted acupuncturist.
   e. Massage or soft tissue techniques that are not part of the acupuncture treatment, except acupressure.
   f. Treatment mainly for obesity or weight control.
   g. Vocational, stroke or long term rehabilitation.
   h. Hypnotherapy.
   i. Behavior training.
   j. Sleep therapy or biofeedback.
   k. Acupuncture Services provided for maintenance or preventive care Services.
   l. Expenses for acupuncture Services provided during visits that exceed your visit limit.
   m. Expenses for any Services provided before coverage begins or after coverage ends for this benefit.
   n. Any Services provided by an acupuncturist who is not contracted. It does not matter if the Services are obtained in or out of Health Plan's Service Area.
   o. Acupuncture Services that Health Plan determines are not clinically appropriate in its utilization review. (Members may not be surcharged for such Services.)
   p. Services not authorized by Health Plan. This exclusion does not apply to Services listed in the "Coverage" section of this benefit.
   q. Any techniques or procedures not generally accepted in a majority of state acupuncture licensing boards.
   r. Benefits, items, or Services that are limited or excluded in the EOC, unless changed by this benefit.

This rider amends the EOC to provide limited coverage for acupuncture Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

   c. Durable Medical Equipment Exclusions
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.
      iv. Exercise or hygiene equipment.
      v. Comfort, convenience, or luxury equipment or features.
      vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
      vii. Replacement of lost or stolen equipment.
      viii. Repairs, adjustments, or replacements necessitated by misuse.
      ix. More than one piece of DME serving essentially the same function, except for replacements.
      x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

   b. Prosthetic Devices Exclusions
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.
v. Replacement of lost or stolen prosthetic devices.
vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
      Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost or stolen orthotic devices.
      vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

HEAR0AC

HEARING AID CREDIT

1. Coverage
   For Members age 18 and over, a credit per ear, which can be applied toward the purchase of a hearing aid (including dispensing fees associated with the hearing aid purchase), is provided as shown on the "Schedule of Benefits (Who Pays What)" when prescribed by, and obtained from, a Plan Provider. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound.

   The full per ear credit must be used at the initial point of sale. Any credit balance remaining after the initial point of sale is forfeited.

2. Hearing Aid Exclusions
   a. Replacement parts for the repair of a hearing aid.
   b. Replacement of lost or broken hearing aids.
   c. Accessory parts and routine maintenance.
   d. Batteries.

This rider amends the EOC to provide coverage for hearing aids. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.
16. Counseling, prevention, and screening for a sexually transmitted infection regardless of your gender.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

RX0BO

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this EOC, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a tier for preferred generic drugs; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Diabetic supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Provider and obtained at Plan Pharmacies; or
   b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law.
   b. Insulin. You are not responsible for more than $100 per thirty-day supply of all covered prescription insulin drugs.
   c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
   d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.
   e. Epinephrine auto-injectors. You are not responsible for more than $60 for all prescription two-pack epinephrine auto-injectors.

   Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs with some exceptions. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.

      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the EOC.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)."
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   k. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   l. Drugs administered during a medical office visit.
   m. Medical Foods and Medical Devices.
   n. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the EOC to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

RX0BO (01-24)

Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

Important plan information

BMO BANK N.A.

TITLE PAGE (Cover Page)

Important Benefit Information Enclosed
Evidence of Coverage

About this Evidence of Coverage (EOC)
This Evidence of Coverage (EOC) describes the health care coverage provided under the Agreement between Kaiser Foundation Health Plan of Colorado (Health Plan) and your Group. In this EOC, Kaiser Foundation Health Plan of Colorado is sometimes referred to as "Plan," "we," or "us." Members are sometimes referred to as "you." Out-of-Health Plan is sometimes referred to as "out-of-Plan." Some capitalized terms have special meaning in this EOC; please see the "Definitions" section for terms you should know.

This EOC is for your Group's 2025 contract year.

kp.org

KAISER PERMANENTE®

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no-cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats

- Provide no-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-800-632-9700** (TTY **711**).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY **711**).

Ɓăsɔ́ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá **1-800-632-9700** (TTY **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700**（TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.
Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY **711**) 번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.
Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).

SCHEDULE OF BENEFITS (WHO PAYS WHAT)

This Schedule of Benefits discusses:

I. DEDUCTIBLES (if applicable)

II. ANNUAL OUT-OF-POCKET MAXIMUMS (OPM)

III. COPAYMENTS AND COINSURANCE

IMPORTANT INFORMATION: PLEASE READ

This Schedule of Benefits does not fully describe the Services covered under this EOC. ***For a complete understanding of the benefits, limitations and exclusions that apply to your coverage under this plan, it is important to read this EOC in conjunction with this Schedule of Benefits.*** Please refer to the heading in the "Benefits/Coverage (What Is Covered)" section and to the “Limitations/Exclusions (What Is Not Covered)” section of this EOC.

Services received may be described in multiple sections of this Schedule of Benefits (for example, Office Services, Durable Medical Equipment, X-ray, Laboratory, and Advanced Imaging Procedures may all apply to a broken arm). See the appropriate sections for applicable Copayment, Coinsurance, and Deductible information.

You are responsible for any applicable Copayment or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits; Emergency Services; urgent care; and outpatient surgery.

Here is some ***important information*** to keep in mind as you read this Schedule of Benefits:

1. For a Service to be a covered Service:
   a. The Service ***must be*** Medically Necessary (refer to the “Definitions” section in this EOC); ***and***
   b. The Service ***must be*** provided, prescribed, recommended, or directed by a Plan Provider; ***and***
   c. The Service ***must be*** described in this EOC as covered. Refer to the “Benefits/Coverage (What is Covered)” section.
2. The Charges for your Services are ***not*** always known at the time you receive the Service. You ***will get a bill*** for any Deductibles, Copayments, or Coinsurance that are not known at the time you receive the Service.
3. The Deductibles, Copayments, or Coinsurance listed here apply to covered Services provided to Members enrolled in this plan. Only covered Services apply to the Deductible and OPM. Non-covered Services will not apply to the Deductible and OPM.
4. Copayments for Services are due at the time you receive the Service. Deductibles or Coinsurance for Services may also be due at the time you receive the Service.
5. Except for #6 below, you may be responsible for any amounts over eligible Charges in addition to any Copayment or Coinsurance.
6. With respect to Emergency Services received in an Out-of-Plan Facility, or Services rendered by an Out-of-Plan Provider in a Plan Facility, you will not be balance billed by either the Out-of-Plan Provider or Out-of-Plan Facility. You are responsible for the same Deductible, Copayment, or Coinsurance amounts that you would pay if the care was provided in a Plan Facility or provided by a Plan Provider.
7. You may be charged separate Deductibles, Copayments, or Coinsurance for additional Services you receive during your visit or if you receive Services from more than one provider during your visit.
8. We reserve the right to reschedule non-emergency, non-routine care if you do not pay all amounts due at the time you receive the Service.
9. For items ordered in advance, you pay the Deductibles, Copayments, or Coinsurance in effect on the order date.
10. You, as the Subscriber, are responsible for any Deductibles, Copayments, and/or Coinsurance incurred by your Dependents enrolled in the Plan.
11. If you are the only person on your plan, your plan will become a family plan upon the addition of any eligible Dependent to your plan. This includes, but is not limited to, any temporary additions to your plan, such as the coverage of a newborn for 31 days as required by state law.

I. DEDUCTIBLES

A. The medical Deductible represents the full amount you must pay for certain covered Services during the Accumulation Period before any Copayment or Coinsurance applies. Covered Services may or may not be subject to the medical Deductible. It depends on the plan your Group has purchased.

For covered Services that are subject to the medical Deductible, any amounts you pay over eligible Charges will not apply toward the medical Deductible.

1. For covered Services that **ARE** subject to the medical Deductible:
   a. You must pay full charges for covered Services until your medical Deductible is satisfied. Please see "III. Copayments and Coinsurance" to find out which covered Services are subject to the medical Deductible.
   b. Once you have met your medical Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those covered Services subject to the medical Deductible (see "III. Copayments and Coinsurance").
   c. Your applicable Copayment, Coinsurance, and medical Deductible may apply to your annual OPM (see "II. Annual Out-of-Pocket Maximums").
2. For covered Services that **ARE NOT** subject to the medical Deductible:
   a. Only services that apply to the medical Deductible are specified in "III. Copayments and Coinsurance." Covered Services that **ARE NOT** subject to the medical deductible will not be specified in "III. Copayments and Coinsurance."
   b. Your Copayment or Coinsurance will apply, as listed in "III. Copayments and Coinsurance."

B. If your Group has purchased a supplemental prescription drug benefit with a pharmacy Deductible, payments made for prescription drugs apply *only* to the pharmacy Deductible.

The pharmacy Deductible represents the full amount you must pay for prescription drugs before any Copayment or Coinsurance applies. Prescription drugs may or may not be subject to the pharmacy Deductible. It depends on the plan your Group has purchased.

1. For prescription drugs that **ARE** subject to the pharmacy Deductible:
   a. You must pay full charges for prescription drugs until your pharmacy Deductible is satisfied. Please see "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements" to find out which prescription drugs are subject to the pharmacy Deductible.
   b. Once you have met your pharmacy Deductible for the Accumulation Period, you will then pay, for the rest of the Accumulation Period, your applicable Copayment or Coinsurance for those prescriptions drugs subject to the pharmacy Deductible (see "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements").
   c. If your Group purchased a plan with a pharmacy Deductible, payments made for prescription drugs will be applied *only* to the pharmacy Deductible. Your pharmacy Deductible does not apply to the medical Deductible and accumulates separately from the medical Deductible.
   d. Your applicable Copayment, Coinsurance, and/or pharmacy Deductible may not apply to your annual OPM (see "II. Annual Out-of-Pocket Maximums").
2. For prescription drugs that **ARE NOT** subject to the pharmacy Deductible:

   Your Copayment or Coinsurance will apply, as listed in "III. Copayments and Coinsurance", "Prescription Drugs, Supplies, and Supplements."

II. ANNUAL OUT-OF-POCKET MAXIMUMS

The OPM limits the total amount you must pay during the Accumulation Period for certain covered Services. Covered Services may or may not apply toward the OPM (see "III. Copayments and Coinsurance"). It depends on the plan your Group has purchased.

For covered Services that apply toward the OPM, any amounts you pay over eligible Charges will not apply toward the OPM.

A. Your Deductible(s) may apply toward the OPM (see "I. Deductibles").

B. For covered Services that **APPLY** toward the OPM:
   1. The only Copayments or Coinsurance ***that apply*** toward the OPM are those made for covered Services listed as ***applying*** to the OPM. Copayments or Coinsurances ***apply*** toward the OPM unless otherwise specified in "III. Copayments and Coinsurance".
   2. Once your OPM is met, you will no longer pay for covered Services ***that apply*** toward the OPM for the rest of the Accumulation Period.

C. For covered Services that do **NOT APPLY** toward the OPM:

1. The only Copayments or Coinsurance that ***do not apply*** toward the OPM are those made for covered Services listed as ***not*** applying to the OPM (see "III. Copayments and Coinsurance").
2. Once your OPM is met, you will continue to pay for covered Services that ***do not apply*** toward the OPM for the rest of the Accumulation Period.

Tracking Deductible(s) and Out-of-Pocket Amounts

Once you have received Services and we have processed the claim for Services rendered, we will provide an Explanation of Benefits (EOB). The EOB will list the Services you received, the cost of those Services, and the payments made for the Services. It will also include information regarding what portion of the payments were applied to your Deductible(s) and/or OPM amounts.

For more information about your Deductible or OPM amounts, please call **Member Services** or go to **kp.org**.

III. COPAYMENTS AND COINSURANCE

Note: Day, visit, and dollar limits, Deductibles, and Out-of-Pocket Maximums are based on a calendar year Accumulation Period.

Medical Deductible

Note: Covered Services do not apply to the medical Deductible unless otherwise specified.

Embedded	$750/Individual per Accumulation Period $1,500/Family per Accumulation Period
Medical Deductible An Embedded Medical Deductible means: • Each individual family Member has their own medical Deductible. • If you reach your individual medical Deductible before the family medical Deductible is met, you will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period. After the family medical Deductible is met, all covered family Members will begin paying Copayments or Coinsurance for most covered Services for the rest of the Accumulation Period. This is true even for family Members who have not met their individual medical Deductible	

Out-of-Pocket Maximum

Note: Covered services apply to the Out-of-Pocket Maximum unless otherwise specified.

Embedded Out-of-Pocket Maximum An Embedded OPM means: • Each individual family Member has their own OPM. • If you reach your individual OPM before the family OPM is met, you will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. • After the family OPM is met, all covered family Members will no longer pay Copayments or Coinsurance for those covered Services that apply to the OPM for the rest of the Accumulation Period. This is true even for family Members who have not met their individual OPM.	$3,000/Individual per Accumulation Period $6,000/Family per Accumulation Period

Covered services are not subject to the medical Deductible unless otherwise specified. Covered services apply to the Out-of-Pocket Maximum unless otherwise specified.

Office Services	You Pay
Note: • Additional charges may apply for Services described elsewhere in this Schedule of Benefits. • For covered Services received during an office visit, your plan coinsurance may be applicable for the following: o Primary care visits o Specialty care visits o Consultations with clinical pharmacists o Allergy injections o Gynecology care visits	
Primary care visits	Visit: $25 Copayment each visit
Specialty care visits	Visit: $40 Copayment each visit
Consultations with clinical pharmacists	Visit: $25 Copayment each visit
Allergy evaluation and testing	
• Primary care visits	Visit: $25 Copayment each visit
• Specialty care visits	Visit: $40 Copayment each visit
Allergy injections	Visit: $25 Copayment each visit An additional charge may apply for allergy serum.
Gynecology care visits	Visit: $40 Copayment each visit
Routine prenatal and postpartum visits	20% Coinsurance after Deductible
Office administered drugs	30% Coinsurance after Deductible
• Travel immunizations	Not Covered
Virtual Care Services	
• Chat with a provider online	
o Primary care visits	No Charge
o Specialty care visits	No Charge
• Email	
o Primary care visits	No Charge
o Specialty care visits	No Charge

• E-visits	
○ Primary care visits	No Charge
○ Specialty care visits	No Charge
• Telephone visits	
○ Primary care visits	No Charge
○ Specialty care visits	No Charge
• Video visits	
○ Primary care visits	No Charge
○ Specialty care visits	No Charge
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility	20% Coinsurance after Deductible

Outpatient Hospital and Surgical Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Outpatient surgery at Plan Facilities	Ambulatory surgical center: 20% Coinsurance after Deductible Outpatient hospital: 20% Coinsurance after Deductible
Outpatient hospital Services, including direct admission to observation care	20% Coinsurance after Deductible

Hospital Inpatient Care	**You Pay**
(See Hospital Inpatient Care in "Benefits/Coverage (What Is Covered)" in this EOC for the list of covered Services.)	20% Coinsurance after Deductible
Inpatient professional Services	20% Coinsurance after Deductible

Alternative Medicine	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Chiropractic Care	
• Evaluation and/or Manipulation	$25 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions
• Laboratory Services or X-rays required for chiropractic care	See "X-ray, Laboratory, and Advanced Imaging Procedures" for applicable Copayment or Coinsurance.
Acupuncture Services	$25 Copayment each visit Limited to 20 visits per Accumulation Period See Additional Provisions

Ambulance Services	You Pay
Ambulance Services	20% Coinsurance after Deductible

Bariatric Surgery	You Pay
Bariatric Surgery	20% Coinsurance after Deductible

Dental Services following Accidental Injury	You Pay
Dental Services following Accidental Injury	Not Covered

Dialysis Care	You Pay
Dialysis Care	20% Coinsurance after Deductible

Durable Medical Equipment (DME) and Prosthetics and Orthotics	You Pay
Durable Medical Equipment	20% Coinsurance after Deductible
• Milk pumps (also known as breast pumps)	No Charge
Prosthetic devices	
• Internally implanted prosthetic devices	See “Outpatient Hospital and Surgical Services” and “Hospital Inpatient Care” for applicable Copayment(s) and/or Coinsurance.
• Prosthetic arm or leg	20% Coinsurance
• All other prosthetic devices	20% Coinsurance after Deductible
Orthotic devices	20% Coinsurance after Deductible
Oxygen	20% Coinsurance
Maximum limit paid by Health Plan for Durable Medical Equipment, certain prosthetic devices, and orthotic devices	Not Applicable

Emergency Services	You Pay
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Plan and Out-of-Plan emergency department visits and related covered Services unless otherwise noted (covered 24 hours a day)	$300 Copayment each Visit Copayment waived if directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient. For advanced imaging procedures, see “X-ray, Laboratory, and Advanced Imaging Procedures” for applicable Copayment or Coinsurance.
Plan and Out-of-Plan emergency department observation care	$300 Copayment each Visit Emergency department Copayment is waived if you receive emergency care and then are transferred to observation care.

	If the above amount is a Coinsurance, the Coinsurance is applied to both the emergency department care and the observation care. If you are directly admitted to observation care, see "Outpatient hospital Services" for applicable Copayment or Coinsurance.

Urgent Care	**You Pay**
Notes: • Additional charges may apply for Services described elsewhere in this Schedule of Benefits. • For covered Services received during an urgent care visit, your plan coinsurance may be applicable.	
Plan and Out-of-Plan urgent care	$40 Copayment each visit Covered Services received during a visit: No Additional Charge

Family Planning and Sterilization Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Family planning counseling	See "Office Services" for applicable Copayment or Coinsurance.
Associated outpatient surgery procedures	See "Office Services" or "Outpatient Hospital and Surgical Services" for applicable Copayment or Coinsurance.
Procedure for the interruption of pregnancy (abortion)	Any exclusions listed below also apply to interruption of pregnancy (abortion) drugs.
• Elective interruption of pregnancy	No Charge
• Therapeutic interruption of pregnancy	No Charge
Vasectomies	No Charge

Health Education Services	**You Pay**
Training in self-care and preventive care	See "Office Services" for applicable Copayment or Coinsurance.

Hearing Services	**You Pay**
Note: For covered Services received during a visit with a specialist other than an audiologist, your plan coinsurance may be applicable	
Hearing exams and tests to determine the need for hearing correction when performed by an audiologist	$25 Copayment each visit
Hearing exams and tests to determine the need for hearing correction when performed by a specialist other than an audiologist	Exam: $40 Copayment each visit
Hearing aids for Members up to age 18	20% Coinsurance after Deductible

• Fitting and recheck visits	20% Coinsurance after Deductible
Hearing aids for Members age 18 and over	$2,000 Credit per ear every 36 months See Additional Provisions
• Fitting and recheck visits	$25 Copayment each visit

Home Health Care	You Pay
Home health Services provided in your home and prescribed by a Plan Provider	No Charge Up to 120 visits per Accumulation Period

Hospice Care	You Pay
Special Services program for hospice-eligible Members who have not yet elected hospice care	No Charge
Hospice care for terminally ill patients	No Charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	20% Coinsurance after Deductible
Inpatient day limit	Not Applicable
Inpatient professional Services for psychiatric hospitalization	20% Coinsurance after Deductible
Individual office visits	Visit: $25 Copayment each visit
Group office visits	Visit: $12 Copayment each visit
Intensive outpatient therapy or partial hospitalization	Visit: No Charge

Out-Of-Area Benefit	You Pay
The following Services are limited to Dependents up to the age of 26 outside the Service Area.	
Outpatient office visits *(Combined office visit limit between primary care, specialty care, outpatient mental health and substance use disorder services, gynecology care, hearing exam, prevention immunizations, preventive care, and the administration of allergy injections.)*	Visit limit: Limited to 10 visits per Accumulation Period Visit: $25 Copayment each visit Other Services received during an office visit: Not Covered Preventive immunizations:No Charge
Diagnostic X-ray Services	Diagnostic X-ray limit:Limited to 10 diagnostic x-rays per Accumulation Period 20% Coinsurance after Deductible
Outpatient physical, occupational, and speech therapy visits	Therapy visit limit:Limited to 10 therapy visits (any combination) per Accumulation Period Visit: $25 Copayment each visit

Outpatient prescription drugs • Copayment/Coinsurance (except as listed below)	Prescription drug fills: Limited to 12 prescription drug fills (any combination) per Accumulation Period 50% Coinsurance Generic/50% Coinsurance Brand name/50% Coinsurance Non-preferred/50% Coinsurance Specialty
• Prescribed diabetic supplies	20% Coinsurance
• Preventive drugs	
○ Contraceptive drugs	No Charge
○ Over the counter (OTC) items *(Federally mandated over the counter items)*	No Charge
○ Tobacco cessation drugs	No Charge

Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services	**You Pay**
Note: Additional charges may apply for Services described elsewhere in this Schedule of Benefits.	
Inpatient treatment in a designated rehabilitation facility	20% Coinsurance after Deductible Up to 60 days per condition per Accumulation Period
Short-term outpatient physical, occupational, and speech therapy visits	
• Habilitative Services	Visit limits are combined between in-person visits and video visits.
○ In-person visits	$25 Copayment each visit Limited to 60 visits combined therapies per Accumulation Period
○ Video visits	No Charge
• Rehabilitative Services	Visit limits are combined between in-person visits and video visits.
○ In-person visits	$25 Copayment each visit Limited to 60 visits combined therapies per Accumulation Period
○ Video visits	No Charge
Outpatient physical, occupational, and speech therapy visits to treat Autism Spectrum Disorder	$25 Copayment each visit
Outpatient physical, occupational, and speech therapy video visits to treat Autism Spectrum Disorder	No Charge
Applied Behavioral Services	
• Applied Behavior Analysis (ABA) to treat Autism Spectrum Disorder	$25 Copayment each visit
• Applied Behavior Analysis (ABA) video visits to treat Autism Spectrum Disorder	No Charge

Cardiac rehabilitation	$25 Copayment each visit
Cardiac rehabilitation video visits	No Charge
Pulmonary rehabilitation	$25 Copayment each visit
Pulmonary rehabilitation video visits	No Charge

Prescription Drugs, Supplies, and Supplements	**You Pay**
See Additional Provisions if your Group has purchased coverage for outpatient prescription drugs.	
Note: Coverage is subject to the drug formulary restrictions and guidelines.	
Outpatient prescription drugs	Prescriptions are not subject to the medical Deductible and are subject to the pharmacy Deductible except as otherwise listed in this "Prescription Drugs, Supplies, and Supplements" section.
• Pharmacy Deductible	250
• Copayment/Coinsurance (except as listed below)	$10 after Rx Deductible Generic Preferred/40% Coinsurance after Rx Deductible Generic Non-Preferred with $350 maximum/30% Coinsurance Brand Preferred with $100 maximum/30% Coinsurance Brand Non-Preferred with $350 maximum Weight loss drugs: $10 after Rx Deductible Generic Preferred/40% Coinsurance after Rx Deductible Generic Non-Preferred with $350 maximum/30% Coinsurance Brand Preferred with $100 maximum/30% Coinsurance Brand Non-Preferred with $350 maximum Prescription refills of maintenance medications must be filled at a pharmacy in a Kaiser Permanente Medical Office Building or through Kaiser Permanente mail order.
• Infertility drugs	See applicable Outpatient prescription drug Copayment or Coinsurance
• Insulin	Applicable Copayment/Coinsurance not to exceed $100 up to a 30-day supply of all prescription insulin drugs.
○ Diabetic supplies (When obtained from sources designated by Kaiser Permanente)	20% Coinsurance
• Interruption of pregnancy (abortion) drugs	See "Family Planning and Sterilization Services" for any applicable exclusions.
• Preventive drugs	No Charge
○ Over the counter (OTC) items *(Federally mandated over the counter (OTC) items. OTCs require a prescription and must be filled at a Kaiser Permanente Pharmacy.)*	No Charge (Not subject to medical or pharmacy Deductible)

○ Prescription contraceptives *(Supply limit according to applicable law)*	No Charge
○ Tobacco cessation drugs	No Charge (Not subject to medical or pharmacy Deductible)
• Preventive maintenance drugs	No Charge
• Sexual dysfunction drugs	Not Covered
• Sexual transmitted infection (STI) drugs	No Charge
• Specialty drugs	30% Coinsurance after Rx Deductible with $250 maximum
• Supply limit	30 days
Mail-order	
• Copayment/Coinsurance	$20 after Rx Deductible Generic Preferred/40% Coinsurance after Rx Deductible Generic Non-Preferred with $700 maximum/30% Coinsurance Brand Preferred with $200 maximum/30% Coinsurance Brand Non-Preferred with $700 maximum See Additional Provisions
• Supply Limit	Up to 90 days

Preventive Care Services	**You Pay**
Preventive care visits • Adult preventive care exams and screenings • Mental health wellness examination • Well-woman care exams and screenings • Well-child care exams • Immunizations	No Charge See Additional Provisions
Colorectal cancer screenings	
• Colonoscopies	No Charge
• Flexible sigmoidoscopies	No Charge
Preventive Virtual Care Services • Chat with a provider online • Email • E-visits • Telephone • Video visits	No Charge
Non-preventive covered Services received in conjunction with preventive care exam	See “Office Services” or “Laboratory Services” for applicable Copayment or Coinsurance.

Reconstructive Surgery	**You Pay**
Reconstructive Surgery	See “Outpatient Hospital and Surgical Services” or “Hospital Inpatient Care” for applicable Copayment or Coinsurance.

Reproductive Support Services	You Pay
Covered Services for diagnosis and treatment of infertility	See “Office Services”, “Prescription Drugs, Supplies, and Supplements”, “X-ray, Laboratory, and Advanced Imaging Procedures”, or appropriate section for applicable Copayment or Coinsurance.
Intrauterine insemination (IUI)	20% Coinsurance after Deductible
In Vitro Fertilization (IVF)	20% Coinsurance after Deductible
Gamete Intrafallopian Transfer (GIFT)	20% Coinsurance after Deductible
Zygote Intrafallopian Transfer (ZIFT)	20% Coinsurance after Deductible
Standard fertility preservation Services **Note**: There is a limit of one (1) year of storage for gametes and embryos unless specified under “You Pay”.	20% Coinsurance after Deductible

Skilled Nursing Facility Care	You Pay
Skilled Nursing Facility Care	20% Coinsurance after Deductible Limited to 100 days per Accumulation Period

Substance Use Disorder Services	You Pay
Inpatient medical detoxification	20% Coinsurance after Deductible
Inpatient professional Services for medical detoxification	20% Coinsurance after Deductible
Individual office visits	Visit: $25 Copayment each visit
Group office visits	Visit: $12 Copayment each visit
Intensive outpatient therapy or partial hospitalization	Visit: No Charge
Residential rehabilitation	20% Coinsurance after Deductible per inpatient admission

Transplant Services	You Pay
Transplant Services	See appropriate section in this Schedule of Benefits for applicable Copayment or Coinsurance.

Vision Services and Optical	You Pay
Eye exams for treatment of injuries and/or diseases	See “Office Services” for applicable Copayment or Coinsurance.
Routine eye exam when performed by an Optometrist • Up to the end of the calendar year the Member turns age 19	Visit: $25 Copayment each visit Refraction Test: $25 Copayment each visit
• Members age 19 and over	Visit: $25 Copayment each visit Refraction Test: $25 Copayment each visit

Routine eye exam when performed by an Ophthalmologist	
• Up to the end of the calendar year the Member turns age 19	Visit:$40 Copayment each visit Refraction Test:$40 Copayment each visit
• Members age 19 and over	Visit: $40 Copayment each visit Refraction Test:$40 Copayment each visit
Covered Services not otherwise listed in this Schedule of Benefits received during an office visit, a scheduled procedure visit, or provided by a Plan Provider or Plan Facility	20% Coinsurance after Deductible
Optical hardware	
• Up to the end of the calendar year the Member turns age 19	Not Covered
• Members age 19 and over	Not Covered

X-ray, Laboratory, and Advanced Imaging Procedures	**You Pay**
Diagnostic laboratory Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals)	20% Coinsurance after Deductible
Diagnostic laboratory Services received in the outpatient department of a Plan Hospital	20% Coinsurance after Deductible
Diagnostic X-ray Services received during an office visit, in a Plan Medical Office, or in a contracted free-standing facility (excluding Plan Hospitals)	20% Coinsurance after Deductible
Diagnostic X-ray Services received in the outpatient department of a Plan Hospital	20% Coinsurance after Deductible
Therapeutic X-ray Services received during an office visit, in a Plan Medical Office, in a contracted free-standing facility, or a Plan Hospital	20% Coinsurance after Deductible
Advanced imaging procedures including but not limited to CT, PET, MRI, nuclear medicine • Diagnostic procedures include administered drugs • Therapeutic procedures may incur an additional charge for administered drugs. *(See "Office Services" for "Office administered drugs".)*	20% Coinsurance after Deductible Copayment waived if an advanced imaging procedure is performed during an Emergency Department visit and you are directly admitted as an inpatient. If the above amount is a Coinsurance, the Coinsurance amount is not waived if directly admitted as an inpatient.

Plus Benefit	**You Pay**
Maximum limit per Accumulation Period	Not Applicable
• Preventive care visits with an Out-of-Plan Provider	Not Covered

• Primary care and allergy injection visits, hearing exams, outpatient mental health and substance use disorder individual therapy visits, and short-term outpatient physical, occupational, or speech therapy visits with an Out-of-Plan Provider. Visits include email, e-visits, online chat, telephone visits, and video visits.	Not Covered
• Specialty and gynecology care visits, hearing exams, and allergy testing and evaluations with an Out-of-Plan Provider. Visits include email, e-visits, online chat, telephone visits, and video visits.	Not Covered
• Covered Services received during an office visit with an Out-of-Plan Provider, allergy injections, durable medical equipment, diagnostic X-ray and laboratory Services, and implantable or injectable contraceptives	Not Covered
Prescription drug fill maximum per Accumulation Period	Not Applicable
• Outpatient prescription drugs filled at an out-of-Plan Pharmacy	Not Covered
Outpatient prescription drugs prescribed by an Out-of-Plan Provider and filled at a Plan Pharmacy	Not Covered

Eligibility Amendments

- Dependent Limiting Age

  The Dependent limiting age as described under Dependents in the "Eligibility" section of the EOC is the end of the month in which age 26 is reached. If the Member continues to meet all other eligibility requirements, a Dependent child will continue to be eligible until the Dependent child reaches this age. For additional information regarding eligible Dependents, including certain Dependents over the limiting age, please refer to the “Eligibility” section in the EOC.

- Domestic Partner

  Your Group coverage includes health benefits for both same- and opposite-sex domestic partners and their Dependents. To be covered they must meet:
  1. The eligibility requirements as described in the “Eligibility” section of this EOC; and
  2. The conditions for domestic partnership as described in the Affidavit of Domestic Partnership.
  You are required to complete and submit an Affidavit of Domestic Partnership to Health Plan. Please check with your Group’s benefit administrator for details.

- Grandchildren

  Under your Group contract, a grandchild of you or your Spouse can be enrolled as your Dependent in this health benefit plan. This includes an adopted or foster grandchild. The grandchild must meet all Group and Health Plan eligibility requirements.

Group-Specific Coverage

- Eligible Organization

  This plan covers federally mandated over-the-counter non-prescription female contraceptive drugs and devices.

Additional Provisions

Please see “Additional Provisions” for any supplemental information that applies to your coverage

CONTACT US

Advice Nurses (Medical Advice) – Available 24 hours a day, 7 days a week

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Clinical Contact Center (to schedule an appointment)

CALL	**303-338-4545** or toll-free **1-800-218-1059**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Behavioral Health

CALL	**303-471-7700** or toll-free **1-866-359-8299** For Members seeking Behavioral Health Services in southern Colorado, please call **1-866-702-9026**.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Member Services – Available Monday through Friday, 8 a.m. to 6 p.m., except major holidays

CALL	Toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WEBSITE	**kp.org**

Patient Financial Services

CALL	**303-743-5900** or toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Patient Financial Services** **Kaiser Foundation Health Plan of Colorado** **Waterpark I** **2500 South Havana Street, Suite 500** **Aurora, CO 80014-1622**

Utilization Management

CALL	Toll free **1-800-632-9700** (Member Services**)**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-529-0934**
WRITE	**Utilization Management** **Kaiser Foundation Health Plan of Colorado** **Waterpark I** **2500 South Parker Road** **Aurora, CO 80014-1622**

Member Relations (to file an appeal)

CALL	Toll-free **1-800-632-9700**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
FAX	**1-866-466-4042**
WRITE	**Member Relations** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 378066** **Denver, CO 80237-8066**

Claims Department

CALL	**303-338-3600** or toll-free **1-800-382-4661**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	**Kaiser Permanente** **National Claims Administration - Colorado** **P.O. Box 373150** **Denver, CO 80237-3150**

Membership Administration

WRITE	**Membership Administration** **Kaiser Foundation Health Plan of Colorado** **P.O. Box 23127** **San Diego, CA 92193**

Transplant Administrative Offices

CALL	**303-636-3131**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

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I. ELIGIBILITY

A. Who Is Eligible

1. General

   To be eligible to enroll and to remain enrolled in this health benefit plan, you must meet the following requirements:

   a. You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of the Group's eligibility requirements; and
   b. You must also meet the Subscriber or Dependent eligibility requirements as described below; and
   c. The Subscriber must live or reside in our Service Area. Our Service Area is described in the "Definitions" section.

2. Subscribers

   You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements. An example would be an employee of your Group who works at least the number of hours stated in those requirements.

3. Dependents

   If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this plan:

   a. Your Spouse. (Spouse includes a partner in a valid civil union under state law.)

   b. Your or your Spouse's children (including adopted children and children placed with you for adoption) who are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)."

   c. Other dependent persons (but not including foster children) who meet all of the following requirements:
      i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
      ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

   d. Your or your Spouse's unmarried children over the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)" who are medically certified as disabled and dependent upon you or your Spouse are eligible to enroll or continue coverage as your Dependents if the following requirements are met:
      i. They are dependent on you or your Spouse; and
      ii. You give us proof of the Dependent's disability and dependency annually if we request it.

   e. Subscriber's designated beneficiary prescribed by Colorado law, if your employer elects to cover designated beneficiaries as dependents.

   Students on Medical Leave of Absence. Dependent children who lose dependent student status at a postsecondary educational institution due to a Medically Necessary leave of absence may remain eligible for coverage until the earlier of: (i) one year after the first day of the Medically Necessary leave of absence; or (ii) the date dependent coverage would otherwise terminate under this EOC. We must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury, and that the leave of absence or other change of enrollment is Medically Necessary.

   If your plan has different eligibility requirements, please see the "Eligibility Amendments" section of the "Schedule of Benefits (Who Pays What)" and/or the "Additional Provisions."

B. Enrollment and Effective Date of Coverage

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

1. New Employees and their Dependents

   If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible. You should check with your Group to see when new employees become eligible. Your membership will become effective on the date specified by your Group.

2. Members Who are Inpatient on Effective Date of Coverage

   If you are an inpatient in a hospital or institution when your coverage with us becomes effective and you had other coverage when you were admitted, state law will determine whether we or your prior carrier will be responsible for payment for your care until your date of discharge.

3. Special Enrollment Due to Newly Acquired Dependents

   You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

   The membership effective date for the Dependents (and, if applicable, the new Subscriber) will be:

   a. For newborn children, the moment of birth. Your newborn child is covered for the first 31 days following birth. This coverage is required by state law, whether or not you intend to add the newborn to this plan.

For existing Subscribers:

i. If the addition of the newborn child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newborn to keep coverage beyond the first 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the first 31-day period of coverage; and (B) notify Health Plan within 31 days of the newborn's birth.

ii. If the addition of the newborn child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the birth of the newborn to get the newborn enrolled onto the Subscriber's Health Plan coverage.

b. For newly adopted children (including children newly placed for adoption), the date of the adoption or placement for adoption. An eligible adopted child must be enrolled within 31 days from the date the child is placed in your custody or the date of the final decree of adoption.

For existing Subscribers:

i. If the addition of the newly adopted child to the Subscriber's coverage will change the amount the Subscriber is required to pay for that coverage, then the Subscriber, in order for the newly adopted child to continue coverage beyond the initial 31-day period of coverage, is required to: (A) pay the new amount due for coverage after the initial 31-day period of coverage; and (B) notify Health Plan within 31 days of the child's adoption or placement for adoption.

ii. If the addition of the newly adopted child to the Subscriber's coverage will not change the amount the Subscriber pays for coverage, the Subscriber must still notify Health Plan after the adoption or placement for adoption of the child to get the child enrolled onto the Subscriber's Health Plan coverage.

c. For all other Dependents, if enrolled within 31 days of becoming eligible, no later than the first day of the month following the date your Group receives the enrollment application. Your Group will let you know the membership effective date. Employees and Dependents who are not enrolled when newly eligible must wait until the next open enrollment period to become Members of Health Plan, unless: (i) they enroll under special circumstances, as agreed to by your Group and Health Plan; or (ii) they enroll under the provisions described in "Special Enrollment."

4. Special Enrollment

You or your Dependent may experience a qualifying event that allows a change in your enrollment. Examples of qualifying events are the loss of coverage, a Dependent's aging off this plan, marriage, and birth of a child. The qualifying event results in a special enrollment period that usually (but not always) starts on the date of the qualifying event and lasts for 30 days. During the special enrollment period, you may enroll your Dependent(s) in this plan, or in certain circumstances, you may change plans (your plan choice may be limited). There are requirements that you must meet to take advantage of a special enrollment period including showing proof of your own or your Dependent's qualifying event. To learn more about qualifying events, special enrollment periods, how to enroll or change your plan (if permitted), timeframes for submitting information to Health Plan and other requirements, contact your Group. If your Group coverage is ending, call **Member Services** or go to kp.org/specialenrollment.

5. Open Enrollment

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

6. Persons Barred from Enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

II. HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

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

- "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Urgent Care" in "Emergency Services and Urgent Care" in the "Benefits/Coverage (What is Covered)" section.
- "Out-of-Area Benefit" in the "Benefits/Coverage (What is Covered)" section.
- "Access to Other Providers" in this section.
- "Visiting Other Kaiser Regional Health Plan Service Areas" in this section.
- "Plus Benefit" if purchased by your Group. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage.

In some circumstances, you might receive Emergency or non-Emergency Services from an Out-of-Plan Provider or Out-of-Plan Facility. **Non-Emergency Services from Out-of-Plan Providers are not covered unless they are authorized by us.** If Services from an Out-of-Plan Provider or Out-of-Plan Facility are authorized, the Deductible, Copayment, and/or Coinsurance for these authorized Services are the same as for covered Services received from a Plan Provider or Plan Facility. You have the right and responsibility to request a Plan Provider to provide Services.

A. Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have their own PCP.

1. Choosing Your Primary Care Provider

   You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. **You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.** You may also receive a second medical opinion from a Plan Provider upon request. Please refer to the "Second Opinions" section.

   You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to kp.org/locations. You can also get a copy of the directory by calling **Member Services**. To choose a PCP, sign into your account online, or call the **Clinical Contact Center** for help choosing a PCP.

2. Changing Your Primary Care Provider

   Please call the **Clinical Contact Center** to change your PCP. You may also change your PCP online or when visiting a Kaiser Permanente Medical Office Building. You may change your PCP at any time.

B. Access to Other Providers

1. Referrals and Authorizations

   If your Plan Provider decides that you need covered Services not available from us, they will request a referral for you to see an Out-of-Plan Provider. If your Plan Provider decides you need specialty care that is not eligible for a self-referral, they will request a referral for you to see a specialty-care Plan Provider. (See the "Specialty Referrals" section below.)

   These referral requests result in an Authorization or a denial. However, there may be circumstances where Health Plan will partially authorize your provider's referral request.

   An Authorization is a referral request that has received approval from Health Plan. An Authorization is limited to a specific Service, treatment or series of treatments, and period of time. The provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

   An Authorization is required for Services provided by Out-of-Plan Providers or Out-of-Plan Facilities. If your provider refers you to an Out-of-Plan Provider or Out-of-Plan Facility, inside or outside our Service Area, you must have a written Authorization in order for us to cover the Services.

   All referral Services must be requested and authorized in advance. We will not pay for any care rendered by a provider unless the care is specifically authorized in advance by Health Plan. A written or verbal recommendation by a provider that you get non-covered Services (whether Medically Necessary or not) is not considered an Authorization, and is **not** covered.

2. Specialty Referrals

   Generally, you will need a referral and prior Authorization for Services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services from a Plan Provider. You do not need a referral or prior Authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

   For additional information on which Services require prior Authorization, please call **Member Services**. You will find specialty-care Plan Providers in the Kaiser Permanente Provider Directory. The Provider Directory is available on our website, kp.org/locations. If you need a printed copy of the Provider Directory, please call **Member Services**.

   Authorization from Health Plan is required for: (i) Services in addition to those provided as part of the routine office visit, such as procedures or surgery; and (ii) visits to specialty-care Plan Providers not eligible for self-referrals; and (iii) Out-of-Plan Providers. The request for these Services can be generated by either your PCP or by a specialty-care provider. If the request is approved, the provider or facility to whom you are referred will receive a notice of the Authorization, and you will receive a written notice of the Authorization. This notice will tell you the provider's information. It will also tell you the Services authorized and the time period that the Authorization is valid.

A Plan Provider can directly refer you for some laboratory or radiology Services and for specialty procedures such as a CT scan or MRI. However, certain laboratory or radiology Services and specialty procedures will still require an Authorization.

3. Second Opinions
Upon request and subject to payment of any applicable Deductible, Copayments, and/or Coinsurance, you may get a second opinion from a Plan Provider about any proposed covered Services.

If the recommendations of the first and second providers differ regarding the need for Services, a third opinion may be covered if authorized by Health Plan. Third medical opinions are not covered unless authorized by Health Plan before Services are rendered.

Authorization of a second or third opinion is limited to a consultation only and does not include any additional Services. Authorization of a second or third opinion may be limited to providers in Kaiser Permanente Medical Office Buildings.

C. Plan Facilities

Services are available at Plan Facilities conveniently located throughout the Service Area. We encourage you to receive routine outpatient Services at a Kaiser Permanente Medical Office Building, which often provides all the covered Services you need, including specialized care. **You may have a different Copayment and/or Coinsurance at certain facilities. Please refer to your "Schedule of Benefits (Who Pays What)" for additional details.**
Plan Facilities are listed in our provider directory, which we update regularly. You can get a current copy of the directory by calling **Member Services**. You can also get a list of Plan Facilities on our website. Go to kp.org/locations.

D. Getting the Care You Need

Emergency care is covered 24 hours a day, 7 days a week anywhere in the world. **If you think you have a Life or Limb Threatening Emergency, call 911 or go to the nearest emergency department or Independent Freestanding Emergency Department.** For coverage information about emergency care, including out-of-Plan Emergency Services, and emergency benefits away from home, please refer to "Emergency Services" in the "Benefits/Coverage (What is Covered)" section.

If you need urgent care, you may use one of the designated urgent care Plan Facilities. There may be instances when you need to receive urgent care outside our Service Area. The Copayment or Coinsurance for urgent care listed in the "Schedule of Benefits (Who Pays What)" will apply. For additional information about urgent care, please refer to "Urgent Care" in the "Benefits/Coverage (What is Covered)" section.

E. Visiting Other Kaiser Regional Health Plan Service Areas

You may receive visiting member services from another Kaiser regional health plan as directed by that other plan so long as such services would be covered under this EOC. Kaiser regional health plan service areas may change at any time. Currently they are: the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For more information, please call **Member Services.** Visiting member services shall be subject to the terms and conditions set forth in this EOC including but not limited to those pertaining to prior Authorization; Deductible; Copayment; Coinsurance; limitations and exclusions, as further described online at kp.org/travel. Certain services are not covered as visiting member services.

For more information about receiving visiting member services in other Kaiser regional health plan service areas, including provider and facility locations, please call our Away from Home Travel Line at 951-268-3900. Information is also available online at kp.org/travel.

F. Using Your Health Plan Identification Card

Each Member is issued a Health Plan Identification (ID) card with a Medical Record Number on it. This is useful when you call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. Please call **Member Services** if: (1) we ever inadvertently issue you more than one Medical Record Number; or (2) you need to replace your Health Plan ID card.

Your Health Plan ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services we provide. In addition, non-Member claims for Emergency or non-emergency care Services will be denied. If you let someone else use your Health Plan ID card, we may keep your card and terminate your membership.

When you receive Services, you will need to show photo identification along with your Health Plan ID card. This allows us to ensure proper identification and to better protect your coverage and medical information from fraud. If you suspect you or your membership is a victim of fraud, please call **Member Services** to report your concern.

III. BENEFITS/COVERAGE (WHAT IS COVERED)

The Services described in this "Benefits/Coverage (What is Covered)" section are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary; and
- The Services are provided, prescribed, recommended, or directed by a Plan Provider. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)" and "Urgent Care" in "Emergency Services and Urgent Care"; and (b) "Out-of-Area Benefit"; and (c) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- You receive the Services from Plan Providers inside our Service Area. This does not apply where noted to the contrary in the following sections of this EOC: (a) "Referrals and Authorizations" and "Specialty Referrals"; and (b) Emergency Services, Urgent Care, certain Post Stabilization Care Services that qualify as Emergency Services (under applicable federal law and state law), and Ancillary Services for which you have prior Authorization in "Emergency Services and Urgent Care"; and (c) "Out-of-Area Benefit"; and (d) "Visiting Other Kaiser Regional Health Plan Service Areas"; and (e) "Plus Benefit" if purchased by your Group (see the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased this coverage); and
- Your provider has received prior Authorization for your Services, as appropriate. When you receive covered Services for which you do not have prior Authorization or that you receive from Out-of-Plan Providers or from Out-of-Plan Facilities that have not been approved by us in advance, we will not pay for them except when they are Emergency Services or urgent care.

We cover COVID-19 testing and treatment required under applicable federal or Colorado laws, regulations, or bulletins.

Exclusions and limitations that apply only to a certain benefit are described in this "Benefits/Coverage (What is Covered)" section. Exclusions, limitations, and reductions that apply to all benefits are described in the "Limitations/Exclusions (What is Not Covered)" section.

Note: Deductibles, Copayments, and/or Coinsurance may apply to the benefits and are described below. For a complete list of Deductible, Copayment, and Coinsurance requirements, see the "Schedule of Benefits (Who Pays What)." You will also be required to pay any amount in excess of eligible Charges and any amount for Services provided by an Out-of-Plan Provider when you consent to their provision of Services. You are responsible for any applicable Deductible, Copayment, or Coinsurance for Services performed as part of or in conjunction with other outpatient Services, including but not limited to: office visits; Emergency Services; urgent care; and outpatient surgery.

A. Office Services

Office Services for Preventive Care, Diagnosis, and Treatment

We cover, under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following office Services for preventive care, diagnosis, and treatment, including professional medical Services of physicians and other health care professionals in the physician's office, during medical office consultations, in a Skilled Nursing Facility, or at home:

1. Primary care visits: Services from family medicine, internal medicine, and pediatrics.
2. Specialty care visits: Services from providers that are not primary care, as defined above.
3. Routine prenatal and postpartum visits: The routine prenatal benefit covers office exams, routine chemical urinalysis and fetal stress tests performed during the office visit. Member may receive Services from a certified nurse midwife. See the applicable section of your "Schedule of Benefits (Who Pays What)" for the Copayment and/or Coinsurance for all other Services received during a prenatal visit.
4. Consultations with clinical pharmacists.
5. Other covered Services received during an office visit or a scheduled procedure visit.
6. Outpatient hospital clinic visits with an Authorization from Health Plan.
7. Blood, blood products, and their administration.
8. House calls when care can best be provided in your home as determined by a Plan Provider.
9. Second opinion.
10. Medical social Services.
11. Preventive care Services (see "Preventive Care Services" in this "Benefits/Coverage (What is Covered)" section for more details).
12. Professional review and interpretation of patient data from a remote monitoring device.
13. Virtual care Services.
14. Office-administered drugs. Some drugs may require prior Authorization.

    Note: If the following are administered during an office visit, urgent care visit, or home visit, and administration or observation by medical personnel is required, they are covered at the applicable office-administered drug Copayment or

Coinsurance shown in the "Schedule of Benefits (Who Pays What)." This Copayment or Coinsurance may be in addition to the Copayment or Coinsurance for your visit.

- Drugs (including Biologics and Biosimilars) and injectables;
- Radioactive materials used for therapeutic purposes;
- Vaccines and immunizations approved for use by the U.S. Food and Drug Administration (FDA); and
- Allergy test and treatment materials.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

B. Outpatient Hospital and Surgical Services

Outpatient Services at Designated Facilities

We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following outpatient Services for diagnosis and treatment, including professional medical Services of physicians:

1. Outpatient surgery at Plan Facilities that are designated to provide surgical Services, including an ambulatory surgical center, surgical suite, or outpatient hospital facility. Kaiser Permanente applies Medicare global surgery guidelines in accordance with the Centers for Medicare and Medicaid Services (CMS).

   Note: Services provided during post-surgical office visits may have a cost-share.

2. Outpatient hospital Services at facilities that are designated to provide outpatient hospital Services, including but not limited to: electroencephalogram; sleep study; stress test; pulmonary function test; any treatment room; or direct admission to any observation room. You may be charged an additional Copayment or Coinsurance for any Service which is listed as a separate benefit under this "Benefits/Coverage (What is Covered)" section.

Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

C. Hospital Inpatient Care

1. Inpatient Services in a Plan Hospital

   We cover, only as described under this "Benefits/Coverage (What is Covered)" section and subject to any specific limitations, exclusions, or exceptions as noted throughout this EOC, the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals in our Service Area:

   a. Room and board, such as semiprivate accommodations or, when it is Medically Necessary, private accommodations or private duty nursing care.
   b. Intensive care and related hospital Services.
   c. Professional Services of physicians and other health care professionals during a hospital stay.
   d. General nursing care.
   e. Obstetrical care and delivery. This includes Cesarean section. If the covered stay for childbirth ends after 8 p.m., coverage will be continued until 8 a.m. the following morning. **Note:** If you are discharged within 48 hours after delivery (or 96 hours if delivery is by Cesarean section), your Plan Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge. All charges incurred by the newborn are subject to all Health Plan provisions. This includes the newborn's own Deductible, Out-of-Pocket Maximum, Copayment, and/or Coinsurance requirements. This applies even if the newborn is covered only for the first 31 days that is required by state law.
   f. Meals and special diets.
   g. Other hospital Services and supplies, such as:
      i. Operating, recovery, maternity, and other treatment rooms.
      ii. Prescribed drugs and medicines.
      iii. Diagnostic laboratory tests and X-rays.
      iv. Blood, blood products and their administration.
      v. Dressings, splints, casts, and sterile tray Services.
      vi. Anesthetics, including nurse anesthetist Services.
      vii. Medical supplies, appliances, medical equipment, including oxygen, and any covered items billed by a hospital for use at home.

   Note: To determine if your Group has the bariatric surgery benefit, see the "Schedule of Benefits (Who Pays What)." If your Group has the bariatric surgery benefit, you must meet Utilization Management Program Criteria to be eligible for coverage.

2. Hospital Inpatient Care Exclusions

   a. Dental Services are excluded, except that we cover hospitalization and general anesthesia for dental Services provided to Members as required by state law.

b. Cosmetic surgery related to bariatric surgery.

D. Ambulance Services and Other Transportation

1. Coverage
   We cover ambulance Services only if your condition requires the use of medical Services that only a licensed ambulance can provide. Kaiser Permanente applies Medicare guidelines for ambulance Services in accordance with the Centers for Medicare and Medicaid Services (CMS).

2. Ambulance Services Exclusions
   a. Non-emergency routine ambulance services to home or other non-acute health care setting are not covered.
   b. Transportation by other than a licensed ambulance is not covered. Transportation by car, taxi, bus, gurney van, minivan, or any other type of transportation is not covered, even if it is the only way to travel to a Plan Provider.

   Note: Health Plan will cover certain non-emergent, non-ambulance transportation when there is prior Authorization by Health Plan.

E. Clinical Trials

Note: We cover the initial evaluation for eligibility and acceptance into a clinical trial only if authorized by Health Plan.

1. Coverage **(applies to non-grandfathered health plans only)**
   We cover Services you receive in connection with a clinical trial if all of the following conditions are met:
   a. We would have covered the Services if they were not related to a clinical trial.
   b. You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
      i. A Plan Provider makes this determination.
      ii. You provide us with medical and scientific information establishing this determination.
   c. If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live.
   d. The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
      i. The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration.
      ii. The study or investigation is a drug trial that is exempt from having an investigational new drug application.
      iii. The study or investigation is approved or funded by at least one of the following:
         (a) The National Institutes of Health.
         (b) The Centers for Disease Control and Prevention.
         (c) The Agency for Health Care Research and Quality.
         (d) The Centers for Medicare & Medicaid Services.
         (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs.
         (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
         (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
            (i) It is comparable to the National Institutes of Health system of peer review of studies and investigations.
            (ii) It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

   For covered Services related to a clinical trial, you will pay the applicable Copayment, Coinsurance, and/or Deductible shown in the "Schedule of Benefits (Who Pays What)" that you would pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Clinical Trials Exclusions
   a. The investigational Service.
   b. Services provided solely for data collection and analysis and that are not used in your direct clinical management.

F. Dialysis Care

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:
1. The Services are provided inside our Service Area; and
2. You meet Utilization Management Program Criteria and medical criteria developed by the facility providing the dialysis; and

3. The facility is certified by Medicare and is a Plan Facility; and
4. A Plan Provider provides a written referral for care at the facility.

After the referral, we cover equipment, training, and medical supplies required for home dialysis.

G. Durable Medical Equipment (DME) and Prosthetics and Orthotics

We cover DME and prosthetics and orthotics, when prescribed by a Plan Provider as described below; when prescribed by a Plan Provider during a covered stay in a Skilled Nursing Facility, but only if Skilled Nursing Facilities ordinarily furnish the DME or prosthetics and orthotics.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines. Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to the standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      DME, with the exception of the following, is **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."
      i. Oxygen dispensing equipment and oxygen used in your home are covered. Oxygen refills are covered while you are temporarily outside the Service Area. To qualify for coverage, you must have a pre-existing oxygen order and must obtain your oxygen from the vendor designated by Health Plan.
      ii. Insulin pumps, insulin pump supplies, and continuous glucose monitors are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. Infant apnea monitors are provided.
      iv. Enteral nutrition, medical foods, and related feeding equipment and supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      v. Home ultraviolet light therapy equipment for certain skin conditions.
   b. Durable Medical Equipment Exclusions
      i. All other DME not described above, unless your Group has purchased additional coverage for DME. See "Additional Provisions."
      ii. Replacement of lost or stolen equipment.
      iii. Repair, adjustments, or replacements necessitated by misuse.
      iv. Spare equipment or alternate use equipment.
      v. More than one piece of DME serving essentially the same function, except for replacements.
2. Prosthetic Devices
   a. Coverage
      We cover the following prosthetic devices, including repairs, adjustments, and replacements other than those necessitated by misuse, theft, or loss, when prescribed by a Plan Provider and obtained from sources designated by Health Plan:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and provided in accordance with this EOC, including repairs and replacements of such prosthetic devices.
      v. Additional prosthetic device or devices if the treating physician determines that the additional prosthetic device or devices are necessary to enable the covered person to engage in physical recreational activities.

      Your Group may have purchased additional coverage for prosthetic devices. See "Additional Provisions."
   b. Prosthetic Devices Exclusions
      i. All other prosthetic devices not described above, unless your Group has purchased additional coverage for prosthetic devices. See "Additional Provisions." Your Plan Provider can provide the Services necessary to determine your need for prosthetic devices and help you make arrangements to obtain such devices at a reasonable rate.

ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction, unless your Group has purchased additional coverage for this benefit.

3. Orthotic Devices
Orthotic devices are **not** covered unless your Group has purchased additional coverage for DME, including prosthetic and orthotic devices. See "Additional Provisions."

H. Early Childhood Intervention Services

1. Coverage
Covered children, from birth up to age three (3), who have significant delays in development or have a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development as defined by state law, are covered for the number of Early Intervention Services (EIS) visits as required by state law. EIS are not subject to any Deductibles, Copayments or Coinsurance, or to any annual Out-of-Pocket Maximum or Lifetime Maximum.

Note: You may be billed for any EIS received after the number of visits required by state law is satisfied.

2. Limitations
The number of visits as required by state law does not apply to:
   a. Rehabilitation or therapeutic Services which are necessary as the result of an acute medical condition or post-surgical rehabilitation;
   b. Services provided to a child who is not an eligible child and whose services are not provided pursuant to an Individualized Family Service Plan (IFSP); and
   c. Assistive technology covered by the durable medical equipment benefit provisions of this EOC.

3. Early Childhood Intervention Services Exclusions
   a. Respite care;
   b. Non-emergency medical transportation;
   c. Service coordination other than case management services; or
   d. Assistive technology, not to include durable medical equipment that is otherwise covered under this EOC.

I. Emergency Services and Urgent Care

1. Emergency Services
Emergency Services are available at all times - 24 HOURS A DAY, 7 DAYS A WEEK. If you have an Emergency Medical Condition or mental health emergency, call 911 or go to the nearest hospital emergency department or Independent Freestanding Emergency Department. You do not need prior Authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the Emergency Services would be covered under your plan if you had received them inside our Service Area. For information about emergency benefits away from home, please call **Member Services**.

You will pay your plan's Deductible, Copayment, and/or Coinsurance for covered Emergency Services, regardless of whether the Emergency Services are provided by a Plan Provider or an Out-of-Plan Provider. Even if you receive Emergency Services from a Plan Provider, you must still obtain prior Authorization from us before you receive Post Stabilization Care from such Plan Provider. We may direct that you receive covered Post Stabilization Care at a particular Plan Hospital or other Plan Facility (such as a Skilled Nursing Facility) so that we may better coordinate your care using Plan Providers and our electronic medical record system. We will pay for Post Stabilization Care only at the Plan Provider authorized by us. If you or your treating providers do not obtain prior Authorization from us for Post Stabilization Care Services that require prior Authorization, we will not pay any amount for those Services and you may be liable to pay for these Services, in addition to any amounts such as Deductibles, Copayments, or Coinsurance.

Please note that in addition to any Copayment or Coinsurance that applies under this section, you may incur additional Copayment or Coinsurance amounts for Services and procedures covered under other sections of this EOC. Coverage for Services that are not Emergency Services, Post Stabilization Care, or Urgent Care Services as described in this "Emergency Services and Urgent Care" section will be covered as described under other sections of this EOC. Please refer to the "Schedule of Benefits" for Copayment and Coinsurance information. If you are admitted to a hospital from its emergency department because your condition is not stabilized, the Copayment or Coinsurance shown under "Hospital Inpatient Care" in the "Schedule of Benefits" applies.

   a. Emergency Services Provided by Out-of-Plan Providers (out-of-Plan Emergency Services)
   "Out-of-Plan Emergency Services" are Emergency Services that are not provided by a Plan Provider or at a Plan Facility. There may be times when you or a family member may receive Emergency Services from Out-of-Plan Providers. The patient's medical condition may be so critical that you cannot call or come to one of our Plan Facilities or the emergency department of a Plan Hospital, or the patient may need Emergency Services while traveling outside our Service Area.

   When you receive Emergency Services from Out-of-Plan Providers, Post Stabilization Care may qualify as Emergency Services pursuant to federal law and state law. We will not require prior Authorization for such Post Stabilization Care

at a non-Plan Hospital when your attending Out-of-Plan Provider determines that, after you receive Emergency (screening and stabilization) Services, you are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider located within a reasonable travel distance taking into account your medical condition.

Out-of-Plan Providers may provide notice and seek your consent to provide Post Stabilization Care Services or other covered Services. Such Services will not be covered when you do not obtain prior Authorization as described herein. If you (or your authorized representative) consent to the furnishing of Services by Out-of-Plan Providers, then you will be responsible for paying for such Services in the absence of any prior Authorization. In addition, if you (or your authorized representative) consent to the provision of Services by an Out-of-Plan Provider, then we will not pay for such Services, and the amount you pay will not count toward satisfaction of the Deductible, if any, or the Out-of-Pocket Maximum(s).

Please refer to "ii. Emergency Services Limitation for Out-of-Plan Providers" if you are hospitalized for Emergency Services.

i. We cover out-of-Plan Emergency Services as follows:

A. Outside our Service Area. If you are injured or become unexpectedly ill while you are outside our Service Area, we will cover out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Facility or a hospital where we have contracted for Emergency Services. This applies only if a prudent layperson, having average knowledge of health services and medicine and acting reasonably, would have believed that an Emergency Medical Condition or Life or Limb Threatening Emergency existed.

B. Inside our Service Area. If you are inside our Service Area, we will cover out-of-Plan Emergency Services only if a prudent layperson would have reasonably believed that the delay in going to a Plan Facility or a hospital where we have contracted for Emergency Services for treatment would worsen the Emergency Medical Condition.

ii. Emergency Services Limitation for Out-of-Plan Providers
If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, you or someone on your behalf must notify us within 24 hours, or as soon as reasonably possible. Please call the **Telephonic Medicine Center** at **303-743-5763**.

When you receive Emergency Services in Colorado (and federal law and state law do not require us to consider the Post Stabilization Care as Emergency Services), we cover Post Stabilization Care only if we provide prior Authorization for the Post Stabilization Care. **Therefore, it is very important that you, your provider including your Out-of-Plan Provider, or someone else acting on your behalf, call us to notify us that you need Post Stabilization Care and to get prior Authorization from us before you receive the Post Stabilization Care.**

After we are notified, we will discuss your condition with your emergency care Out-of-Plan Provider. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a Plan Facility we designate once you are Stabilized. If you are admitted to an Out-of-Plan Facility or a hospital where we have contracted for Emergency Services, we may transfer you to a Plan Hospital or Plan Facility. By notifying us of your hospitalization as soon as possible, you will protect yourself from potential liability for payment for Services you receive after transfer to one of our Plan Facilities would have been possible. If you choose to remain at an Out-of-Plan Facility for Post Stabilization Care, non-Emergency Services are not covered after we have made arrangements to transfer you to a Plan Facility for care. You will be responsible for payment for any Post Stabilization Care received at the Out-of-Plan Facility.

b. Emergency Services Exclusions and Limitations
Continuing or follow-up treatment: We cover only the Emergency Services that are required before you could have been moved to a Plan Facility we designate either inside or outside our Service Area. If you are admitted to a Plan Facility, we may transfer you to another Plan Facility. When approved by Health Plan, we will cover ambulance Services or other transportation Medically Necessary to move you to a designated Plan Facility for continuing or follow-up treatment.

The exclusions and limitations of your plan will still apply if non-covered Services are provided by an Out-of-Plan Provider or Out-of-Plan Facility.

c. Payment
Our payment is reduced by:
i. any applicable Deductible, Copayment, and/or Coinsurance for Emergency Services and advanced imaging procedures performed in the emergency department. The emergency department and advanced imaging procedures Copayments, if applicable, are waived if you are admitted directly to the hospital as an inpatient; and
ii. the Deductible, Copayment, and/or Coinsurance for ambulance Services, if any; and
iii. coordination of benefits; and
iv. any other payments you would have had to make if you received the same Services from our Plan Providers; and

v. all amounts paid or payable, or which in the absence of this EOC would be payable, for the Services in question, under any insurance policy or contract, or any other contract, or any government program except Medicaid; and
vi. amounts you or your legal representative recover from motor vehicle insurance or because of third-party liability.

Note: As part of an emergent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

Note: If you receive Emergency Services or Post Stabilization Care from an Out-of-Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance transportation described under the "Ambulance Services and Other Transportation" section, you may have to pay the Out-of-Plan Provider and file a claim for reimbursement unless the Out-of-Plan Provider must refrain from billing you under applicable law or agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by an Out-of-Plan Provider as part of your Emergency Services or Post Stabilization Care even if you receive the services at a Plan Provider.

2. Urgent Care

Urgent care Services are Services that are not Emergency Services, are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen illness, injury, or condition.

Urgent care that cannot wait for a scheduled visit with your PCP or specialist can be received at one of our designated urgent care Plan Facilities. In some circumstances, you may be able to receive care in your home. There may be instances when you need to receive urgent care outside our Service Area. When urgent care Services are required, we cover urgent care Services you receive from Plan Providers and Out-of-Plan Providers anywhere in the world, as long as the urgent care Services would be covered under your plan if you had received them inside our Service Area. For Copayment and Coinsurance information, see "Urgent Care" in the "Schedule of Benefits (Who Pays What)." For information regarding the designated urgent care Plan Facilities, please call **Member Services** during normal business hours. You can also go to our website, kp.org, for information on designated urgent care facilities.

You may call **Advice Nurses** at any time, and one of our advice nurses can speak with you. Our advice nurses are registered nurses (RNs) specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. They can often answer questions about a minor concern or advise you about what to do next, including making an appointment for you if appropriate.

Note: The procedure for receiving reimbursement for out-of-Plan urgent care Services is described in the "Appeals and Complaints" section regarding "Post-Service Claims and Appeals."

Note: As part of an urgent care episode, Medically Necessary DME and prosthetics and orthotics following Stabilization will be covered if authorized by Health Plan.

J. Family Planning and Sterilization Services

1. Coverage
   a. Family planning counseling. This includes counseling and information on birth control.
   b. Tubal ligations.
   c. Vasectomies.
   d. Interruption of pregnancy (abortion). Your group may exclude coverage for part or all interruption of pregnancy services. Please refer to the "Schedule of Benefits (Who Pays What)".

Note: The following are covered, but not under this section: diagnostic procedures, see "X-ray, Laboratory, and Advanced Imaging Procedures"; contraceptive drugs and devices, see the "Prescription Drugs, Supplies, and Supplements" section.

2. Family Planning and Sterilization Services Exclusions

Any and all Services to reverse voluntary, surgically induced sterilization.

K. Gender Affirming Health Services

We cover gender affirming health Services when Medically Necessary to treat gender dysphoria or gender identity disorder. Prior Authorization may be required. You must meet Utilization Management Program Criteria to be eligible for coverage.

1. Coverage

Non-surgical Services:
   a. Office visits and mental health visits.
   b. Laboratory Services and X-ray Services.
   c. Hormone therapy visits and administration.
   d. Facial and body hair removal (assigned male at birth).
   e. Outpatient prescription drugs, if covered by your plan.
   f. Inpatient and outpatient hospital care.
   g. Treatment for complications of surgery.

Surgical Services:
a. Pre-surgical and post-surgical consultations with surgeon.
b. Gender affirmation surgeries including:
   i. **Assigned female at birth**: hysterectomy; oophorectomy; metoidioplasty; phalloplasty; vaginectomy; scrotoplasty; erectile prosthesis; urethral extension; bilateral mastectomy with chest reconstruction; breast reduction; body contouring; gender affirming facial surgery.
   ii. **Assigned male at birth**: penectomy; vaginoplasty; clitoroplasty; labiaplasty; orchiectomy; breast augmentation; tracheal shave; body contouring; gender affirming facial surgery.
c. Inpatient and outpatient hospital care.
d. Treatment for complications of surgery.

You pay the applicable Copayment, Coinsurance, and/or Deductible shown in the "Schedule of Benefits (Who Pays What)." For example, see "Hospital Inpatient Care" in the "Schedule of Benefits (Who Pays What)" for the Copayment, Coinsurance, and/or Deductible that apply to hospital inpatient care.

2. Gender Affirming Health Services Exclusions
   a. Any gender affirming health Service that is not Medically Necessary.
   b. Calf implants.
   c. Hairline advancement.
   d. Pectoral implants.
   e. Permanent hair implantation.
   f. Voice modification surgery, unless medically necessary.

L. Health Education Services

We provide health education appointments to support understanding of chronic diseases such as diabetes and hypertension. We also teach self-care on topics such as stress management and nutrition.

M. Hearing Services

1. Members up to Age 18

   We cover hearing exams and tests to determine the need for hearing correction. For minor children with a verified hearing loss, coverage shall also include:
   a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
   b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child; and
   c. Services and supplies including, but not limited to: the initial assessment; fitting; adjustments; and auditory training that is provided according to accepted professional standards.

2. Members Age 18 Years and Over
   a. Coverage

      We cover hearing exams and tests to determine the need for hearing correction. Your Group may have purchased additional coverage for hearing aids. See "Additional Provisions."

   b. Hearing Services Exclusions
      i. Tests to determine an appropriate hearing aid model, unless your Group has purchased that coverage.
      ii. Hearing aids and tests to determine their usefulness, unless your Group has purchased that coverage.

N. Home Health Care

1. Coverage

   We cover skilled nursing care, home infusion therapy, physical therapy, occupational therapy, speech therapy, home health aide Services, and medical social Services:
   a. only on an Intermittent Care basis (as described below); and
   b. only within our Service Area; and
   c. only to an eligible Member when ordered by a Plan Provider. Care must be provided under a home health care plan established by the Plan Provider and the approved home health services provider; and
   d. only if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

   Intermittent Care basis means skilled nursing, therapy, social work, and home health aide Services, that are not custodial, and require a skilled professional, and are provided less than 8 hours (combined) each day and 28 or fewer hours each week.

   Note: Services that are performed in the home, but that do not meet the Home Health Care requirements above, will be covered at the applicable Copayment or Coinsurance and limits for the Service performed (e.g. urgent care, physical, occupational, and/or speech therapy). See the "Schedule of Benefits (Who Pays What)."

Note: X-ray, laboratory, and advanced imaging procedures are not covered under this section. See "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Home Health Care Exclusions
   a. Custodial care. Custodial care is care that helps with activities of daily living (like bathing, dressing, using the bathroom, and eating) or personal needs that could be done safely and reasonably without professional skills or training.
   b. Homemaker Services.
   c. Services that Health Plan determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, if we offer to provide that care in one of these facilities.

O. Hospice Special Services and Hospice Care

1. Hospice Special Services

   If you have been diagnosed with a life limiting illness with a life expectancy of 24 months or less, but are not yet ready to elect hospice care, you are eligible for Hospice Special Services. Coverage of hospice care is described below.

   Hospice Special Services give you and your family time to become more familiar with hospice-type Services and to decide what is best for you. It helps you bridge the gap between your diagnosis and preparing for the end of life.

   The difference between Hospice Special Services and regular Home Health Care visiting nurse visits is that: you may or may not be homebound or have skilled nursing care needs; or you may only require spiritual or emotional care. Services available through this program are provided by professionals with specific training in end-of-life issues.

2. Hospice Care

   We cover hospice care for terminally ill Members inside our Service Area. If a Plan Provider diagnoses you with a terminal illness and determines that your life expectancy is six (6) months or less, you can choose hospice care instead of traditional Services otherwise provided for your illness.

   If you elect to receive hospice care, you will not receive **additional** benefits for the terminal illness. However, you can continue to receive Health Plan benefits for conditions other than the terminal illness.

   We cover the following Services and other benefits when: (1) prescribed by a Plan Provider and the hospice care team; and (2) received from a licensed hospice approved, in writing, by Health Plan:
   a. Physician care.
   b. Nursing care.
   c. Physical, occupational, speech, and respiratory therapy.
   d. Medical social Services.
   e. Home health aide and homemaker Services.
   f. Medical supplies, drugs, biologicals, and appliances.
   g. Palliative drugs in accordance with our drug formulary guidelines.
   h. Short-term inpatient care including respite care, care for pain control, and acute and chronic pain management.
   i. Counseling and bereavement Services.
   j. Services of volunteers.

P. Mental Health Services

1. Coverage

   We cover mental health Services as shown below. Mental health includes but is not limited to biologically based illnesses or disorders.

   a. Outpatient Therapy
      i. We cover individual office visits and group office visits. Psychological testing as part of diagnostic evaluation is covered.
      ii. We cover partial hospitalization and intensive outpatient therapy.
      iii. We cover visits for the purpose of monitoring drug therapy.

   b. Inpatient Services

      We cover psychiatric hospitalization in a hospital or Residential Treatment Center designated by Health Plan. Hospital Services for psychiatric conditions include all Services of Plan Providers and mental health professionals and the following Services and supplies as prescribed by a Plan Provider while you are a registered bed patient: room and board; psychiatric nursing care; group therapy; electroconvulsive therapy; occupational therapy; drug therapy; and medical supplies.

   We cover mental health Services, whether they are voluntary or are court-ordered, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

   We will not deny coverage for intentionally self-inflicted injuries, including attempted suicide.

2. Mental Health Services Exclusions
   a. Evaluations for any purpose other than mental health treatment. This includes evaluations for: child custody; disability; or fitness for duty/return to work, unless Medically Necessary.
   b. Custodial Care, as defined in "Exclusions" under "Limitations/Exclusions (What is Not Covered)."

Q. Out-of-Area Benefit

A limited benefit is available to Dependents, up to the age of 26, receiving care outside any Kaiser regional health plan service area.

1. Coverage
   The Out-of-Area Benefit is limited to certain office visits; diagnostic X-rays; physical, occupational, and speech therapy; and prescription drug fills as covered under this EOC.
   a. Office visit exam limited to:
      i. Primary care visit.
      ii. Specialty care visit.
      iii. Preventive care visit.
      iv. Gynecology care visit.
      v. Hearing exam.
      vi. Mental health visit.
      vii. Substance use disorder visit.
      viii. The administration of allergy injections.
      ix. Prevention immunizations pursuant to the schedule established by the Advisory Committee on Immunization Practices (ACIP).

   b. Diagnostic X-rays.

   c. Physical, occupational, and speech therapy visits.

   d. Prescription drug fills.

   See the "Schedule of Benefits (Who Pays What)" for more details.

2. Out-of-Area Benefit Exclusions and Limitations
   The Out-of-Area Benefit does not include the following Services:
   a. Other Services provided during a covered office visit such as, but not limited to: procedures; laboratory tests; and office administered drugs and devices, except for allergy injections and prevention immunizations as listed in the "Coverage" section of this benefit.
   b. Services received outside the United States.
   c. Transplant Services.
   d. Services covered outside the Service Area under another section of this EOC (e.g., Emergency Services and Urgent Care).
   e. Allergy evaluation; routine prenatal and postpartum visits; chiropractic care; acupuncture services; applied behavior analysis (ABA); hearing tests; hearing aids; home health visits; hospice services; and travel immunizations.
   f. Breast cancer screening and/or imaging.
   g. Ultrasounds.
   h. Advanced imaging procedures, including but not limited to: CT; PET; MRI; nuclear medicine.
   i. Any and all Services not listed in the "Coverage" section of this benefit.

R. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services

1. Coverage
   a. Hospital Inpatient Care, Care in a Skilled Nursing Facility, and Home Health Care
      We cover physical, occupational, and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility, and Home Health Care benefit. Therapies that are performed in the home, but that do not meet the Home Health Care requirements, will be covered at the applicable Copayment or Coinsurance and limits for the therapy performed (i.e., physical, occupational, and/or speech). See the "Schedule of Benefits (Who Pays What)."

   b. Outpatient Care
      We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility or other location approved by Health Plan, to improve or develop skills or functioning due to medical deficits, illness, or injury. See the "Schedule of Benefits (Who Pays What)."

   c. Inpatient Rehabilitation Services
      We will cover treatment while you are in a designated inpatient rehabilitation facility. See the "Schedule of Benefits (Who Pays What)."

d. Cardiac Rehabilitation
We cover treatment in a cardiac rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

e. Pulmonary Rehabilitation
We cover treatment in a pulmonary rehabilitation program if prescribed or recommended by a Plan Provider and provided by therapists at designated facilities.

f. Therapies for Congenital Defects and Birth Abnormalities
After the first 31 days of life, the limitations and exclusions applicable to this EOC apply, except that Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children from age three (3) to age six (6) shall be provided. The benefit level shall be the greater of the number of such visits provided under this health benefit plan or 20 therapy visits per Accumulation Period for each physical, occupational, and speech therapy. Such visits shall be distributed as Medically Necessary throughout the Accumulation Period without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or improve functional capacity. See the "Schedule of Benefits (Who Pays What)."

Note 1: This benefit is also available for eligible children under the age of three (3) who are not participating in Early Intervention Services.

Note 2: The visit limit for therapy to treat congenital defects and birth abnormalities is not applicable if such therapy is Medically Necessary to treat autism spectrum disorders.

g. Therapies for the Treatment of Autism Spectrum Disorders
For the treatment of Autism Spectrum Disorders when prescribed by a Plan Provider and Medically Necessary, we cover:
i. Outpatient physical, occupational, and speech therapy in a Kaiser Permanente Medical Office Building or Plan Facility. See the "Schedule of Benefits (Who Pays What)."
ii. Applied behavior analysis, including consultations, direct care, supervision, or treatment, or any combination thereof by autism services providers. See the "Schedule of Benefits (Who Pays What)."

2. Limitations
Occupational therapy is limited to treatment to achieve improved self-care and other customary activities of daily living.

3. Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services Exclusions
a. Long-term rehabilitation, not including treatment for autism spectrum disorders.
b. Speech therapy that is not Medically Necessary, such as: (i) therapy for educational placement or other educational purposes; or (ii) training or therapy to improve articulation in the absence of injury, illness, or medical condition affecting articulation; or (iii) therapy for tongue thrust in the absence of swallowing problems.

S. Prescription Drugs, Supplies, and Supplements

We use a drug formulary. A drug formulary includes the list of prescription drugs (including Biologics and Biosimilars) that have been approved by our formulary committee for our Members. Our committee is comprised of physicians, pharmacists, and a nurse practitioner. This committee selects prescription drugs for our drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature and research. The committee meets regularly to consider adding and removing prescription drugs on the drug formulary. If you would like information about whether a drug is included in our drug formulary, please call **Member Services**.

If your prescription drug has a Copayment shown in the "Schedule of Benefits (Who Pays What)" and it exceeds the Charges for your prescribed medication, then you pay Charges for the medication instead of the Copayment. The drug formulary, discussed above, also applies.

For outpatient prescription drugs and/or items that are covered under the "Prescription Drugs, Supplies, and Supplements" section and obtained at a pharmacy owned and operated by Health Plan, you may be able to use approved manufacturer coupons as payment for the Copayment, Coinsurance, and/or Deductible that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire Copayment, Coinsurance, and/or Deductible for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information about the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.

1. Coverage
a. Limited Drug Coverage Under Your Basic Drug Benefit
If your Group has not purchased supplemental prescription drug coverage, then prescribed drug coverage under your basic drug benefit is limited. It includes base drugs such as: contraceptives; orally administered anti-cancer medication; and post-surgical immunosuppressive drugs required after a transplant. These drugs are available only when prescribed by a Plan Provider and obtained at Plan Pharmacies. You may obtain these drugs at the Copayment or Coinsurance shown in the "Schedule of Benefits (Who Pays What)." The amount covered cannot exceed the day

supply for each maintenance drug or up to the day supply for each non-maintenance drug. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply, you will be charged as a non-Member for any amount that exceeds that limit. Each prescription refill is provided on the same basis as the original prescription.

If your Group has purchased supplemental prescription drug coverage, the applicable generic or brand-name Copayment or Coinsurance and any pharmacy Deductible apply for these types of drugs. For more information, please refer to the "Schedule of Benefits (Who Pays What)."

Note: Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs, regardless of whether your Group has limited or supplemental prescription drug coverage.

i. We cover:
   (a) prescription contraceptives intended to last:
      (i) for a three-month period the first time the prescription contraceptive is dispensed to the covered person; and
      (ii) for a twelve-month period or through the end of the covered person's coverage under the policy, contract, or plan, whichever is shorter, for any subsequent dispensing of the same prescription contraceptive to the covered person, regardless of whether the covered person was enrolled in the policy, contract, or plan at the time the prescription contraceptive was first dispensed; or
   (b) a prescribed vaginal contraceptive ring intended to last for a three-month period.

   Note: For non-grandfathered health plans, we cover twelve (12) months of a prescription contraceptive at one time.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices, please refer to your "Schedule of Benefits (Who Pays What)."

ii. We cover a five-day supply of an FDA-approved drug for the treatment of opioid dependence without prior authorization, except that the drug supply is limited to a first request within a twelve-month period.

b. Outpatient Prescription Drugs

Unless your Group has purchased additional outpatient prescription drug coverage, we do not cover outpatient drugs except as provided in other provisions of this "Prescription Drugs, Supplies, and Supplements" section. If your Group has purchased additional coverage for outpatient prescription drugs, see "Additional Provisions." The drug formulary, discussed above, also applies.

i. Prescriptions by Mail

If requested, refills of maintenance drugs will be mailed through Kaiser Permanente's mail-order prescription service by First-Class U.S. Mail with no charge for postage and handling. We cannot mail prescription drugs to some states. Refills of maintenance drugs prescribed by Plan Providers may be obtained for up to the day supply by mail order at the applicable Copayment or Coinsurance. Maintenance drugs are determined by Health Plan. Certain drugs and supplies may not be available through our mail-order service, for example, drugs that require special handling or refrigeration, have a significant potential for waste or diversion, or are high cost. Drugs and supplies available through our mail-order prescription service are subject to change at any time without notice. For information regarding our mail-order prescription service and specialty drugs not available by mail order, please contact **Member Services**.

ii. Specialty Drugs

Prescribed specialty drugs, such as self-administered injectable drugs, are provided at the specialty drug Copayment or Coinsurance up to the maximum amount per drug dispensed shown in the "Schedule of Benefits (Who Pays What)."

c. Food Supplements

We cover prescribed amino acid modified products used in the treatment of congenital errors of amino acid metabolism and severe protein allergic conditions, elemental enteral nutrition, and parenteral nutrition. Such products are covered for self-administered use upon payment of a $3.00 Copayment per product, per day. Food products for enteral feedings are not covered.

d. Diabetic Supplies and Accessories

Diabetic supplies, when obtained at Plan Pharmacies or from sources designated by Health Plan, will be provided. Such items include, but may not be limited to:

i. home glucose monitoring supplies.
ii. disposable syringes for the administration of insulin.
iii. glucose test strips.
iv. acetone test tablets and nitrate screening test strips for pediatric patient home use.

For more information, see the "Schedule of Benefits (Who Pays What)." If your Group has purchased supplemental prescription drug coverage, see "Additional Provisions."

2. Limitations
   a. Adult and pediatric immunizations are limited to those that are not experimental, are medically indicated and are consistent with accepted medical practice. If you experience a severe adverse reaction from a covered countermeasure, please visit hrsa.gov/cicp.
   b. Some drugs may require prior authorization.
   c. If applicable, we may apply Step Therapy to certain drugs. You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   d. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as: bandages; gauze; tape; antiseptics; dressings; and ace-type bandages.
   c. Drugs or injections for treatment of sexual dysfunction, unless your Group has purchased additional coverage, which is described in the "Schedule of Benefits (Who Pays What)."
   d. Any packaging except the dispensing pharmacy's standard packaging.
   e. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   f. Drugs or injections for the treatment of infertility, unless your Group has purchased outpatient prescription drug coverage, which is described in the "Schedule of Benefits (Who Pays What)" and "Additional Provisions."
   g. Drugs to shorten the length of the common cold.
   h. Drugs to enhance athletic performance.
   i. Drugs for the treatment of weight control.
   j. Drugs available over the counter and by prescription for the same strength.
   k. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   l. Unless approved by Health Plan, drugs not approved by the FDA.
   m. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   n. Prescription drugs necessary for Services excluded under this EOC.
   o. Drugs administered during a medical office visit. See "Office Services."
   p. Medical Foods and Medical Devices. See "Durable Medical Equipment (DME) and Prosthetics and Orthotics."

T. Preventive Care Services

If your plan has a different preventive care Services benefit, please see "Additional Provisions."

We cover certain preventive care Services that do one or more of the following:
1. Protect against disease;
2. Promote health; and/or
3. Detect disease in its earliest stages before noticeable symptoms develop.

Preventive Services may help you stay healthy. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services during a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services.

U. Reconstructive Surgery

1. Coverage
   We cover reconstructive surgery when it: (a) will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or (b) will correct a congenital defect, disease, or anomaly to produce major improvement in physical function; or (c) will treat congenital hemangioma and port wine stains. Following Medically Necessary removal of all or part of a breast, we also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. An Authorization is required for all types of reconstructive surgeries.

2. Reconstructive Surgery Exclusions
   Plastic surgery or other cosmetic Services and supplies primarily to change your appearance. This includes cosmetic surgery related to bariatric surgery.

V. Reproductive Support Services

Note: If your Group is a religious purchaser, the coverage shown below may not apply to you. See the "Schedule of Benefits (Who Pays What)" to determine what coverage, if any, your Group has purchased.

1. Coverage

We cover Services for the diagnosis and treatment of involuntary infertility, including Services for Members who may experience future impairment to their fertility due to medical treatment, or are unable to reproduce due to factors associated with their partner or lack of partner. The following Services are covered as shown in the "Schedule of Benefits (Who Pays What)":

a. Office visits.
b. Services including, but not limited to, X-ray and laboratory tests.
c. Intrauterine insemination (IUI).
d. In Vitro Fertilization (IVF).
e. Gamete intrafallopian transfer (GIFT).
f. Zygote intrafallopian transfer (ZIFT).
g. Standard fertility preservation Services.
h. Office administered drugs supplied and used during an office visit for IUI, IVF, GIFT, or ZIFT.

Note: Prescription drugs are not covered under this section. See "Prescription Drugs, Supplies, and Supplements" in the "Schedule of Benefits (Who Pays What)" to determine if you have coverage for prescription drugs received from a Plan Pharmacy.

2. Limitations
   a. There is a limit of three (3) completed oocyte retrievals with unlimited embryo transfers, using single embryo transfer when recommended and medically appropriate.
   b. There is a limit of one (1) year of storage for gametes and embryos.
   c. Services are covered only for the person who is the Member.

3. Reproductive Support Services Exclusions
   a. Any and all Services to reverse voluntary, surgically induced infertility.
   b. Donor semen, eggs, and embryos.
   c. Acupuncture for the treatment of infertility, unless your Group has purchased additional coverage for this service. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has the acupuncture benefit.
   d. Prescription drugs received from a pharmacy for infertility services, unless prescription drug coverage is purchased.
   e. Any and all Services related to elective cryopreservation (e.g. elective egg freezing). This exclusion applies to, but is not limited to, the procurement and/or storage of semen, sperm, eggs, embryos, or other reproductive materials.

W. Skilled Nursing Facility Care

1. Coverage

   We cover skilled inpatient Services in a licensed Skilled Nursing Facility. Prior Authorization is required for all Skilled Nursing Facility admissions. The skilled inpatient Services must be those usually provided by Skilled Nursing Facilities. A prior three (3)-day stay in an acute care hospital is not required. We cover the following Services:

   a. Room and board.
   b. Nursing care.
   c. Medical social Services.
   d. Medical and biological supplies.
   e. Blood, blood products, and their administration.

   A Skilled Nursing Facility is an institution that: provides skilled nursing or skilled rehabilitation Services, or both; provides Services on a daily basis 24 hours a day; is licensed under applicable state law; and is approved in writing by Health Plan.

   Note: The following are covered, but not under this section: drugs, see "Prescription Drugs, Supplies, and Supplements"; DME and prosthetics and orthotics, see "Durable Medical Equipment (DME) and Prosthetics and Orthotics"; X-ray, laboratory, and advanced imaging procedures, see "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Skilled Nursing Facility Care Exclusion

   Custodial Care, as defined in "Exclusions" under the "Limitations/Exclusions (What is Not Covered)" section.

X. Substance Use Disorder Services

1. Inpatient Medical and Hospital Services

   We cover Services for the medical management of withdrawal symptoms. Detoxification is the process of removing toxic substances from the body.

2. Residential Rehabilitation

   The determination of the need for Services of a residential rehabilitation program and referral to such a facility or program is made by or under the supervision of a Plan Provider.

   We cover inpatient Services in a residential rehabilitation program authorized by Health Plan for the treatment of alcoholism, drug abuse, or drug addiction.

3. Outpatient Services
   a. We cover individual office visits and group office visits.
   b. We cover partial hospitalization and intensive outpatient therapy.
   c. We cover visits for the purpose of monitoring drug therapy.
   d. We cover substance use disorder Services intended to reduce, eliminate, or avoid the use of opioids for persons with chronic pain conditions.

We cover substance use disorder Services, whether they are voluntary or are court-ordered, when they are Medically Necessary and otherwise covered under the plan, and when rendered by a Plan Provider. We do not cover court-ordered treatment that exceeds the scope of coverage of this health benefit plan.

Mental health Services required in connection with treatment for substance use disorder are covered as provided in the "Mental Health Services" section.

4. Substance Use Disorder Services Exclusion
   Counseling for a patient who is not responsive to therapeutic management, as determined by a Plan Provider.

Y. Transplant Services

1. Coverage for Members who are transplant recipients
   Transplants are covered on a limited basis as follows:
   a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.
   b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease, and Wiskott-Aldrich syndrome.
   c. If all Utilization Management Program Criteria are met, we cover: stem cell rescue; and transplants of organs, tissue, or bone marrow.
   d. Prescribed post-surgical immunosuppressive outpatient drugs required after a transplant.
   e. These Services must be directly related to a covered transplant for you.

2. Coverage for Members who are living organ donors
   We cover Services related to living organ donation for a Member who is a living organ donor. We will not impose any Deductibles, Copayments, Coinsurance, benefit maximums, waiting periods, or other limitations on coverage for the living organ donation.

3. Terms and Conditions
   a. Health Plan, Medical Group, and Plan Providers do not undertake: to provide a donor or donor organ or bone marrow or cornea; or to assure the availability of a donor or donor organ or bone marrow or cornea; or to assure the availability or capacity of referral transplant facilities approved by Health Plan. For information specific to your situation, please call your assigned Transplant Coordinator; or the **Transplant Administrative Offices**.
   b. Plan Providers must determine that you meet Utilization Management Program Criteria before you receive Services.
   c. A Plan Provider must provide a written referral for care at a transplant facility. The transplant facility must be from a list of approved facilities selected by Health Plan. The referral may be to a transplant facility outside our Service Area. Transplants are covered only at the facility Health Plan selects for the particular transplant, even if another facility within the Service Area could also perform the transplant.
   d. After referral, if a Plan Provider or the medical staff of the referral facility determines you do not satisfy its respective criteria for the Service, Health Plan's obligation is only to pay for covered Services provided prior to such determination.

4. Transplant Services Exclusions and Limitations
   a. Bone marrow transplants associated with high dose chemotherapy for solid tissue tumors (except bone marrow transplants covered under this EOC) are excluded.
   b. Non-human and artificial organs and their implantation are excluded.
   c. Pancreas alone transplants are limited to patients without renal problems who meet set criteria.
   d. Travel and lodging expenses are excluded, except that in some situations, when Health Plan refers you to a provider outside our Service Area for transplant Services, as described in "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section, we may pay certain expenses we preauthorize under our internal travel and lodging guidelines. For information specific to your situation, please call your assigned Transplant Coordinator or the **Transplant Administrative Offices.**

Z. Vision Services

1. Coverage

   We cover routine and non-routine eye exams. Refraction tests to determine the need for vision correction and to provide a prescription for eyeglasses are covered unless specifically excluded in the "Schedule of Benefits (Who Pays What)." We also cover professional exams and the fitting of Medically Necessary contact lenses when a Plan Provider or Plan Optometrist prescribes them for a specific medical condition.

   Professional Services for exams and fitting of contact lenses that are not Medically Necessary are provided at an additional Charge when obtained at Kaiser Permanente Medical Office Buildings.

2. Vision Services Exclusions
   a. Eyeglass lenses and frames.
   b. Contact lenses.
   c. Professional exams for fittings and dispensing of contact lenses except when Medically Necessary as described above.
   d. Miscellaneous Services and supplies, such as: eyeglass holders; eyeglass cases; repair kits; contact lens cases; contact lens cleaning and wetting solution; and lens protection plans.
   e. All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures).
   f. Orthoptic (eye training) therapy or low vision therapy.

Your Group may have purchased additional optical coverage. See "Additional Provisions."

AA. X-ray, Laboratory, and Advanced Imaging Procedures

1. Coverage
   a. Outpatient

      We cover the following Services:

      i. Diagnostic X-ray tests, Services, and materials, including but not limited to isotopes, mammograms, and ultrasounds.

      ii. Laboratory tests, Services, and materials, including but not limited to electrocardiograms.
      Note: We use a laboratory formulary. A laboratory formulary is a list of laboratory tests, Services, and other materials that have been approved by Health Plan for our Members. If you would like information about whether a particular test or Service is included in our laboratory formulary, please call **Member Services**.

      iii. Therapeutic X-ray Services and materials.

      iv. Advanced imaging procedures such as: MRI; CT; PET; and nuclear medicine.
      Note: For advanced imaging procedures, you will be billed for each individual procedure performed. As such, if more than one procedure is performed in a single visit, more than one Copayment will apply. A procedure is defined in accordance with the Current Procedural Terminology (CPT) medical billing codes published annually by the American Medical Association. You are responsible for any applicable Deductible, Copayment, and/or Coinsurance for advanced imaging procedures performed as a part of or in conjunction with other outpatient Services, including but not limited to: Emergency Services; urgent care; and outpatient surgery.

      Diagnostic procedures include administered drugs. Therapeutic procedures may incur an additional charge for administered drugs.

   b. Inpatient

      During hospitalization, prescribed diagnostic X-ray and laboratory tests, Services and materials, including: diagnostic and therapeutic X-rays and isotopes; electrocardiograms; electroencephalograms; MRI; CT; PET; and nuclear medicine, are covered under your hospital inpatient care benefit.

2. X-ray, Laboratory, and Advanced Imaging Procedures Exclusions
   a. Testing of a Member for a non-Member's use and/or benefit.
   b. Testing of a non-Member for a Member's use and/or benefit.

IV. LIMITATIONS/EXCLUSIONS (WHAT IS NOT COVERED)

A. Exclusions

The Services listed below are not covered. These exclusions apply to all covered Services under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits/Coverage (What is Covered)" section.

1. **Alternative Medical Services.** The following are not covered unless your Group has purchased additional coverage for these Services. See the "Schedule of Benefits (Who Pays What)" to determine if your Group has purchased additional coverage.
   a. Acupuncture Services.

b. Naturopathy Services.
c. Massage therapy.
d. Chiropractic Services and supplies that are not provided by a Plan Provider under this Agreement.

2. **Behavioral Problems.** Any treatment or Service for a behavioral problem not associated with a manifest mental disorder or condition.

3. **Certain Maternity Services that are not Medically Necessary.** Certain maternity Services that are not Medically Necessary, including but not limited to: home birth Services and doula Services.

4. **Cosmetic Services.** Services that are intended: primarily to change or maintain your appearance; and that will not result in significant improvement in physical function. Examples of this include cosmetic surgery related to bariatric surgery and hair prostheses due to hair loss. Exception: Services covered under "Reconstructive Surgery" in the "Benefits/Coverage (What is Covered)" section.

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

6. **Dental Services.** Dental Services and dental X-rays, including: dental Services following injury to teeth; dental appliances; implants; orthodontia; TMJ; and dental Services as a result of and following medical treatment such as radiation treatment. This exclusion does not apply to: (a) Medically Necessary Services for the treatment of cleft lip or cleft palate when prescribed by a Plan Provider, unless the Member is covered for these Services under a dental insurance policy or contract, or (b) hospitalization and general anesthesia for dental Services, prescribed or directed by a Plan Provider for Dependent children who: (i) have a physical, mental, or medically compromising condition; or (ii) have dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or (iii) are extremely uncooperative, unmanageable, anxious, or uncommunicative with dental needs deemed sufficiently important that dental care cannot be deferred; or (iv) have sustained extensive orofacial and dental trauma, or (c) Medically Necessary Services required for the direct treatment of a covered transplant procedure for a Member who is a transplant recipient. Unless otherwise specified herein, (a) and (b) must be received at a Plan Facility or Skilled Nursing Facility.

   The following Services for TMJ may be covered if determined Medically Necessary: diagnostic X-rays; laboratory testing; physical therapy; and surgery.

7. **Directed Blood Donations.**

8. **Disposable Supplies.** All disposable, non-prescription, or over-the-counter supplies for home use such as:
   a. Bandages.
   b. Gauze.
   c. Tape.
   d. Antiseptics.
   e. Dressings.
   f. Ace-type bandages.
   g. Any other supplies, dressings, appliances, or devices not specifically listed as covered in the "Benefits/Coverage (What is Covered)" section.

9. **Educational Services.** Educational services are not health care services and are not covered. Examples include, but are not limited to:
   a. Items and services to increase academic knowledge or skills;
   b. Special education or care for learning deficiencies, whether or not associated with a manifest mental disorder or condition, including but not limited to attention deficit disorder, learning disabilities, and developmental delays;
   c. Teaching and support services to increase academic performance;
   d. Academic coaching or tutoring for skills such as grammar, math, and time management;
   e. Speech training that is not Medically Necessary, and not part of an approved treatment plan, and not provided by or under the direct supervision of a Plan Provider acting within the scope of their license under Colorado law that is intended to address speech impediments;
   f. Teaching you how to read, whether or not you have dyslexia;
   g. Educational testing; testing for ability, aptitude, intelligence, or interest;
   h. Teaching, or any other items or services associated with, recreational activities such as: art; dance; horse riding; music; swimming; or teaching you how to play.

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

11. **Excess Charges from Out-of-Plan Providers.** Charges from Out-of-Plan Providers that exceed eligible Charge(s).

12. **Experimental or Investigational Services**
    a. A Service is experimental or investigational for a Member's condition if any of the following statements apply at the time the Service is or will be provided to the Member. The Service:
        i. has not been approved or granted by the U.S. Food and Drug Administration (FDA); or
        ii. is the subject of a current new drug or new device application on file with the FDA; or
        iii. is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner that is intended to determine the safety, toxicity, or efficacy of the Service; or
        iv. is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity, or efficacy as among its objectives; or
        v. is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research on the safety, toxicity, or efficacy of Services; or
        vi. has not been recommended for coverage by the Interregional New Technology Committee, the Medical Technology Assessment Team, or any committees reviewing new technologies within Kaiser Permanente, based on analysis of clinical studies and literature for safety and appropriateness, unless otherwise covered by Health Plan; or,
        vii. is provided pursuant to informed consent documents that describe the Service as experimental or investigational or in other terms that indicate that the Service is being looked at for its safety, toxicity, or efficacy; or
        viii. is part of a prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that (A) use of the Service should be substantially confined to research settings or (B) further research is needed to determine the safety, toxicity, or efficacy of the Service.

    b. In determining whether a Service is experimental or investigational, the following sources of information will be solely relied upon:
        i. The Member's medical records; and
        ii. The written protocol(s) or other document(s) under which the Service has been or will be provided; and
        iii. Any consent document(s) the Member or the Member's representative has executed or will be asked to execute to receive the Service; and
        iv. The files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body; and
        v. The published authoritative medical or scientific literature on the Service as applied to the Member's illness or injury; and
        vi. Regulations, records, applications and other documents or actions issued by, filed with, or taken by the FDA, or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

    c. If two (2) or more Services are part of the same plan of treatment or diagnosis, all of the Services are excluded if one of the Services is experimental or investigational.

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

    Note: For non-grandfathered health plans only, this exclusion does not apply to Services covered under "Clinical Trials" in the "Benefits/Coverage (What is Covered)" section.

13. **Genetic Testing and Gene Therapy.** Genetic testing and gene therapy, unless determined to be: Medically Necessary; and you meet Utilization Management Program Criteria.

14. **Intermediate Care.** Care in an intermediate care facility.

15. **Residential Care.** Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Residential Treatment Center, a Skilled Nursing Facility, or inpatient respite care covered in the "Hospice Care" section.

16. **Routine Foot Care Services.** Routine foot care Services that are not Medically Necessary.

17. **Services for Members in the Custody of Law Enforcement Officers.** Out-of-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as out-of-Plan Emergency Services or urgent care outside the Service Area.

18. **Services Not Available in our Service Area.** Services not generally and customarily available in our Service Area, except when it is a generally accepted medical practice in our Service Area to refer patients outside our Service Area for the Service.

19. **Services Related to a Non-Covered Service.** When a Service is not covered, all Services related to the non-covered Service are excluded. This does not include Services we would otherwise cover to treat complications as a result of the non-covered Service.

20. **Services that Are the Subject of an Out-of-Plan Provider's Notice and Consent.** Amounts owed to Out-of-Plan Providers when you or your authorized representative consent to waive your right against surprise billing/balance billing (unexpected medical bills) under applicable state or federal law.

21. **Third Party Requests or Requirements.** Physical exams, tests, or other services that do not directly treat an actual illness, injury, or condition, and any related reports or paperwork in connection with third party requests or requirements, including but not limited to those for:
    a. Employment;
    b. Participation in employee programs;
    c. Insurance;
    d. Disability;
    e. Licensing;
    f. School events, sports, or camp;
    g. Governmental agencies;
    h. Court order, parole, or probation;
    i. Travel.

22. **Travel and Lodging Expenses.** Travel and lodging expenses are excluded. We may pay certain expenses we preauthorize in accordance with our internal travel and lodging guidelines in some situations, when a Plan Provider refers you to an Out-of-Plan Provider outside our Service Area as described under "Access to Other Providers" in the "How to Access Your Services and Obtain Approval of Benefits" section.

23. **Unclassified Medical Technology Devices and Services.** Medical technology devices and Services which have not been classified as durable medical equipment or laboratory by a National Coverage Determination (NCD) issued by the Centers for Medicare & Medicaid Services (CMS), unless otherwise covered by Health Plan.

24. **Weight Management Facilities.** Services received in a weight management facility.

25. **Workers' Compensation or Employer's Liability.** If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide Services obtained at a Kaiser facility. We will not cover any workers compensation services obtained at contracted or non-contracted providers. Any workers' compensation services provided or paid for by the health plan are subject to your obligation to reimburse us to the extent of a payment or any other benefit, including any amount received as a settlement that you receive under applicable law.

    In addition, we or our Participating Providers will be permitted to seek reimbursement for these Services directly from the responsible employer or the government agency that administers applicable law.

B. Limitations

We will use our best efforts to provide or arrange covered Services in the event of unusual circumstances that delay or render impractical the provision of Services. Examples include: major disaster; epidemic; war; riot; civil insurrection; disability of a large share of personnel at a Plan Facility; complete or partial destruction of facilities; and labor disputes not involving Health Plan, Kaiser Foundation Hospitals or Medical Group. In these circumstances, Health Plan, Kaiser Foundation Hospitals, Medical Group and Medical Group Plan Providers will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying your care is safe and will not result in harmful health consequences.

C. Reductions

1. Coordination of Benefits (COB)

   The Services covered under this EOC are subject to Coordination of Benefit (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB guidelines below.

   This coordination of benefits (COB) provision applies when a person has health care coverage under more than one **Plan**. **Plan** is defined below.

   The order-of-benefit determination rules govern the order in which each **Plan** will pay a claim for benefits. The **Plan** that pays first is called the **Primary plan**. The **Primary plan** must pay benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary plan** is the **Secondary plan**. The **Secondary plan** may reduce the benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable expense**.

   DEFINITIONS

a. A **Plan** is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   i. **Plan** includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
   ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

   Each contract for coverage under i. or ii. is a separate **Plan**. If a **Plan** has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate **Plan**.

b. **This plan** means, in a **COB** provision, the part of the contract providing the health care benefits to which the **COB** provision applies and which may be reduced because of the benefits of other **Plans**. Any other part of the contract providing health care benefits is separate from **This plan**. A contract may apply one **COB** provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another **COB** provision to coordinate other benefits.

c. The order-of-benefit determination rules determine whether **This plan** is a **Primary plan** or **Secondary plan** when the person has health coverage under more than one **Plan**.

   When **This plan** is primary, its benefits are determined before those of any other **Plan** and without considering any other **Plan's** benefits. When **This plan** is secondary, its benefits are determined after those of another **Plan** and may be reduced because of the **Primary plan's** benefits, so that all **Plan** benefits do not exceed 100% of the total **Allowable expense**.

d. **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any **Plan** covering the person. When a **Plan** provides benefits in the form of services, the reasonable cash value of each service will be considered an **Allowable expense** and a benefit paid. An expense that is not covered by any **Plan** covering the person is not an **Allowable expense**. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **Allowable expense**.

   The following are examples of expenses that are not **Allowable expenses**:
   i. The difference between the cost of a semi-private hospital room and a private hospital room is not an **Allowable expense**, unless one of the **Plans** provides coverage for private hospital room expenses or the patient's stay is medically necessary in terms of generally accepted medical practice or the hospital does not have a semi-private room.
   ii. If a person is covered by two or more **Plans** that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an **Allowable expense**.
   iii. If a person is covered by two or more **Plans** that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an **Allowable expense**.
   iv. If a person is covered by one **Plan** that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another **Plan** that provides its benefits or services on the basis of negotiated fees, the **Primary plan's** payment arrangement shall be the **Allowable expense** for all **Plans**. However, if the provider has contracted with the **Secondary plan** to provide the benefit or service for a specific negotiated fee or payment amount that is different than the **Primary plan's** payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the **Allowable expense** used by the **Secondary plan** to determine its benefits.
   v. The amount of any benefit reduction by the **Primary plan** because a covered person has failed to comply with the **Plan** provisions is not an **Allowable expense**. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. **Claim determination period** is usually a calendar year, but a **Plan** may use some other period of time that fits the coverage of the group contract. A person is covered by a **Plan** during a portion of a **Claim determination period** if that person's coverage starts or ends during the **Claim determination period**. However, it does not include any part of a year during which a person has no coverage under **This plan**, or before the date this **COB** provision or a similar provision takes effect.

f. **Closed panel plan** is a **Plan** that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with either directly or indirectly or are employed by the **Plan**, and that limits

or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

g. **Custodial parent** means a parent awarded primary custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

ORDER-OF-BENEFIT DETERMINATION RULES

When a person is covered by two or more **Plans**, the rules for determining the order-of-benefit payment are as follows:

a. The **Primary plan** pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other **Plan**.

b.

i. Except as provided in paragraph ii, a **Plan** that does not contain a coordination of benefits provision that is consistent with these rules is always primary unless the provisions of both **Plans** state that the complying **Plan** is primary.

ii. Coverage that is obtained by virtue of being members in a group, and designed to supplement part of the basic package of benefits, may provide supplementary coverage that shall be in excess of any other parts of the **Plan** provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a **Closed panel plan** to provide out-of-network benefits.

c. A **Plan** may consider the benefits paid or provided by another **Plan** in determining its benefits only when it is secondary to that other **Plan**.

d. Each **Plan** determines its order-of-benefits using the first of the following rules that apply:

i. Non-Dependent or Dependent. The **Plan** that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is the **Primary plan** and the **Plan** that covers the person as a dependent is the **Secondary plan**. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the **Plan** covering the person as a dependent; and primary to the **Plan** covering the person as other than a dependent (e.g. a retired employee); then the order-of-benefits between the two **Plans** is reversed so that the **Plan** covering the person as an employee, member, subscriber or retiree is the **Secondary plan** and the other **Plan** is the **Primary plan**.

ii. Dependent Child Covered Under More Than One **Plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one **Plan**, the order-of-benefits is determined as follows:

A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The **Plan** of the parent whose birthday (month and day) falls earlier in the calendar year is the **Primary plan**; or
2. If both parents have the same birthday, the **Plan** that has covered the parent the longest is the **Primary plan**.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the **Plan** of that parent has actual knowledge of those terms, that **Plan** is primary. This rule applies to plan years commencing after the **Plan** is given notice of the court decree;
2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph A. above shall determine the order-of-benefits;
3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph A. above shall determine the order-of-benefits; or
4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order-of-benefits for the child are as follows:
   - The **Plan** covering the **Custodial parent**;
   - The **Plan** covering the spouse of the **Custodial parent**;
   - The **Plan** covering the **non-custodial parent**; and then
   - The **Plan** covering the spouse of the **non-custodial parent**.

C. For a dependent child covered under more than one **Plan** of individuals who are not the parents of the child, the provisions of Subparagraph A. or B. above shall determine the order-of-benefits as if those individuals were the parents of the child.

iii. Active Employee or Retired or Laid-off Employee. The **Plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the **Primary plan**. The **Plan** covering that same person as a

retired or laid-off employee is the **Secondary plan**. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

iv. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another **Plan**, the **Plan** covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the **Primary plan** and the COBRA or state or other federal continuation coverage is the **Secondary plan**. If the other **Plan** does not have this rule, and as a result, the **Plans** do not agree on the order-of-benefits, this rule is ignored. This rule does not apply if the rule labeled d.1. can determine the order-of-benefits.

v. Longer or Shorter Length of Coverage. The **Plan** that covered the person as an employee, member, policyholder, subscriber or retiree longer is the **Primary plan** and the **Plan** that covered the person the shorter period of time is the **Secondary plan**.

vi. If the preceding rules do not determine the order-of-benefits, the **Allowable expenses** shall be shared equally between the **Plans** meeting the definition of **Plan**. In addition, **This plan** will not pay more than it would have paid had it been the **Primary plan**.

EFFECT ON THE BENEFITS OF THIS PLAN

a. When **This plan** is secondary, it may reduce its benefits so that the total benefits paid or provided by all **Plans** during a plan year are not more than the total **Allowable expenses**. In determining the amount to be paid for any claim, the **Secondary plan** will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any **Allowable expense** under its **Plan** that is unpaid by the **Primary plan**. The **Secondary plan** may then reduce its payment by the amount so that, when combined with the amount paid by the **Primary plan**, the total benefits paid or provided by all **Plans** for the claim do not exceed the total **Allowable expense** for that claim. In addition, the **Secondary plan** shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

b. If a covered person is enrolled in two or more **Closed panel plans** and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one **Closed panel plan**, **COB** shall not apply between that **Plan** and other **Closed panel plans**.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these **COB** rules and to determine benefits payable under **This plan** and other **Plans**. We may get the facts we need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under **This plan** and other **Plans** covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under **This plan** must give Health Plan any facts we need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

If the amount of the payments made by Health Plan is more than it should have paid under this **COB** provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

2. Injuries or Illnesses Alleged to be Caused by Other Parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under applicable law. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by applicable law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused

by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, personal injury, medical payments and all other first party types.

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

The Phia Group, LLC.
40 Pequot Way
Canton, MA 02021
Fax: 781-848-1154

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us directly. You may not agree to waive, release, reduce or, in any other manner, take action that may affect our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights under applicable law to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

3. Surrogacy Arrangements: Traditional or Gestational Carriers
In situations where you receive monetary compensation to act as either a traditional or gestational surrogate, Health Plan will seek reimbursement for covered Services you receive that are associated with conception, pregnancy and/or delivery of the child, except that we will recover no more than half of the monetary compensation you receive. A surrogate arrangement is one in which an individual agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. This section applies to any person who is impregnated by artificial insemination, intrauterine insemination, in vitro fertilization or through the surgical implantation of a fertilized egg of another person and applies to both traditional surrogacy and gestational carriers.

Note: This "Surrogacy Arrangements: Traditional or Gestational Carriers" section does not affect your obligation to pay your Copayment, Coinsurance, and/or Deductible for these Services.

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

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

You must send this information to:

The Phia Group, LLC.
40 Pequot Way
Canton, MA 02021
Fax: 781-848-1154

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements"

section and to satisfy those rights. You may not agree to waive, release, reduce, or in any other manner, take action that may affect our rights under this "Surrogacy Arrangements" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent under applicable law as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call Member Services.

Note: A baby born under a Surrogacy Arrangement does not have health coverage rights under the surrogate's health coverage. The intended parents of a child born under a Surrogacy Arrangement will need to arrange for health coverage for the newborn.

V. MEMBER PAYMENT RESPONSIBILITY

Information on Member payment responsibility, including applicable Deductibles, annual Out-of-Pocket Maximum, Copayments, and Coinsurance, can be found in the "Schedule of Benefits (Who Pays What)." Payment responsibility information for Emergency Services and urgent care can be found in the "Benefits/Coverage (What is Covered)" section. For additional questions, contact **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe them for covered Services. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments, or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

For Emergency Services (including Post Stabilization Care that federal law and state law define as Emergency Services) provided by an Out-of-Plan Provider, your Deductible, Copayment and/or Coinsurance, as applicable, will be the same amount or percentage, as applicable, as they would be for Emergency Services provided by a Plan Provider pursuant to applicable state law or, if state law is inapplicable, then federal law. In addition, in the event that an Out-of-Plan Provider provides Ancillary Services at a Plan Provider, then your Deductible, Copayment and/or Coinsurance shall be calculated as required by applicable state law or, if state law is inapplicable, then federal law. In addition, if you (or your authorized representative) consent to the provision of Services by an Out-of-Plan Provider, then we will not pay for such Services, and the amount you pay will not count toward satisfaction of the Deductible, if any, or the Out-of-Pocket Maximum(s).

VI. CLAIMS PROCEDURE (HOW TO FILE A CLAIM)

Plan Providers submit claims for payment for covered Services directly to Health Plan. For general information on claims, and how to submit pre-service claims, concurrent care claims, and post-service claims, see the "Appeals and Complaints" section. For covered Services by Out-of-Plan Providers, you may need to submit a claim on your own. Contact **Member Services** for more information on how to submit such claims. Health Plan complies with the time frames for resolution and payment of filed claims as required by state law.

You may file a claim (request for payment/reimbursement):

- by signing in to kp.org, completing an electronic form, and uploading supporting documentation;
- by mailing a paper form that can be obtained by visiting kp.org/formsandpubs or calling Member Services; or
- if you are unable to access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claims:
  1. Member/patient name and Medical Record Number
  2. The date you received the Services
  3. Where you received the Services
  4. Who provided the Services
  5. Why you think we should pay for the Services
  6. A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services.

  Mailing address to submit your claim:

  Kaiser Permanente
  National Claims Administration - Colorado
  P.O. Box 373150
  Denver, CO 80237-3150

VII. GENERAL POLICY PROVISIONS

A. Access Plan

Colorado law requires that an Access Plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider Services. To obtain a copy, please call **Member Services**.

B. Access to Services for Foreign Language Speakers

1. **Member Services** will provide a telephone interpreter to assist Members who speak limited or no English.
2. Plan Providers have telephone access to interpreters in over 150 languages.
3. Plan Providers can also request an onsite interpreter for an appointment, procedure, or Service.
4. Any interpreter assistance we arrange or provide will be at no charge to the Member.

C. Administration of Agreement

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

D. Advance Directives

Federal law requires Kaiser Permanente to tell you about your right to make health care decisions.

Colorado law recognizes the right of an adult to accept or reject medical treatment, artificial nourishment and hydration, and cardiopulmonary resuscitation.

Each adult has the right to establish, in advance of the need for medical treatment, any directives and instructions for the administration of medical treatment in the event the person lacks the decisional capacity to provide informed consent to or refusal of medical treatment. (Colorado Revised Statutes, Section 15-14-504)

Kaiser Permanente will not discriminate against you whether or not you have an advance directive. We will follow the requirements of Colorado law respecting advance directives. If you have an advance directive, please give a copy to the Kaiser Permanente medical records department or to your provider.

A health care provider or health care facility shall provide for the prompt transfer of the principal to another health care provider or health care facility if such health care provider or health care facility wishes not to comply with an agent's medical treatment decision on the basis of policies based on moral convictions or religious beliefs. (Colorado Revised Statutes, Section 15-14-507)

Two (2) brochures are available: *Your Right to Make Health Care Decisions* and *Making Health Care Decisions*. For copies of these brochures or for more information, please call **Member Services**.

E. Agreement Binding on Members

By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

F. Amendment of Agreement

Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

G. Applications and Statements

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

H. Assignment

You may assign, in writing, payments due under the policy to a licensed hospital, other licensed health care provider, an occupational therapist, or a massage therapist, for covered Services provided to you. You may not assign this EOC or any other rights, interests, or obligations hereunder without our prior written consent.

I. Attorney Fees and Expenses

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

J. Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this EOC. We have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC. If this EOC is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this EOC.

K. Contracts with Plan Providers

Plan Providers are paid in a number of ways, including: salary; capitation; per diem rates; case rates; fee for service; and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please call **Member Services**.

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from Out-of-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered Services you receive from that provider, in excess of any applicable Deductibles, Copayments, and/or Coinsurance amounts, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

We may seek payment for any claims paid to Plan Providers for Services rendered after termination of your enrollment.

L. Deductible/Out-of-Pocket Maximum Takeover Credit

Deductible/Out-of-Pocket Maximum Takeover Credit is a one-time event which may occur at the point of the initial open enrollment. It applies only to:

1. Members of new groups enrolling with Kaiser Foundation Health Plan of Colorado for the first time. (In this situation, Members must have been covered under one of the group's other carriers at the time of the group's enrollment.).
2. Members of new or current groups who move from non-sole carrier status to sole-carrier status with Kaiser Foundation Health Plan of Colorado. Non-sole carrier status refers to when an employee has the option of choosing a group health plan either through Kaiser Foundation Health Plan of Colorado or through another carrier. (In this situation, Members must have been covered under one of the group's other carriers at the time the group moved to sole-carrier status.).

A credit may be applied toward your Deductible with Health Plan for certain eligible expenses accumulated toward your deductible under your prior coverage. You may also be eligible for a credit to be applied toward your Out-of-Pocket Maximum accumulated under your prior coverage. In order for expenses to be considered for this credit, you must submit an Explanation of Benefits ("EOB") issued by your prior carrier showing that the expense was applied toward your deductible and/or out-of-pocket maximum under your prior coverage. All such expenses must be for Services that are covered and subject to the Deductible and/or Out-of-Pocket Maximum under this EOC.

For groups with effective dates of coverage during the months of April through December, expenses incurred from January 1 of the current year through the effective date of coverage with Kaiser Foundation Health Plan of Colorado may be eligible for credit.

For groups with effective dates of coverage during the months of January through March, expenses incurred up to 90 days prior to the effective date of coverage with Kaiser Foundation Health Plan may be eligible for credit.

You must submit all claims for Deductible/Out-of-Pocket Maximum Takeover Credit within 90 days from the effective date of coverage with Health Plan. To submit a claim, send all EOBs along with a completed Prior Carrier Information Cover Form to the **Kaiser Permanente Claims Department.** To get a copy of the Prior Carrier Information Cover Form, please call the **Claims Department**.

M. Genetic Testing Information

In accordance with state law: (1) Information derived from genetic testing shall be confidential and privileged. Any release, for purposes other than diagnosis, treatment, or therapy, of genetic testing information that identifies the person tested with the test results released requires specific written consent by the person tested. (2) Any entity that receives information derived from genetic testing may not seek, use, or keep the information for any nontherapeutic purpose or for any underwriting purpose connected with the provision of group disability insurance or long-term care insurance coverage.

N. Governing Law

Except as preempted by federal law, this EOC will be governed in accordance with Colorado law. Any provision that is required to be in this EOC by state or federal law shall bind Members and Health Plan whether or not set forth in this EOC.

O. Group and Members are not Health Plan's Agents

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

P. No Waiver

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

Q. Nondiscrimination

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

R. Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Members who move should call **Member Services** as soon as possible to give us their new address.

S. Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment, or from any person or organization obligated to pay for the Services.

T. Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You generally may access and receive copies of your PHI, update or amend your PHI, and ask us for an accounting of certain disclosures of your PHI. You also may request delivery of confidential communications to a location other than your usual address or by alternate means.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, such as quality improvement. Sometimes we may be required by law to disclose PHI to others, such as government agencies or pursuant to judicial actions. Kaiser Permanente will not use or disclose your PHI for any other purpose without your (or your representative's) authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* provides additional information about our privacy practices and your rights regarding your PHI and will be provided to you upon request. To request a paper copy, please call Member Services. You can also find the notice at a Kaiser Permanente Medical Office Building or on our website, kp.org.

U. Value-Added Services

In addition to the Services we cover under this EOC, we make available a variety of value-added services. Value-added services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

1. Certain health education classes not covered by your plan;
2. Certain health education publications;
3. Discounts for fitness club memberships;
4. Health promotion and wellness programs; and
5. Rewards for participating in those programs.

Some of these value-added services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

1. Show your Health Plan ID card, and
2. Pay the fee, if any,

to the company that provides the value-added service. Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as Deductible or Out-of-Pocket Maximum.

To learn about value-added services and which ones are available to you, please check our website, kp.org.

These value-added services are neither offered nor guaranteed under your Health Plan coverage. Health Plan may change or discontinue some or all value-added services at any time and without notice to you. Value-added services are not offered as inducements to purchase a health care plan from us. Although value-added services are not covered by your plan, we may have included an estimate of their cost when we calculated Premiums.

Health Plan does not endorse or make any representations regarding the quality or medical efficacy of value-added services, or the financial integrity of the companies offering them. We expressly disclaim any liability for the value-added services provided by these companies. If you have a dispute regarding a value-added service, you must resolve it with the company offering such service. Although Health Plan has no obligation to assist with this resolution, you may call **Member Services**, and a representative may try to assist in getting the issue resolved.

V. Women's Health and Cancer Rights Act

In accordance with the "Women's Health and Cancer Rights Act of 1998," as determined in consultation with the attending physician and the patient, we provide the following coverage after a mastectomy:

1. Reconstruction of the breast on which the mastectomy was performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical (balanced) appearance.
3. Prostheses (artificial replacements).
4. Services for physical complications resulting from the mastectomy.

VIII. TERMINATION/NONRENEWAL/CONTINUATION

Your Group is required to inform the Subscriber of the date coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. Dependents' memberships end at the same time the Subscriber's membership ends. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under "Termination of Group Agreement" in this "Termination/Nonrenewal/Continuation" section.

This section describes: how your membership may end; and explains how you may maintain Health Plan coverage if your membership under this EOC ends.

A. Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements in the "Eligibility" section, we or your Group will provide 30 days' advance written notice of termination.

B. Termination of Group Agreement

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

If your Group's Agreement terminates for reasons other than nonpayment of Premiums, fraud or abuse, while you are inpatient in a hospital or institution, your coverage will continue until your date of discharge.

C. Termination for Cause

We may terminate the memberships in your Family Unit if anyone in your Family Unit commits any of the following acts.

1. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You are disruptive, unruly, or abusive so that Health Plan's or a Plan Provider's ability to provide Services to you, or to other Members, is seriously impaired; or
   b. You fail to establish and maintain a satisfactory provider-patient relationship, after the Plan Provider has made reasonable efforts to promote such a relationship; or
2. We will send written notice that will include the reason for termination to the Subscriber at least 30 days before the termination date if:
   a. You knowingly: (a) misrepresent enrollment eligibility information or membership status; (b) present an invalid prescription or physician order; (c) misuse (or let someone else misuse) a Health Plan ID card; or (d) commit any other type of fraud in connection with your membership (including your enrollment application), Health Plan or a Plan Provider; or
   b. You knowingly: furnish incorrect or incomplete information to us; or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits.

Termination of membership for any one of these reasons applies to all members of your Family Unit. All rights to benefits cease on the date of termination. You will be billed as a non-Member for any Services received after the termination date. You have the right to appeal such a termination. To appeal, please call **Member Services**; or you can call the Colorado Division of Insurance.

We may report any member fraud to the authorities for prosecution. We may also pursue appropriate civil remedies.

D. Termination for Nonpayment

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

After termination of your enrollment for nonpayment of Premiums, Health Plan may require payment of any outstanding Premiums for prior coverage if permitted by applicable law.

E. Termination of a Product or all Products (applies to non-grandfathered health plans only)

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's Agreement by sending you written notice at least 180 days before the Agreement terminates.

F. Rescission of Membership

We may rescind your membership after it is effective if you or anyone on your behalf did one of the following with respect to your membership (or application) prior to your membership effective date:

1. Performed an act, practice, or omission that constitutes fraud; or
2. Misrepresented a material fact with intent, such as an omission on the application.

We will send written notice to the Subscriber in your Family at least 30 days before we rescind your membership. The rescission will cancel your membership so no coverage ever existed. You will be required to pay as a non-Member for any Services we covered. We will refund all applicable Premiums, less any amounts you owe us.

G. Continuation of Group Coverage Under Federal Law, State Law or USERRA

1. Federal Law (COBRA)

   You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

2. State Law

   If you are not eligible to continue uninterrupted group coverage under federal law (COBRA), you may be eligible to continue group coverage under Colorado law. Colorado law states that if you have been a Member for at least six (6) consecutive months immediately prior to termination of employment, continue to meet the eligibility requirements of Group and Health Plan and continue to pay applicable monthly Premiums to your Group, you may continue uninterrupted group coverage. If loss of eligibility occurs because of the following reasons, you and/or your Dependents may continue group coverage subject to the terms below:

   a. Your coverage is through a Subscriber who dies, divorces or legally separates, or becomes entitled to Medicare or Medicaid benefits; or
   b. You are a Subscriber (or your coverage is through a Subscriber) whose employment terminates, including voluntary termination or layoff, or whose hours of employment have been reduced.

   You may enroll children born or placed for adoption with you during the period of continuation coverage. The enrollment and effective date shall be as specified under the "Eligibility" section.

   To continue coverage, you must request continuation of group coverage on a form furnished by and returned to your Group along with payment of applicable Premiums, no later than 30 days after the date of termination of employment.

   Termination of State Continuation Coverage. Continuation of coverage under this provision continues upon payment of the applicable Premiums to your Group and terminates on the earlier of:

   a. 18 months after your coverage would have otherwise terminated because of termination of employment; or
   b. The date you become covered under another group medical plan; or
   c. The date Health Plan terminates its contract with the Group.

   We may terminate your continuation coverage if payment is not received when due.

   If you have chosen an alternate health care plan offered through your Group but elect during open enrollment to receive continuation coverage through Health Plan, you will only be entitled to continued coverage for the remainder of the 18-month maximum coverage period.

3. USERRA

   If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

H. Moving Outside of our Service Area

If you move to an area not within any Kaiser regional health plan service area, your membership may be terminated. We will provide you with thirty (30) days' notice of termination which will include the reason for termination.

I. Moving to Another Kaiser Regional Health Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser regional health plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this plan, but you may be able to transfer your group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, Deductibles, Copayments, Coinsurance, and Out-of-Pocket Maximum limits may not be the same in the other service area.

IX. APPEALS AND COMPLAINTS

A. Claims and Appeals

Health Plan will review claims and appeals, and we may use medical experts to help us review them. The following terms have the following meanings when used in this "Appeals and Complaints" section:

1. A **claim** is a request for us to:
   a. provide or pay for a Service that you have not received (pre-service claim),
   b. continue to provide or pay for a Service that you are currently receiving (concurrent care claim), or
   c. pay for a Service that you have already received (post-service claim).

2. An **adverse benefit determination** is our decision to do any of the following:
   a. deny your claim, in whole or in part, including (1) a denial, in whole or in part, of a pre-service claim (preauthorization for a Service), a concurrent care claim (continue to provide or pay for a Service that you are currently receiving) or a post-service claim (a request to pay for a Service) in whole or in part; (2) a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not provided in or at the appropriate health care setting or level of care; or, (3) a denial of a request for Services on the ground that the Service is experimental or investigational,
   b. terminate your membership retroactively except as the result of non-payment of Premiums (also called rescission or cancellation retroactively),
   c. deny your (or, if applicable, your dependent's) application for individual plan coverage,
   d. uphold our previous adverse benefit determination when you appeal.

   In addition, when we deny a request for medical care because it is excluded under this EOC, and you present evidence from a Colorado medical professional that there is a reasonable medical basis that the contractual exclusion does not apply to the denied medical care, then our denial shall be considered an adverse benefit determination.

3. An **appeal** is a request for us to review our initial adverse benefit determination.

If you miss a deadline for making a claim or appeal, we may decline to review it.

Except when simultaneous external review can occur, you must exhaust the internal claims and appeals procedure as described in this "Appeals and Complaints" section unless we fail to follow the claims and appeals process described in this Section IX.

Language and Translation Assistance
You may request language assistance with your claim and/or appeal by calling **Member Services**.

SPANISH (Español): Para obtener asistencia en Español, llame al 303-338-3800.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-338-3800.
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 303-338-3800.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-338-3800.

Appointing a Representative
If you would like someone (including your provider (medical facility or health care professional)) to act on your behalf regarding your claim, you may appoint an authorized representative. You must make this appointment in writing. Please contact **Member Services** for information about how to appoint a representative. You must pay the cost of anyone you hire to represent or help you.

Help with Your Claim and/or Appeal
You may contact the Colorado Division of Insurance at:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202
(303) 894-7499

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 may request our Authorization for Release of Appeal Information form by calling **Member Services**.

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 **Member Services**.

Providing Additional Information Regarding Your Claim and/or Appeal
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, if you ask for one. Please send all additional information to the Department that issued the adverse benefit determination.

When you appeal, you may give testimony in writing or by telephone. Please send your written testimony to **Member Relations**. To arrange to give testimony by telephone, you should contact **Member Services**.

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

If we believe that your appeal of our initial adverse benefit determination will be denied, then before we issue our next 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 next decision, that decision will be based on the information already in your claim file.

Internal Claims and Appeals Procedures

There are several types of claims, and each has a different procedure described below for sending your claim and appeal to us as described in this Internal Claims and Appeals Procedures section:

1. Pre-service claims (urgent and non-urgent)
2. Concurrent care claims (urgent and non-urgent)
3. Post-service claims

In addition, there is a separate appeals procedure for adverse benefit determinations due to a retroactive termination of membership (rescission) or a denial of an application for individual plan coverage.

When you file an appeal, we will review your claim without regard to our previous adverse benefit determination. The individual who reviews your appeal will not have participated in our original decision regarding your claim nor will the reviewer be the subordinate of someone who did participate in our original decision.

1. Pre-Service Claims and Appeals

   Pre-service claims are requests that we provide or pay for a Service that you have not yet received. Failure to receive Authorization before receiving a Service that must be authorized or pre-certified in order to be a covered Service may be the basis for our denial of your pre-service claim. If you receive any of the 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 **Member Services**.

   Here are the procedures for filing a pre-service claim, a non-urgent pre-service appeal, and an urgent pre-service appeal.

   a. Pre-Service Claim

      Tell Health Plan in writing that you want us to provide or pay for a Service you have not yet received. Your request and any related documents you give us constitute your claim. You must either mail or fax your claim to **Utilization Management**.

      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 if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; 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 may, but are not required to, waive the requirements related to an urgent claim and appeal, to permit you to pursue an expedited external review.

      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, so long as we notify you prior to the expiration of the initial 15-day period and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information within 15 days of receiving your claim, 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 all of the information that you send us when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

      We will send written notice of our decision to you and, if applicable to your provider. Please let us know if you wish to have our decision sent to your provider.

      If your pre-service claim was considered on an urgent basis, we will notify you of our decision (whether adverse or not) 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 three (3) days after that.

If we deny your claim (if we do not agree to provide or pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. 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 or fax your appeal to **Member Relations**.

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally, please contact **Member Services**. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

We will review your appeal and send you a written decision within a reasonable period of time that is appropriate given your medical condition but not more than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

c. 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 may submit your appeal orally to **Member Services**, by mail or by fax to **Member Relations**.

When you send your appeal, you may also request simultaneous external review of our initial adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section), if our internal appeal decision is not in your favor.

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat your appeal as non-urgent. Generally, an appeal is urgent only if using the procedure for non-urgent appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function or if you have a physical or mental disability, creates an imminent and substantial limitation on your existing ability to live independently; 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 may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

We will review your appeal and give you oral or written notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your appeal. If we notify you of our decision orally, we will send you a written confirmation within three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

2. Concurrent Care Claims and Appeals.

Concurrent care claims are requests that Health Plan continue to provide, or pay for, an ongoing course of covered treatment or Services for a period of time or number of treatments or Services, when the course of treatment already being received will end. If you have any general questions about concurrent care claims or appeals, please call **Member Services**.

Unless you are appealing an urgent care concurrent claim, 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 then appeal our decision (an adverse benefit determination), then during the time that we are

considering your appeal, you may continue to receive the authorized Services. If you continue to receive these Services while we consider your appeal and your appeal does not result in our approval of your concurrent care claim, then we will only pay for the continuation of Services until we notify you of our appeal decision.

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

a. 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 or fax your claim to **Utilization Managment**.

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 if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; 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 may, but are not required to, waive the requirements related to an urgent claim or an appeal thereof, to permit you to pursue an expedited external review.

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 (that is, within 24 hours of receipt of your claim). If your authorized care ended before you submitted your claim, we will make our decision within a reasonable period of time 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-days end and explain why we need the extra time and when we expect to make a decision. 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 45 days that we gave you for sending the additional information.

We will send written notice of our decision to you and, if applicable to your provider, upon request. Please let us know if you wish to have our decision sent 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 three (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 or Services), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. 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 either mail or fax your appeal to **Member Relations**.

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally, please contact **Member Services**. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

We will review your appeal and send you a written decision as soon as possible if you care has not ended but not later than 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination decision will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

c. Urgent Concurrent Care Appeal

Tell us that you want to urgently appeal our adverse benefit determination regarding your urgent concurrent claim. Please include the following: (1) your name and Medical Record Number, (2) your medical condition or symptoms, (3) the ongoing course of covered treatment that you want to continue or extend, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) all supporting documents. Your request and the supporting documents constitute your appeal. You may submit your appeal orally to **Member Services**, by mail or by fax to **Member Relations**.

When you send your appeal, you may also request simultaneous external review of our adverse benefit determination. If you want simultaneous external review, your appeal must tell us this. You will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you do not request simultaneous external review in your appeal, then you may be able to request external review after we make our decision regarding your appeal (see "External Review" in this "Appeals and Complaints" section).

We will decide whether your appeal is urgent or non-urgent unless your attending health care provider tells us your appeal is urgent. If we determine that your appeal is not urgent, we will treat 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 if you have a physical or mental disability, create an imminent and substantial limitation on your existing ability to live independently; or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without continuing your course of covered treatment. We may, but are not required to, waive the requirements related to an urgent appeal to permit you to pursue an expedited external review.

You do not have the right to attend or have counsel, advocates and health care professionals in attendance at the expedited review. You are, however, entitled to submit written comments, documents, records and other materials for the reviewer or reviewers to consider; and receive, upon request and free of charge, copies of all documents, records and other information regarding your request for benefits.

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 three (3) days after that.

If we deny your appeal, our adverse benefit determination notice will tell you why we denied your appeal and will include information about any further process, including external review, that may be available to you.

3. Post-Service Claims and Appeals

Post-service claims are requests that we for pay for Services you already received, including claims for out-of-Plan Emergency Services or urgent care Services. If you have any general questions about post-service claims or appeals, please call **Member Services**.

Here are the procedures for filing a post-service claim and a post-service appeal:

a. Post-Service Claim

Within twelve (12) months from the date you received the Services, mail us a letter explaining the Services for which you are requesting payment. Provide us with the following: (1) the date you received the Services, (2) where you received them, (3) who provided them, and (4) why you think we should pay for the Services. You must include a copy of the bill, your medical record(s) and any supporting documents. Your letter and the related documents constitute your claim. Or, you may contact **Member Services** to obtain a claims form. You must either mail or fax your claim to the **Claims Department**.

We will not accept or pay for claims received from you after twelve (12) months from the date of Services.

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 15 days after we receive your claim and explain the circumstances for which we need the extra time and when we expect to make a decision. If we tell you we need more information, we will ask you for the information, and we will give you 45 days to send us the information. We will make a decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after we send our request, we will make a decision based on the information we have within 15 days following the end of the 45-day period.

If we deny your claim (if we do not pay for all the Services you requested), our adverse benefit determination notice will tell you why we denied your claim and how you can appeal.

b. 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 Services that you want us to pay for, (4) all of the reasons why you disagree with our adverse benefit determination, and (5) include all supporting documents such as medical records. Your request and the supporting documents constitute your appeal. You must either mail or fax your appeal to **Member Relations**.

You have the right to provide additional information regarding your appeal. You may provide this information either verbally or in writing, but you are not required to do so. If you would like to provide additional information verbally, please contact Member Services. If you would like to provide additional written documentation, please fax or mail this information to **Member Relations**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination will tell you why we denied your appeal and will include information regarding any further process, including external review, that may be available to you.

Voluntary Second Level of Appeal
Within 60 days after you receive our adverse decision regarding your appeal, you may ask us to review our adverse benefit decisions again. We will schedule a review of your second appeal within 60 days of receiving your request, and we will notify you about the date and time of this review no less than 20 days before it occurs. You have the right to request a postponement. You have the right to appear in person or by telephone conference at the meeting. We will make our decision within 7 days of the completion of this meeting.

Appeals of Retroactive Membership Termination (rescission or cancellation retroactively)
We may terminate your membership retroactively (see "Rescission of Membership" under the "Termination/Nonrenewal/Continuation" section). We will send you written notice at least 30 days prior to the termination. If you have general questions about retroactive membership terminations or appeals, please call **Member Services**.

Here is the procedure for filing an appeal of a retroactive membership termination:

Within 180 days after you receive our adverse benefit determination that your membership will be terminated retroactively, you must tell us in writing that you want to appeal our termination of your membership retroactively. Please include the following: (1) your name and Medical Record Number, (2) all of the reasons why you disagree with our retroactive membership termination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to **Membership Administration**.

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination 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.

Appeals of Denial of Individual Plan Application
Here is the procedure for filing an appeal of our denial of an individual plan application:

Within 180 days after you receive our adverse benefit determination regarding your individual plan application, you must tell us in writing that you want to appeal our denial of an individual plan application. Please include the following: (1) your name and application reference number, (2) all of the reasons why you disagree with our adverse benefit determination, and (3) all supporting documents. Your request and the supporting documents constitute your appeal. You must mail your appeal to:

Member Services
P.O. Box 23127
San Diego, CA 92193

We will review your appeal and send you a written decision within 30 days after we receive your appeal.

If we deny your appeal, our adverse benefit determination 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.

External Review
Following receipt of an adverse decision letter regarding your First Level Appeal or Voluntary Second Level Appeal, you may have a right to request an external review.

You have the right to request an independent external review of our decision if our decision involves an adverse benefit determination regarding a denial of a claim, in whole or in part, that (1) is a denial of a preauthorization for a Service; (2) is a denial of a request for Services on the ground that the Service is not Medically Necessary, appropriate, effective or efficient or is not

provided in or at the appropriate health care setting or level of care; (3) is a denial of a request for Services on the ground that the Service is experimental or investigational; (4) concludes that parity exists in the non-quantitative treatment limitations applied to behavioral health care (mental health and/or substance abuse) benefits; or, (5) involves consideration of whether we are complying with federal law and state law requirements regarding balance (surprise) billing and/or cost sharing protections pursuant to the No Surprises Act (Public Health Service Act sections 2799A-1 and 2799A-2 and 45 C.F.R. §§149.110 --149.130). If our final adverse decision does not involve an adverse benefit determination described in the preceding sentence, then your claim is **not** eligible for external review provided, however, independent external review is available when we deny your appeal because you request medical care that is excluded under your Kaiser Permanente plan and you present evidence from a licensed Colorado professional that there is a reasonable medical basis that the exclusion does not apply.

You will not be responsible for the cost of the external review. There is no minimum dollar amount for a claim to be eligible for an external review.

To request external review, you must:

1. Submit a completed Independent External Review of Carrier's Final Adverse Determination form which will be included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Member Services** to request a copy of this form) to **Member Relations** within four (4) months of the date of receipt of the mandatory internal appeal decision or Voluntary Second Level Appeal decision. We shall consider the date of receipt for our notice to be three (3) days after the date on which our notice was drafted, unless you can prove that you received our notice after the three (3) day period ends.
2. Include in your written request a statement authorizing us to release your claim file with your health information including your medical records; or, you may submit a completed Authorization for Release of Appeal Information form which is included with the mandatory internal appeal decision letter and explanation of your appeal rights (you may call **Member Services** to request a copy of this form).

If we do not receive your external review request form and/or authorization form to release your health information, then we will not be able to act on your request. We must receive all of this information prior to the end of the applicable timeframe (4 months) for your request of external review.

Expedited External Review

You may request an expedited review if (1) you have a medical condition for which the timeframe for completion of a standard review would seriously jeopardize your life, health, or ability to regain maximum function, or, if you have a physical or mental disability, would create an imminent and substantial limitation to your existing ability to live independently, or (2) in the opinion of a physician with knowledge of your medical condition, the timeframe for completion of a standard review would subject you to severe pain that cannot be adequately managed without the medical services that you are seeking. A request for an expedited external review must be accompanied by a written statement from your physician that your condition meets the expedited criteria. You must include the physician's certification that you meet expedited external review criteria when you submit your request for external review along with the other required information (described, above).

Additional Requirements for External Review regarding Experimental or Investigational Services

You may request external review or expedited external review involving an adverse benefit determination based upon the Service being experimental or investigational. Your request for external review or expedited external review must include a written statement from your physician that either (a) standard health care services or treatments have not been effective in improving your condition or are not medically appropriate for you, or (b) there is no available standard health care service or treatment covered under this EOC that is more beneficial than the recommended or requested health care service (the physician must certify that scientifically valid studies using accepted protocols demonstrate that the requested health care service or treatment is more likely to be more beneficial to you than an available standard health care services or treatments), and the physician is a licensed, board-certified, or board-eligible physician to practice in the area of medicine to treat your condition. If you are requesting expedited external review, then your physician must also certify that the requested health care service or treatment would be less effective if not promptly initiated. These certifications must be submitted with your request for external review.

No expedited external review is available when you have already received the medical care that is the subject of your request for external review. If you do not qualify for expedited external review, we will treat your request as a request for standard external review.

After we receive your request for external review, we shall notify you of the information regarding the independent external review entity that the Division of Insurance has selected to conduct the external review.

If we deny your request for standard or expedited external review, including any assertion that we have not complied with the applicable requirements related to our internal claims and appeals procedure, then we may notify you in writing and include the specific reasons for the denial. Our notice will include information about your right to appeal the denial to the Division of Insurance. At the same time that we send this denial notice to you, we will send a copy of it to the Division of Insurance.

You will not be able to present your appeal in person to the independent external review organization. You may, however, send any additional information that is significantly different from information provided or considered during the internal claims and appeal procedure and, if applicable Voluntary Second Level of Appeal process. If you send new information, we may consider it and reverse our decision regarding your appeal.

You may submit your additional information to the independent external review organization for consideration during its review within five (5) working days of your receipt of our notice describing the independent review organization that has been selected to conduct the external review of your claim. Although it is not required to do so, the independent review organization may accept and consider additional information submitted after this five (5) working day period ends.

The independent external review entity shall review information regarding your benefit claim and shall base its determination on an objective review of relevant medical and scientific evidence. Within 45 days of the independent external review entity's receipt of your request for standard external review, it shall provide written notice of its decision to you. If the independent external review entity is deciding your expedited external review request, then the independent external review entity shall make its decision as expeditiously as possible and no more than 72 hours after its receipt of your request for external review and within 48 hours of notifying you orally of its decision provide written confirmation of its decision. This notice shall explain the external review entity's decision and that the external review decision is the final appeal available under state insurance law. An external review decision is binding on Health Plan and you except to the extent Health Plan and you have other remedies available under federal or state law. You or your designated representative may not file a subsequent request for external review involving the same Health Plan adverse determination for which you have already received an external review decision.

If the independent external review organization overturns our denial of payment for care you have already received, we will issue payment within five (5) working days. If the independent review organization overturns our decision not to authorize pre-service or concurrent care claims, Kaiser Permanente will authorize care within one (1) working day. Such covered services shall be provided subject to the terms and conditions applicable to benefits under your plan.

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 (but not the Voluntary Second Level of Appeal) for your claim before you may request external review unless we have failed to substantially comply with federal and/or state law requirements regarding our claims and appeals procedures.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedures, and if applicable, 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.

B. Complaints

1. If you are not satisfied with the Services received at a particular Plan Facility, or if you have a concern about the personnel or some other matter relating to Services and wish to file a complaint, you may do so by:
   a. Sending your written complaint to **Member Relations**; or
   b. Telephoning **Member Services**.

2. After you notify us of a complaint, this is what happens:
   a. A **Member Relations** Liaison reviews the complaint and conducts an investigation, verifying all the relevant facts.
   b. The **Member Relations** or a Plan Provider evaluates the facts and makes a recommendation for corrective action, if any.
   c. When you file a written complaint, we usually respond in writing within 30 calendar days, unless additional information is required.
   d. When you make a verbal complaint, a verbal response is usually made within 30 calendar days.

3. If you are dissatisfied with the resolution, you have the right to request a second review. Please put your request in writing to **Member Relations**. **Member Relations** will respond to you in writing within 30 calendar days of receipt of your request.

We want you to be satisfied with our Plan Facilities, Services, and Plan Providers. Using this Member satisfaction procedure gives us the opportunity to correct any problems that keep us from meeting your expectations and your health care needs. If you are dissatisfied for any reason, please let us know. Please call **Member Services**.

X. INFORMATION ON POLICY AND RATE CHANGES

Your Group's Agreement with us will change periodically. If these changes affect this EOC or your Premiums, your Group is required to notify you of them. If it is necessary to make revisions to this EOC, we will issue revised materials to you.

XI. DEFINITIONS

The following terms, when capitalized and used in any part of this EOC, have the following meaning:

Accumulation Period: As stated in the "Schedule of Benefits (Who Pays What)," the period of time during which benefits are paid and are counted toward the maximum allowed for the specific benefit.

Affiliated Provider: A licensed medical provider, other than a Medical Group or Health Plan provider, who is contracted to provide covered Services to Members under this EOC. Affiliated Providers may change during the year.

Ancillary Services: Services that are:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner
- Items and services provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services, including radiology and laboratory services
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility
- Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Out-of-Plan Provider satisfies the notice and consent requirements under federal law and state law.

Authorization: A referral request that has received approval from Health Plan.

Biologic: A drug produced from a living organism and used to treat or prevent disease.

Biosimilar: A drug highly similar to an already approved biological drug.

Charge(s):

1. For Services provided by Plan Providers or Medical Group, the charges in Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members; or
2. For Services for which a provider (other than Medical Group or Health Plan) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider; or
3. For items obtained at a Plan Pharmacy, the amount the Plan Pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the Plan Pharmacy program's contribution to the net revenue requirements of Health Plan); or
4. For Emergency Services received from Out-of-Plan Providers (including Post Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process; or
5. For all other Services received from Out-of-Plan Providers (including Post Stabilization Services that are not Emergency Services under federal law and Ancillary Services), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, including any amount determined through negotiation or an independent dispute resolution (IDR) process, or (2) in the even that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Out-of-Plan Provider and us, or absent such an agreement, the usual, customary and reasonable rate for those services as determined by us based on objective criteria.
6. For all other Services, the payments that Health Plan makes for the Services (or, if Health Plan subtracts a Copayment, Coinsurance or Deductible from its payment, the amount Health Plan would have paid if it did not subtract the Copayment, Coinsurance or Deductible).

CMS: The Centers for Medicare & Medicaid Services, the federal agency responsible for administering Medicare.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Copayment (Copay): The specific dollar amount you must pay for a covered Service, as listed in the "Schedule of Benefits (Who Pays What)."

Deductible: The amount you must pay in an Accumulation Period for certain Services before we will cover those Services in that Accumulation Period. The "Schedule of Benefits (Who Pays What)" explains the amount of the Deductible and which Services are subject to the Deductible.

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

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

1. Serious jeopardy to the health of a person or, with respect to a pregnant individual, the health of the individual or their unborn child;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

- An appropriate medical screening examination (as required under the federal Emergency Medical Treatment and Active Labor Act (section 1867 of the Social Security Act) ("EMTALA")) that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, 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, or Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment required under EMTALA (or would be required under EMTALA if EMTALA applied to an Independent Freestanding Emergency Department) to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).
- Post Stabilization Care furnished by an Out-of-Plan Provider (including a nonparticipating emergency facility) is covered as Emergency Services when federal law and state law applies AND
    - Your attending Out-of-Plan Provider determines that you are not able to travel using nonmedical transportation or nonemergency medical transportation to an available Plan Provider within a reasonable travel distance, taking into account your medical condition; or,
    - You (or your authorized representative) are not in a condition to receive, and/or to provide consent to, the Out-of-Plan Provider's notice and consent form, in accordance with applicable state law pertaining to informed consent as determined by your attending Out-of-Plan Provider using appropriate medical judgment.

Note: Once your condition is stabilized, covered Services that you receive are Post Stabilization Care and not Emergency Services EXCEPT when you receive Emergency Services from Out-of-Plan Providers AND federal law and state law require coverage of your Post Stabilization Care as Emergency Services. Post Stabilization Care is subject to all of the terms and conditions of this EOC including but not limited to prior Authorization requirements unless federal law and state law applies and defines such Post Stabilization Care as Emergency Services.

Family Unit: A Subscriber and all of their Dependents.

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

Health Plan: Kaiser Foundation Health Plan of Colorado, a Colorado nonprofit corporation.

Independent Freestanding Emergency Department: A health care facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and that provides Emergency Services.

Kaiser Permanente: The direct service medical care program conducted by Health Plan, Kaiser Foundation Hospitals, and Medical Group, together.

Kaiser Permanente Medical Office Building: An outpatient treatment facility operated and staffed by Health Plan and Medical Group. Please refer to your Provider Directory for additional information about each Medical Office Building.

Life or Limb Threatening Emergency: Any event that a prudent layperson would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Medical Group: The Colorado Permanente Medical Group, P.C., a for-profit medical corporation.

Medically Necessary services or supplies are those that are determined by Health Plan to be all of the following:

- Required to prevent, diagnose, or treat your condition or clinical symptoms; and
- In accordance with generally accepted standards of medical practice; and
- Not solely for the convenience of you, your family, and/or your provider; and
- The most appropriate level of care that can safely be provided to you.

The fact that a Plan Provider or Out-of-Plan Provider prescribes, recommends, or refers you to a Service does not make that Service Medically Necessary or covered under this EOC.

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

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

Observation Services: Outpatient hospital Services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation Services may be given in the emergency department or another area of the hospital.

Out-of-Plan Facility: Those facilities that are not contracted with, or owned by, Kaiser Permanente.

Out-of-Plan Provider: Those providers who are not contracted with, or employed by, Kaiser Permanente.

Out-of-Pocket Maximum: The annual limit to the total amount of Deductible (if any), certain Copayments, and certain Coinsurance you must pay in an Accumulation Period for covered Services, as described in the "Schedule of Benefits (Who Pays What)."

Plan Facility: A medical office, ambulatory surgery center, urgent care center, Plan Hospital, or other facility that is owned by, or contracted with, Kaiser Permanente. This does not include facilities that contract only for referral Services. Plan Facilities may change during the year.

Plan Hospital: A hospital that has contracted to provide Services under this EOC. Services available at Plan Hospitals may vary. Plan Hospitals may change during the year.

Plan Optometrist: A licensed optometrist who is an employee of Health Plan or any licensed optometrist who contracts to provide Services to Members.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Plan Pharmacies may change during the year.

Plan Provider: A licensed medical provider who is an employee of Medical Group or Health Plan, or an Affiliated Provider (but not including providers who contract only to provide referral Services). Plan Providers may change during the year.

Post Stabilization Care: Means Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your Emergency Medical Condition is Stabilized. We cover Post Stabilization Care only when (1) it is considered to be Emergency Services under federal law and state law (without prior Authorization) or, (2) we determine that such Services are Medically Necessary pursuant to a request for prior Authorization for the Service.

Premiums: Periodic membership charges paid by Group.

Residential Treatment Center: A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment. The term Residential Treatment Center does not include a provider, or that part of a provider, used mainly for:

1. Nursing care.
2. Rest care.
3. Convalescent care.
4. Care of the aged.
5. Custodial Care.
6. Educational care.

Service Area: Our Service Area consists of certain geographic areas in Colorado which we designate by county, where appropriate. Our Service Area may change. Contact Member Services for a complete listing of our Service Area counties.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is licensed as such by the state of Colorado, certified by Medicare and approved by Health Plan. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care for patients who need skilled nursing or skilled rehabilitation care, or both, on a daily basis, as part of an ongoing medical treatment plan.

Spouse: Your partner in marriage or a civil union as determined by state law.

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

Step Therapy: A protocol that requires a covered person to use a prescription drug or sequence of prescription drugs, other than the drug that the covered person's health care provider recommends for the covered person's treatment, before the carrier provides coverage for the recommended prescription drug.

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Eligibility" section).

Utilization Management Program Criteria: Evidence-based guidelines, sources, and criteria used by Health Plan to make Medical Necessity determinations.

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CHIR0AA

CHIROPRACTIC CARE

1. Coverage
   Chiropractic Services are covered as shown in the "Schedule of Benefits (Who Pays What)" when provided by Plan Providers. Coverage includes:
   a. Evaluation;
   b. Manual and manipulative therapy of the spinal and extraspinal regions.

   You may self-refer for visits to Plan Providers.

   Note: The following are covered, but not under this section: Physical therapy, see "Physical, Occupational, and Speech Therapy and Inpatient Rehabilitation Services"; X-ray and laboratory tests, see "X-ray, Laboratory, and Advanced Imaging Procedures."

2. Exclusions
   a. Hypnotherapy.
   b. Behavior training.
   c. Sleep therapy.
   d. Weight loss programs.
   e. Services related to the treatment of the musculoskeletal system, except for the spinal and extraspinal regions.
   f. Vocational rehabilitation Services.
   g. Thermography.
   h. Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices and appliances.
   i. Transportation costs. This includes local ambulance charges.
   j. Prescription drugs, vitamins, minerals, food supplements, or other similar products.
   k. Educational programs.
   l. Non-medical self-care or self-help training.
   m. All diagnostic testing related to these excluded Services.
   n. MRI and/or other types of diagnostic radiology.
   o. Massage therapy that is not a part of the manual and manipulative therapy.
   p. Durable medical equipment (DME) and/or supplies for use in the home.

This rider amends the EOC to provide coverage for chiropractic care. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

CMPL0AA

ACUPUNCTURE SERVICES

1. Coverage

   Acupuncture Services are covered as shown in the "Schedule of Benefits (Who Pays What)" when provided by contracted acupuncturists and if clinically appropriate.

   Coverage includes treatment for:
   a. Neuromusculoskeletal pain due to an injury or illness; or
   b. Allergy, asthma, nausea, or vomiting.

   Services include:
   a. Acupuncture by manual stimulation.
   b. Electro-acupuncture applied to inserted needles and acupressure.

   Cupping or moxibustion are only covered in lieu of electrical stimulation.

   You may self-refer for visits to contracted acupuncturists.

2. Acupuncture Services Exclusions
   a. Rental or purchase of durable medical equipment (DME).
   b. Air purifiers, therapeutic mattresses, supplies or similar devices, appliances, or equipment. Their use or installation does not have to be for therapy or easy access.
   c. Radiology and lab tests.
   d. Prescription drugs, vitamins, herbs or food supplements. It does not matter if they are prescribed or recommended by a contracted acupuncturist.
   e. Massage or soft tissue techniques that are not part of the acupuncture treatment, except acupressure.
   f. Treatment mainly for obesity or weight control.
   g. Vocational, stroke or long term rehabilitation.
   h. Hypnotherapy.
   i. Behavior training.
   j. Sleep therapy or biofeedback.
   k. Acupuncture Services provided for maintenance or preventive care Services.
   l. Expenses for acupuncture Services provided during visits that exceed your visit limit.
   m. Expenses for any Services provided before coverage begins or after coverage ends for this benefit.
   n. Any Services provided by an acupuncturist who is not contracted. It does not matter if the Services are obtained in or out of Health Plan's Service Area.
   o. Acupuncture Services that Health Plan determines are not clinically appropriate in its utilization review. (Members may not be surcharged for such Services.)
   p. Services not authorized by Health Plan. This exclusion does not apply to Services listed in the "Coverage" section of this benefit.
   q. Any techniques or procedures not generally accepted in a majority of state acupuncture licensing boards.
   r. Benefits, items, or Services that are limited or excluded in the EOC, unless changed by this benefit.

This rider amends the EOC to provide limited coverage for acupuncture Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB

DURABLE MEDICAL EQUIPMENT (DME) AND PROSTHETIC AND ORTHOTIC DEVICES

When prescribed by a Plan Provider and obtained from sources designated by Health Plan on either a purchase or rental basis, as determined by Health Plan, DME, prosthetics and orthotics, including replacements other than those necessitated by misuse, theft, or loss, are provided as shown on the "Schedule of Benefits (Who Pays What)" for your use during the period prescribed. Necessary fittings, repairs and adjustments, other than those necessitated by misuse, are covered. Health Plan may repair or replace a device at its option. Repair or replacement of defective equipment is covered at no additional charge.

Health Plan uses Local Coverage Determinations (LCD) and National Coverage Determinations (NCD) (hereinafter referred to as Medicare Guidelines) for our DME, prosthetic, and orthotic formulary guidelines. These are guidelines only. Health Plan reserves the right to exclude items listed in the Medicare Guidelines (does not apply to Kaiser Permanente Senior Advantage plans). Please note that this EOC may contain some, but not all, of these exclusions.

Limitations: Coverage is limited to a standard item of DME, prosthetic device, or orthotic device that adequately meets your medical needs.

1. Durable Medical Equipment (DME)
   a. Coverage
      i. DME is equipment that is appropriate for use in the home, able to withstand repeated use, Medically Necessary, not of use to a person in the absence of illness or injury, and approved for coverage under Medicare. It includes, but is not limited to, infant apnea monitors, insulin pumps and insulin pump supplies, and oxygen and oxygen dispensing equipment.
      ii. Insulin pumps and insulin pump supplies are provided when clinical guidelines are met and when obtained from sources designated by Health Plan.
      iii. When use is no longer prescribed by a Plan Provider, DME must be returned to Health Plan or its designee. If the equipment is not returned, you must pay Health Plan or its designee the fair market price, established by Health Plan, for the equipment.

   b. Limitation: Coverage is limited to the lesser of the purchase or rental price, as determined by Health Plan.

   c. Durable Medical Equipment Exclusions
      i. Electronic monitors of bodily functions, except infant apnea monitors are covered.
      ii. Devices to perform medical testing of body fluids, excretions or substances, except nitrate urine test strips for home use for pediatric patients are covered.
      iii. Non-medical items such as sauna baths or elevators.
      iv. Exercise or hygiene equipment.
      v. Comfort, convenience, or luxury equipment or features.
      vi. Disposable supplies for home use such as bandages, gauze*, tape, antiseptics, dressings, and ace-type bandages. *Gauze not excluded in Kaiser Permanente Senior Advantage Part D plans.
      vii. Replacement of lost or stolen equipment.
      viii. Repairs, adjustments, or replacements necessitated by misuse.
      ix. More than one piece of DME serving essentially the same function, except for replacements.
      x. Spare equipment or alternate use equipment is not covered.

2. Prosthetic Devices
   a. Coverage
      Prosthetic devices are those rigid or semi-rigid external devices that are required to replace all or part of a body organ or extremity. Coverage of prosthetic devices includes:
      i. Internally implanted devices for functional purposes, such as pacemakers and hip joints.
      ii. Prosthetic devices for Members who have had a mastectomy. Health Plan will designate the source from which external prostheses can be obtained. Replacement will be made when a prosthesis is no longer functional. Custom-made prostheses will be provided when necessary.
      iii. Prosthetic devices, such as obturators and speech and feeding appliances, required for the treatment of cleft lip and cleft palate are covered when prescribed by a Plan Provider and obtained from sources designated by Health Plan.
      iv. Prosthetic devices intended to replace, in whole or in part, an arm or leg when prescribed by a Plan Provider, as Medically Necessary and when obtained from sources designated by Health Plan.

   b. Prosthetic Devices Exclusions
      i. Dental prostheses, except for Medically Necessary prosthodontic treatment.
      ii. Internally implanted devices, equipment, and prosthetics related to treatment of sexual dysfunction.
      iii. More than one prosthetic device for the same part of the body, except for replacements.

iv. Spare devices or alternate use devices.
v. Replacement of lost or stolen prosthetic devices.
vi. Repairs, adjustments, or replacements necessitated by misuse.

3. Orthotic Devices
   a. Coverage
      Orthotic devices are those rigid or semi-rigid external devices that are required to support or correct a defective form or function of an inoperative or malfunctioning body part or to restrict motion in a diseased or injured part of the body.

   b. Orthotic Devices Exclusions
      i. Corrective shoes and orthotic devices for podiatric use and arch supports, except for diabetic shoes in accordance with clinical guidelines and therapeutic shoes for patients with a diagnosis of peripheral vascular disease or peripheral neuropathy.
      ii. Dental devices and appliances except that Medically Necessary treatment of cleft lip or cleft palate is covered when prescribed by a Plan Provider, unless you are covered for these Services under a dental insurance policy or contract.
      iii. Experimental and research braces.
      iv. More than one orthotic device for the same part of the body, except for covered replacements.
      v. Spare devices or alternate use devices.
      vi. Replacement of lost or stolen orthotic devices.
      vii. Repairs, adjustments, or replacements necessitated by misuse.

This rider amends the EOC to provide coverage for Durable Medical Equipment (DME) and prosthetic and orthotic devices. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

DMES0AB (01-21)

HEAR0AC

HEARING AID CREDIT

1. Coverage
   For Members age 18 and over, a credit per ear, which can be applied toward the purchase of a hearing aid (including dispensing fees associated with the hearing aid purchase), is provided as shown on the "Schedule of Benefits (Who Pays What)" when prescribed by, and obtained from, a Plan Provider. Hearing aid means an electronic device worn on the person for the purpose of amplifying sound.

   The full per ear credit must be used at the initial point of sale. Any credit balance remaining after the initial point of sale is forfeited.

2. Hearing Aid Exclusions
   a. Replacement parts for the repair of a hearing aid.
   b. Replacement of lost or broken hearing aids.
   c. Accessory parts and routine maintenance.
   d. Batteries.

This rider amends the EOC to provide coverage for hearing aids. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

PV0AD

PREVENTIVE SERVICES RIDER

Preventive care Services, as defined under the Patient Protection and Affordable Care Act, are provided at no charge including those shown on the "Schedule of Benefits (Who Pays What)" when prescribed by a Plan Provider. Please contact **Member Services** for a complete list of covered Preventive Services.

Note: If you receive any other covered Services before, during, or after a preventive care visit, you may pay the applicable Deductible, Copayment, and Coinsurance for those Services. For example:

- You schedule a routine physical maintenance exam. During your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory or radiology tests). You may pay the applicable Deductible, Copayment, or Coinsurance for these additional diagnostic Services.
- You schedule a routine preventive exam. Your provider orders laboratory tests that are not preventive care Services according to the guidelines below. You may pay the applicable Deductible, Copayment, or Coinsurance for these additional non-preventive Services.
- You schedule a routine well-person exam. During your exam, you discuss new symptoms with your provider, or new health concerns are discovered. You may pay the applicable Deductible, Copayment, or Coinsurance for this visit.

Coverage includes, but is not limited to, preventive health care Services for the following in accordance with the A or B recommendations of the U.S. Preventive Services Task Force, the Health Resources and Services Administration women's preventive services guidelines, and those preventive services mandates required by state law, for the particular preventive health care Service:

1. Office visits for preventive care Services.
2. Alcohol misuse screening and behavioral counseling interventions for adults by your primary care provider.
3. Cervical cancer screening.
4. Breast cancer screening in accordance with state law.
5. Blood pressure screening.
6. Cholesterol screening.
7. Colorectal cancer screening.
8. Prostate cancer screening.
9. Immunizations pursuant to the schedule established by the ACIP.
10. Tobacco use screening, counseling, cessation attempt services, FDA-approved tobacco cessation medications, and the Colorado QuitLine.
11. Type 2 diabetes screening for adults with high blood pressure.
12. Diet counseling for adults with hyperlipidemia and at higher risk for cardiovascular and diet-related chronic disease.
13. Cervical cancer vaccines.
14. Influenza and pneumococcal vaccinations.
15. Approved Affordable Care Act contraceptive categories.
16. Counseling, prevention, and screening for a sexually transmitted infection regardless of your gender.

"ACIP" means the Advisory Committee on Immunization Practices to the Center for Disease Control and Prevention in the federal Department of Health and Human Services, or any successor entity. Go to cdc.gov/vaccines/acip/. For a list of preventive services that have a rating of A or B from the U.S. Preventive Task Force, go to uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. For the Health Resources and Services Administration women's preventive services guidelines, go to hrsa.gov/womensguidelines/.

This rider amends the EOC to provide coverage for preventive Services. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

RX0BO

PRESCRIPTION DRUG BENEFIT

NOTE: When used in this EOC, the term "preferred" refers to drugs that are included in the Health Plan drug formulary. The term "non-preferred" refers to drugs that are not included in the Health Plan drug formulary.

Please refer to the "Schedule of Benefits (Who Pays What)" in this booklet for the specific Copayments, Coinsurance, Deductible, and supply limits that apply to the covered prescription drugs described below.

1. Coverage

   Prescribed covered drugs are provided at the applicable prescription drug Copayment or Coinsurance for each tier of drug coverage. This may include: a tier for preferred generic drugs; a tier for preferred brand-name drugs or medications not having a generic or a generic equivalent; a tier for prescribed non-preferred drugs authorized through the non-preferred drug process; and a tier for certain specialty drugs. **Note:** Some specialty drugs are available in other tiers. To learn more, please visit our website at **kp.org/formulary**.

   Non-Formulary Drug Exception Process:
   You, your designee, or your Plan Provider may request access to clinically appropriate drugs not otherwise covered by Health Plan (non-formulary drugs) through a special exception process. For additional information about the prescription drug exception processes for non-formulary drugs, please contact **Member Services**.

   Diabetic supplies and accessories include, but may not be limited to:
   a. Home glucose monitoring supplies.
   b. Glucose test strips.
   c. Acetone test tablets.
   d. Nitrate urine test strips for pediatric patients.
   e. Disposable syringes for the administration of insulin.

   Such items are provided when obtained at Plan Pharmacies or from sources designated by Health Plan.

   For Copayment or Coinsurance information related to contraceptive drugs and certain devices please refer to your "Schedule of Benefits (Who Pays What)."

   For each drug, the amount covered will be the lesser of the quantity prescribed or the day supply limit. Any amount you receive that exceeds the day supply will not be covered. If you receive more than the day supply limit, you will be charged as a non-Member for any prescribed amount exceeding the limit. Certain drugs have a significant potential for waste and diversion. Those drugs will be provided for up to a 30-day supply. Each prescription refill is provided on the same basis as the original prescription. Health Plan may, in its sole discretion, establish quantity limits for specific prescription drugs.

   Generic drugs that are available in the United States only from a single manufacturer and not listed as generic in the current commercially available drug database(s) to which Health Plan subscribes are provided at the brand-name Copayment or Coinsurance. The amount covered will be the lesser of the quantity prescribed or the day supply limit.

   Prescription drugs are covered only when prescribed by a:
   a. Plan Provider and obtained at Plan Pharmacies; or
   b. Provider to whom a Member has been referred by a Plan Provider and obtained at Plan Pharmacies; or
   c. Dentist (when prescribed for acute conditions) and obtained at Plan Pharmacies.

   Covered drugs include:
   a. Drugs for which a prescription is required by law.
   b. Insulin. You are not responsible for more than $100 per thirty-day supply of all covered prescription insulin drugs.
   c. Renewal of prescription eye drops and one additional bottle of prescription eye drops in accordance with state law.
   d. Compounded medications. **Note:** Compounded medications must be obtained from the pharmacy that is designated by Health Plan. Refills of compounded medications cannot be ordered on **kp.org**, by mail order, or through the automated refill line. Please call **303-764-4900** (TTY **711**) and press "0" to speak to the pharmacy staff for assistance.
   e. Epinephrine auto-injectors. You are not responsible for more than $60 for all prescription two-pack epinephrine auto-injectors.

   Plan Pharmacies may substitute a generic equivalent for a brand-name drug unless prohibited by the Plan Provider. If you request a brand-name drug when a generic equivalent drug is the preferred product, you must pay the brand-name Copayment, plus any difference in price between the preferred generic equivalent drug prescribed by the Plan Provider and the requested brand-name drug. If the brand-name drug is prescribed and authorized by the Plan due to Medical Necessity, you pay the applicable Copayment or Coinsurance.

2. Limitations
   a. Some drugs may require prior authorization. You do not need prior authorization for any FDA-approved prescription drug listed on our formulary for the treatment of substance use disorder, or for FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.
   b. We may apply Step Therapy to certain drugs with some exceptions. The exceptions are:
      i. substance use disorder drugs;
      ii. stage four advanced metastatic cancer drugs;
      iii. FDA-approved HIV infection prevention drugs when prescribed and dispensed by a pharmacist.

      You or your Plan Provider may request a Step Therapy exception if you previously tried a drug and your use of the drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event.
   c. Coverage determinations for the off-label use of medications will be consistent with Medicare compendia, and coverage determinations for the off-label use of oncologic agents will be consistent with the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

3. Prescription Drugs, Supplies, and Supplements Exclusions
   a. Drugs for which a prescription is not required by law.
   b. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing and ace-type bandages.
   c. Prescription drugs necessary for Services excluded in the EOC.
   d. Non-preferred drugs, except those prescribed and authorized through the non-preferred drug process.
   e. Any drugs listed as not covered in the "Schedule of Benefits (Who Pays What)."
   f. Drugs to shorten the length of the common cold.
   g. Drugs to enhance athletic performance.
   h. Drugs available over the counter and by prescription for the same strength.
   i. Certain drugs determined excluded by our Pharmacy and Therapeutics Committee.
   j. Any prescription drug packaging except the dispensing pharmacy's standard packaging.
   k. Replacement of prescription drugs for any reason. This includes spilled, lost, damaged, or stolen prescriptions.
   l. Drugs administered during a medical office visit.
   m. Medical Foods and Medical Devices.
   n. Unless approved by Health Plan, drugs not approved by the FDA.

This rider amends the EOC to provide coverage for prescription drugs. All of the terms, conditions, limitations and exclusions of the EOC shall also apply to this rider except where specifically changed by this rider.

RX0BO (01-24)

Kaiser Foundation Health
Plan of Colorado
2500 S. Havana St.
Aurora, CO 80014-1622

Important plan information

BMO BANK N.A.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

EOC #49 - Kaiser Permanente Deductible HMO Plan
Evidence of Coverage for
BMO FINANCIAL CORP.

Group ID: 1932 Contract: 1 Version: 96 *EOC* Number: 49 Issue Date: November 19, 2024

January 1, 2025, through December 31, 2025

Member Services
24 hours a day, seven days a week (closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

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Cost Share Summary

This "Cost Share Summary" is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductibles and Out-of-Pocket Maximums

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

If your Group's plan changes during an Accumulation Period, your deductibles and out-of-pocket maximums may increase or decrease, which may change the total amount you must accumulate to reach the deductibles or out-of-pocket maximums during that Accumulation Period.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Deductible	$750	$750	$1,500
Drug Deductible	$250	$250	Not applicable
Plan Out-of-Pocket Maximum ("OOPM")	$3,000	$3,000	$6,000

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, refer to the same benefit heading in the "Benefits" section of this *EOC*.

- **Copayment / Coinsurance**. This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the "Deductibles and Out-of-Pocket Maximums" section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read "Not covered." If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible**. This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a "✓" or "D" in this column, depending on which deductible applies ("✓" for Plan Deductible, "D" for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, refer to "Plan Deductible" and "Drug Deductible" in the "Benefits" section of this *EOC*.
- **Applies to OOPM**. This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum ("OOPM") after you have met any applicable deductible. If the Services count toward the Plan OOPM, there will be a "✓" in this column. If the Services do not count toward the Plan OOPM, this column will be

blank. For a more detailed explanation of the Plan OOPM, refer to "Plan Out-of-Pocket Maximum" in the "Benefits" section of this *EOC*.

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge	✓	✓
Allergy antigens (including administration)	No charge	✓	✓
Cancer chemotherapy drugs and adjuncts	No charge		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood	No charge		✓
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance Services

Description of Ambulance Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency ambulance Services	20% Coinsurance	✓	✓
Nonemergency ambulance and psychiatric transport van Services	20% Coinsurance	✓	✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge	✓	✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	$40 per visit	✓	✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Blood glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance		✓
Other Base DME Items as described in this *EOC*	20% Coinsurance		✓
Supplemental DME items as described in this *EOC*	20% Coinsurance		
Retail-grade milk pumps	No charge		✓
Hospital-grade milk pumps	No charge		✓

Emergency Services and Urgent Care

Description of Emergency Services and Urgent Care	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency department visits	$300 per visit	✓	✓
Urgent Care visits	$25 per visit		✓

Note: If you are admitted to the hospital as an inpatient from the emergency department, the emergency department visits Cost Share above does not apply. Instead, the Services you received in the emergency department, including any observation stay, if applicable, will be considered part of your hospital inpatient stay. For the Cost Share for inpatient Services, refer to "Hospital inpatient Services" in this "Cost Share Summary." The emergency department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Fertility Services

Diagnosis and treatment of Infertility

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Artificial insemination

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Assisted reproductive technology ("ART") Services

Description of ART Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Assisted reproductive technology ("ART") Services lifetime maximum
Covered ART Services are limited to one treatment cycle per lifetime.

Health education

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to tobacco cessation	No charge		✓

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	$25 per visit		✓
Physician Specialist Visits to diagnose and treat hearing problems	$40 per visit		✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	We provide a $2,000 Allowance for each ear every 36 months		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care Services (120 visits per Accumulation Period)	No charge		✓

Hospice care

Description of Hospice Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospice Services	No charge		✓

Hospital inpatient Services

Description of Hospital Inpatient Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient stays	20% Coinsurance	✓	✓

Injury to teeth

Description of Injury to Teeth Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	20% Coinsurance	✓	✓
Individual mental health evaluation and treatment	$25 per visit		✓
Group mental health treatment	$12 per visit		✓
Partial hospitalization	20% Coinsurance	✓	✓
Other intensive psychiatric treatment programs	20% Coinsurance	✓	✓
Residential mental health treatment Services	20% Coinsurance	✓	✓
Behavioral Health Treatment for Autism Spectrum Disorder	20% Coinsurance up to a maximum of $25 per day		✓
Electroconvulsive therapy	$25 per visit		✓
Transcranial magnetic stimulation	$25 per visit		✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	$25 per visit		✓
Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	$40 per visit		✓
Group appointments that are not described elsewhere in this “Cost Share Summary”	$12 per visit		✓

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Acupuncture Services	$25 per visit		✓

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	No charge		✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	20% Coinsurance	✓	✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	20% Coinsurance	✓	✓
Nuclear medicine	20% Coinsurance	✓	✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge	✓	✓
Over-the-counter COVID-19 tests obtained from Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month)	No charge		✓
Over-the-counter COVID-19 tests obtained from Non-Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month, not to exceed $12 per test, including all fees and taxes, if you obtain the test from a Non-Plan Provider)	50% Coinsurance	✓	
Laboratory tests to diagnose or screen for COVID-19 obtained from Plan Providers	No charge		✓
Laboratory tests to diagnose or screen for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance	✓	

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	20% Coinsurance	✓	✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	20% Coinsurance	✓	✓
Radiation therapy	No charge	✓	✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge		✓

Outpatient prescription drugs, supplies, and supplements

If an item in this section is subject to a deductible there will be a "✓" or "D" in the "Subject to Deductible" column. "✓" indicates the item is subject to the Plan Deductible. "D" indicates the item is subject to the Drug Deductible.

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on Tier 1 not described elsewhere in this "Cost Share Summary"	$10 for up to a 30-day supply	$20 for up to a 100-day supply	D	✓
Items on Tier 2 not described elsewhere in this "Cost Share Summary"	30% Coinsurance (not to exceed $100) for up to a 100-day supply	30% Coinsurance (not to exceed $100) for up to a 100-day supply	D	✓
Items on Tier 4 not described elsewhere in this "Cost Share Summary"	30% Coinsurance (not to exceed $100) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓
All other items on Tier 1 as described in this *EOC*	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓
All other items on Tier 2 as described in this *EOC*	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓
All other items on Tier 4 as described in this *EOC*	30% Coinsurance (not to exceed $100) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 2	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 4	30% Coinsurance (not to exceed $100) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Non-oral anticancer drugs on Tier 2	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓
Non-oral anticancer drugs on Tier 4	30% Coinsurance (not to exceed $100) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

Home infusion drugs

Description of Home Infusion Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available		✓
Supplies necessary for administration of home infusion drugs	No charge	No charge		✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Certain state-mandated items

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Therapeutics for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Therapeutics for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance for up to a 30-day supply	Not available	✓	
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available		✓

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, refer to the "Most items" table above. For insulin pumps, refer to the "Durable Medical Equipment ("DME") for home use" table above.

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items on Tier 1: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 1: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items on Tier 2: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 2: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms, cervical caps, and up to a 30-day supply of condoms	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓
Items on our preventive items list on Tier 1	No charge for up to a 100-day supply	No charge for up to a 100-day supply		✓
Items on our preventive items list on Tier 2 and Tier 4	No charge for up to a 100-day supply	No charge for up to a 100-day supply		✓

Items on our preventive items list are covered at the Cost Share indicated when prescribed to prevent the onset of disease or illness (to get the current list, call Member Services).

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on Tier 1 prescribed to treat Infertility or in connection with covered artificial insemination Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	D	
Drugs on Tier 2 and Tier 4 prescribed to treat Infertility or in connection with covered artificial insemination Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	D	
Drugs on Tier 1 prescribed in connection with covered assisted reproductive technology (“ART”) Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	D	
Drugs on Tier 2 and Tier 4 prescribed in connection with covered assisted reproductive technology (“ART”) Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	D	
Drugs on Tier 1 prescribed for sexual dysfunction disorders	$10 for up to a 30-day supply	$20 for up to a 100-day supply	D	✓
Drugs on Tier 2 and Tier 4 prescribed for sexual dysfunction disorders	30% Coinsurance (not to exceed $100) for up to a 100-day supply	30% Coinsurance (not to exceed $100) for up to a 100-day supply	D	✓

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$40 per procedure		✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman, postpartum follow-up, and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Immunizations (including the vaccine) for COVID-19 administered by Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance	✓	
Tuberculosis skin tests	No charge		✓
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection ("STI") tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
External prosthetic and orthotic devices as described in this *EOC*	No charge		✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	No charge		✓

Rehabilitative and habilitative Services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	$25 per visit	✓	✓
Group outpatient physical, occupational, and speech therapy	$12 per visit	✓	✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	$25 per day	✓	✓

Reproductive Health Services

Family planning Services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		✓

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		✓
Sterilization procedures for Members assigned female at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned female at birth	No charge		✓
Sterilization procedures for Members assigned male at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned male at birth	No charge		✓

Abortion and abortion-related Services

Description of abortion and abortion-related Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Surgical abortion	No charge		✓
Prescription drugs, in accord with our drug formulary guidelines	No charge		✓
Other abortion-related Services	No charge		✓

Plan Doula services

Description of Plan Doula services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Initial, prenatal, or postpartum visits	No charge		✓
Support during labor and delivery	No charge		✓

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility Services up to 100 days per benefit period*	20% Coinsurance	✓	✓

*A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	20% Coinsurance	✓	✓
Individual substance use disorder evaluation and treatment	$25 per visit		✓
Group substance use disorder treatment	$12 per visit		✓
Intensive outpatient and day-treatment programs	20% Coinsurance		✓
Methadone maintenance treatment	No charge		✓
Residential substance use disorder treatment	20% Coinsurance	✓	✓

Telehealth visits

Interactive video visits

Description of Interactive Video Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Scheduled telephone visits

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Physician Specialist Visits	No charge		✓

Vision Services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$40 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$25 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$40 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$25 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Low vision devices (including fitting and dispensing)	Not covered		

CARE Plan

The California Community Assistance, Recovery, and Empowerment ("CARE") Act established a system for individuals with severe mental illness to be evaluated and given a treatment plan developed by a county behavioral health agency ("CARE Plan"). If a Member has a court-approved CARE Plan, we cover the Services required under that plan when provided by Plan Providers or Non-Plan Providers at **no charge (not subject to the Plan Deductible)**, with the exception of prescription drugs. Prescription drugs required under a court-approved CARE Plan are subject to the same Cost Share as drugs prescribed by Plan Providers, as described in this Cost Share Summary, and are also subject to prior authorization by Health Plan. To inform us that you have a court-approved CARE Plan, please call Member Services.

Introduction

This *Evidence of Coverage* (*"EOC"*) describes the health care coverage of this Kaiser Permanente Deductible HMO Plan provided under the *Group Agreement* (*"Agreement"*) between Kaiser Foundation Health Plan, Inc. ("Health Plan") and the entity with which Health Plan has entered into the *Agreement* (your "Group").

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan's evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

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

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The coverage information in this *EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Term of this *EOC*

This *EOC* is for the period January 1, 2025, through December 31, 2025, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC*. If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Behavioral Health Treatment for Autism Spectrum Disorder: 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 a person with autism spectrum disorder (or treat mental health conditions other than autism spectrum disorder when this treatment is clinically indicated) that meet the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is administered by a Plan Provider who is a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional, as defined in California Health and Safety Code section 1374.73(c)

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For air ambulance Services received from Non-Plan Providers when you have an Emergency Medical Condition, the amount required to be paid by Health Plan pursuant to federal law
- For other Emergency Services received from Non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law
- For all other Services received from Non-Plan Providers (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Plan Provider and Health Plan or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Health Plan based on objective criteria
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Cigna Healthcare PPO Network: The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of a shared administration network arrangement called Cigna Healthcare PPO for Shared Administration.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare

name, logo, and other marks are owned by Cigna Intellectual Property, Inc.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Disclosure Form ("DF"): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

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

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

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

- A medical screening exam that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the facility, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post-Stabilization Care and not Emergency Services)
- Post-Stabilization Care furnished by a Non-Plan Provider is covered as Emergency Services when federal law applies, as described under "Post-Stabilization Care" in the "Emergency Services" section

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" under Health Plan's *Agreement* with your Group.

Family: A Subscriber and all of their Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Infertility: A person's inability to conceive a pregnancy or carry a pregnancy to live birth either as an individual or with their partner; or, a Plan Physician's determination of Infertility, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Kaiser Permanente State: California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, a Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under "Dental and Orthodontic Services" in the "Benefits" section, non-physician specialists include dentists and orthodontists.

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Doula: A contracted birth worker who provides physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth.

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities**. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices

may change. If you have questions, please call Member Services.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call Member Services.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Refer to the "Cost Share Summary" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services.

Plan Physician: Any licensed physician who is an employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the emergency department), an independent freestanding emergency department, or a skilled nursing facility after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from an emergency department and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC,* except that you are responsible for paying Premiums if you have Cal-COBRA coverage. "Full Premiums" means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the "Premiums" section of Health Plan's *Agreement* with your Group.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at **kp.org/facilities** for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services.

Service Area: The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501-02, 94505, 94514, 94536-46, 94550-52, 94555, 94557, 94560, 94566, 94568, 94577-80, 94586-88, 94601-15, 94617-21, 94622-24, 94649, 94659-62, 94666, 94701-10, 94712, 94720, 95377, 95391

- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Northern California Service Area: 94505-07, 94509, 94511, 94513-14, 94516-31, 94547-49, 94551, 94553, 94556, 94561, 94563-65, 94569-70, 94572, 94575, 94582-83, 94595-98, 94706-08, 94801-08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903-04, 94912-15, 94920, 94924-25, 94929-30, 94933, 94937-42, 94945-50, 94952, 94956-57, 94960, 94963-66, 94970-71, 94973-74, 94976-79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- The following ZIP codes in Monterey County are inside our Northern California Service Area: 93901, 93902, 93905, 93906, 93907, 93912, 93915, 93933, 93955, 93962, 95004, 95012, 95039, 95076
- All ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203-09, 94211, 94229-30, 94232, 94234-37, 94239-40, 94244-45, 94247-50, 94252, 94254, 94256-59, 94261-63, 94267-69, 94271, 94273-74, 94277-80, 94282-85, 94287-91, 94293-98, 94571, 95608-11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638-39, 95641, 95652, 95655, 95660, 95662, 95670-71, 95673, 95678, 95680, 95683, 95690, 95693, 95741-42, 95757-59, 95763, 95811-38, 95840-43, 95851-53, 95860, 95864-67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Northern California Service Area: 94102-05, 94107-12, 94114-34, 94137, 94139-47, 94151, 94158-61, 94163-64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Northern California Service Area: 94514, 95201-15, 95219-20, 95227, 95230-31, 95234, 95236-37, 95240-42, 95253, 95258, 95267, 95269, 95296-97, 95304, 95320, 95330, 95336-37, 95361, 95366, 95376-78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Northern California Service Area: 94002, 94005, 94010-11, 94014-21, 94025-28, 94030, 94037-38, 94044, 94060-66, 94070, 94074, 94080, 94083, 94128, 94303, 94401-04, 94497
- The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, 95196
- All ZIP codes in Santa Cruz County are inside our Northern California Service Area: 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77
- All ZIP codes in Solano County are inside our Northern California Service Area: 94503, 94510, 94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Northern California Service Area: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- All ZIP codes in Stanislaus County are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397

- The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95836-7
- The following ZIP codes in Tulare County are inside our Northern California Service Area: 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95615-18, 95620, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in our Service Area, please call Member Services.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes physical health care, mental health care, and substance use disorder treatment), and Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

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

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children). The person may be impregnated in any manner including, but not limited to, artificial insemination, intrauterine insemination, in vitro fertilization, or through the surgical implantation of a fertilized egg of another person. For the purposes of this *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Full Premiums, except that you are responsible for paying Full Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *EOC*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) they live inside or move to the service area of another Region and do not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside our Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another Region, please contact your Group to learn about your Group health care options:

- **Regions outside California**. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Southern California Region's service area**. Your Group may have an arrangement with us that permits membership in the Southern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Northern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the service areas of the other Regions, please call Member Services.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - biological children
  - stepchildren
  - adopted children
  - children placed with you for adoption
  - foster children if you or your Spouse have the legal authority to direct their care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care), if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they meet the requirements described under "Age limit of Dependent children"

- ♦ they receive all of their support and maintenance from you or your Spouse
- ♦ they permanently reside with you or your Spouse

- Certain Dependents may continue their memberships for a limited time after membership would otherwise terminate as a result of the Subscriber's death if permitted by your Group (please ask your Group for details)

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth).

Age limit of Dependent children

Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as a disabled Dependent. If we request it, the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Members with Medicare and retirees

This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *EOC* if permitted by your Group (please ask your Group for details).

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *EOC* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

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

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, placement for adoption, or placement for foster care by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments of newly acquired Dependent children are effective as follows:

- Enrollments due to birth are effective on the date of birth
- Enrollments due to adoption are effective on the date of adoption
- Enrollments due to placement for adoption or foster care are effective on the date you or your Spouse have newly assumed a legal right to control health care

Special enrollment due to loss of other coverage

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

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - ♦ exhaustion of COBRA coverage
  - ♦ termination of employer contributions for non-COBRA coverage
  - ♦ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ♦ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - ♦ reaching a lifetime maximum on all benefits

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for

submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order
Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance
You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

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

Other special enrollment events
You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
  - a qualified individual was not enrolled in a qualified health plan
  - a qualified individual was not enrolled in the qualified health plan that the individual selected
  - a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

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

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in this "How to Obtain Services" section

- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call Member Services. To request an appointment online, go to our website at **kp.org**.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

For information about Out-of-Area Urgent Care, refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

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 Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside our Service Area

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call Member Services). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Benefits" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org** or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy.

Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary

guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment

Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Medical Group's decision time frames

The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or specialist that is needed, and the date that the Medical Group expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Completion of Services from Non–Plan Providers

New Member

If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility

The cases that are subject to this completion of Services provision are:

- Acute conditions, which are 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. We may cover these Services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months

from the mental health diagnosis or from the end of pregnancy, whichever occurs later

- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Services
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area (the requirement that the provider agree to providing Services inside our Service Area doesn't apply if you were receiving covered Services from the provider outside our Service Area when the provider's contract terminated)
- The Services to be provided to you would be covered Services under this *EOC* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information
For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call Member Services.

Travel and Lodging for Certain Services

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside your Home Region Service Area for certain specialty Services such as a transplant or transgender surgery
- If you are outside of California and you need an abortion on an emergency or urgent basis, and the abortion can't be obtained in a timely manner due to a near total or total ban on health care providers' ability to provide such Services

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical

background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital Services for Members, please visit our website at **kp.org** or call Member Services.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals

If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Receiving Care Outside of Your Home Region Service Area

For information about your coverage when you are away from home, visit our website at **kp.org/travel**. You can also call the Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

Receiving care in another Kaiser Permanente service area

If you are visiting in another Kaiser Permanente service area, you may receive certain covered Services from designated providers in that other Kaiser Permanente service area, subject to exclusions, limitations, prior authorization or approval requirements, and reductions. For more information about receiving covered Services in another Kaiser Permanente service area, including provider and facility locations, please visit **kp.org/travel** or call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

For covered Services you receive in another Kaiser Permanente service area, you pay the Cost Share required for Services provided by a Plan Provider inside our Service Area as described in this *EOC*.

Receiving care outside of any Kaiser Permanente service area

If you are traveling outside of any Kaiser Permanente service area, we cover Emergency Services and Urgent Care as described in the "Emergency Services and Urgent Care" section.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent care appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days
- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. Except as specified above for mental health care and substance use disorder treatment, the standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Access to mental health Services and substance use disorder treatment

State law requires evidence of coverage documents to include the following notice:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Plan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment

for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at http://www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call	**1-800-464-4000 (**English and more than 150 languages using interpreter services**)** **1-800-788-0616 (**Spanish**)** **1-800-757-7585 (**Chinese dialects**)** TTY users call **711** 24 hours a day, seven days a week (closed holidays)
Visit	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Write	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Website	**kp.org**

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week

- Emergency Services are available from Plan Hospital emergency departments (for emergency department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)

Note: State law requires evidence of coverage documents to include the following notice:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract 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 enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Kaiser Permanente Member Services, to ensure that you can obtain the health care services that you need.

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

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

Post-Stabilization Care

When you receive Post-Stabilization Care from a Non-Plan Provider inside of California, or from a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State

When you receive Emergency Services, we cover Post-Stabilization Care from a Non–Plan Provider only if prior authorization for the care is obtained as described below, or if otherwise required by applicable law ("prior authorization" means that the Services must be approved in advance).

- **Post-Stabilization Care authorization at a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State:** If you are outside of a Kaiser Permanente state and you were treated at a Cigna Healthcare PPO Network facility for an Emergency Medical Condition, Cigna Payer Solutions is responsible for authorizing any Post-Stabilization Care
- **Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State):** To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered

  Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non–Plan Hospital or independent freestanding emergency department, please notify us as soon as possible by

calling **1-800-225-8883** or the notification phone number on your ID card

When you receive Post-Stabilization Care from a Non-Plan Provider that is not a Cigna Healthcare PPO Network provider outside of California

After you receive Emergency Services from Non-Plan Providers and your condition is Stabilized, Post-Stabilization Care is considered Emergency Services under federal law if either of the following are true:

- Your treating physician determines that you are not able to travel using nonemergency transportation to an available Plan Provider located within a reasonable travel distance, taking into account your medical condition; or
- Your treating physician, using appropriate medical judgment, determines that you are not in a condition to receive, and/or to provide consent to, the Non-Plan Provider's notice and consent form, in accordance with applicable state informed consent law

If the Post-Stabilization Care is considered Emergency Services under the criteria above, prior authorization for Post-Stabilization Care at a Non-Plan Provider will not be required.

If the Post-Stabilization Care is not considered Emergency Services, the Services are not covered unless you have received prior authorization from Health Plan as described under "Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State)" above. Non-Plan Providers outside of California may provide notice and seek your consent to waive your balance billing protections under the federal No Surprises Act, if such consent is permissible under applicable state informed consent law. If you consent to waive your balance billing protections and receive Services from the Non-Plan Provider, you will have to pay the full cost of the Services.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Cost Share Summary" section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the emergency department of a Non–Plan Hospital, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient Services as described in the "Cost Share Summary" under "Hospital inpatient Services"
- If we gave prior authorization for durable medical equipment after discharge from a Non–Plan Hospital, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"
- If you receive COVID-19 laboratory testing or immunizations in the emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If you obtain a prescription in the emergency department related to your Emergency Medical Condition, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient prescription drugs, supplies, and supplements" in addition to the Cost Share for the emergency department visit

Urgent Care

Inside our Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Getting a Referral" in the "How to Obtain Services" section.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the "Cost Share Summary" section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If the Out-of-Area Urgent Care you receive includes a COVID-19 test, you may have to pay the Cost Share for a COVID-19 test as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If you obtain a prescription as part of an Out-of-Area Urgent Care visit related to the condition for which you obtained Urgent Care, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient prescription drugs, supplies, and supplements" in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits" section, you are not responsible for any amounts beyond your Cost Share for covered Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits" section

- other health care items and services

- The Services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" below
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" below
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" below
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - hospice care, as described under "Hospice Care" below
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance.

If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Refer to the "Cost Share Summary" section of this *EOC* for the amount you will pay for Services.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered hospital inpatient or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Cost Share for Services received by newborn children of a Member

During the 31 days of automatic coverage for newborn children described under "If you have a baby" under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, the parent or guardian of the

newborn must pay the Cost Share indicated in the "Cost Share Summary" section of this *EOC* for any Services that the newborn receives, whether or not the newborn is enrolled. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Share, or your Plan Provider is not able to collect Cost Share, if any, for Telehealth Visits you receive at home).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Please refer to the "Emergency Services and Urgent Care" section for more information about when you may be billed for Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care.

Reimbursement for COVID-19 Services from Non-Plan Providers

If you receive covered COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see "Initial Claims" in the "the "Post-Service Claims and Appeals" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services

If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Benefit limits

Some benefits may include a limit on the number of visits, days, treatment cycles, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the "Cost Share Summary" section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Services you receive during the benefit limit period toward the benefit limit, including Services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count Services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer group's plan, when you move from group to individual plan coverage (or vice versa), or when you received Services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company ("KPIC").

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m. Refer to the "Cost Share Summary" section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Drug Deductible

Refer to the "Cost Share Summary" section of this *EOC* for Services that are subject to the Drug Deductible and the Drug Deductible amount. When the Cost Share for the Services is described as "subject to the Drug Deductible," your Cost Share for those Services will be Charges until you reach the Drug Deductible. Note: When the Cost Share for the Services is described as "no charge subject to the Drug Deductible," your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Plan Deductible

In any Accumulation Period, you must pay Charges for Services subject to the Plan Deductible until you reach one of the Plan Deductible amounts listed in the "Cost Share Summary" section of this *EOC*.

If you are a Member in a Family of two or more Members, you reach the Plan Deductible either when you reach the amount for any one Member, or when your entire Family reaches the Family amount. For example, suppose you have reached the deductible amount for any one Member. For Services subject to the Plan Deductible, you will not pay Charges during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Charges during the remainder of the Accumulation Period until either they reach the deductible amount for any one Member, or the entire Family reaches the Family amount.

After you reach the Plan Deductible and for the remainder of the Accumulation Period, you pay the applicable Copayment or Coinsurance subject to the limits described under "Plan Out-of-Pocket Maximum" in this "Benefits" section.

Services that are subject to the Plan Deductible

The Cost Share that you must pay for covered Services is described in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Note: When the Cost Share for the Services is "no charge" and the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Also, if you pay a Plan Deductible amount for a Service that has a limit, such as a visit limit, the Services count toward reaching the limit.

The only payments that count toward the Plan Deductible are those you make for covered Services that are subject to this Plan Deductible under this *EOC*.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. Refer to the "Cost Share Summary" section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the Plan Out-of-Pocket Maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either they reach the maximum for any one Member or your Family reaches the Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for covered Services apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a covered Service will apply to the maximum refer to the "Cost Share Summary" section of this *EOC*.

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, those Services will apply toward the maximum. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org** or call Member Services. We will provide you with accrual balance information for every month that you receive Services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

We will provide accrual balance information by mail unless you have opted to receive notices electronically. You can change your document delivery preferences at any time at **kp.org** or by calling Member Services.

Administered Drugs and Products

Administered drugs and products are medications and products that require administration or observation by medical personnel, such as:

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood
- Other administered drugs and products

We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

Certain administered drugs are Preventive Services. Refer to "Reproductive Health Services" for information about administered contraceptives and refer to "Preventive Services" for information on immunizations.

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient Services related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

For covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Share you would pay if the Services were not related to a bariatric surgical procedure. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

For the following Services, refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services under this *EOC*, but we do cover some dental and

orthodontic Services as described in this "Dental and Orthodontic Services" section.

For covered dental and orthodontic procedures that you may receive, you will pay the Cost Share you would pay if the Services were not related to dental and orthodontic Services. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services.

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

For the following Services, refer to these sections

- Accidental injury to teeth (refer to "Injury to Teeth")
- Office visits not described in the "Dental and Orthodontic Services" section (refer to "Office Visits")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- The Services are provided inside our Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient Services (refer to "Hospital Inpatient Services")
- Office visits not described in the "Dialysis Care" section (refer to "Office Visits")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

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

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

We cover DME that is not described under "Base DME Items" or "Lactation supplies," including repair and replacement of covered equipment, if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met.

Lactation supplies

We cover one retail-grade milk pump (also known as a breast pump) per pregnancy and associated supplies, as listed on our website at **kp.org/prevention**. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

If you or your baby has a medical condition that requires the use of a milk pump, we cover a hospital-grade milk pump and the necessary supplies to operate it, in accord with the coverage rules described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to an Emergency Medical Condition or Urgent Care episode (refer to "Post-Stabilization Care" and "Out-of-Area Urgent Care")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusions

- Comfort, convenience, or luxury equipment or features except for retail-grade milk pumps as described under "Lactation supplies" in this "Durable Medical Equipment ("DME") for Home Use" section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse

Emergency Services and Urgent Care

We cover the following Services:

- Emergency department visits
- Urgent Care consultations, evaluations, and treatment

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Diagnosis and treatment of Infertility

We cover the following Services for the diagnosis and treatment of Infertility:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services

- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stay directly related to diagnosis and treatment of Infertility

Artificial insemination

We cover the following Services for artificial insemination:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stays directly related to diagnosis and treatment of Infertility

Assisted reproductive technology ("ART") Services

We cover the following ART Services:

- Gamete intrafallopian transfer ("GIFT")
- In vitro fertilization ("IVF")
- Zygote intrafallopian transfer ("ZIFT")
- Transfer of cryopreserved embryos

Covered ART Services are limited to one treatment cycle per lifetime under any Health Plan evidence of coverage offered by your Group. If you reach the treatment cycle limit, we will not cover any more treatment cycles for as long as you are covered under this or any other Health Plan evidence of coverage offered by your Group.

A covered treatment cycle includes cryopreservation and storage of embryos for up to 6 months.

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Fertility Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Services related to the procurement and storage of semen and eggs, except if the retrieval is part of your covered ART treatment cycle
- Services related to the procurement and storage of embryos, except for storage of embryos that is part of your covered ART treatment cycle

Fertility Preservation Services for Iatrogenic Infertility

Standard fertility preservation Services are covered for Members undergoing treatment or receiving covered Services that may directly or indirectly cause iatrogenic Infertility. Fertility preservation Services do not include diagnosis or treatment of Infertility.

For covered fertility preservation Services that you receive, you will pay the Cost Share you would pay if the Services were not related to fertility preservation. For example, see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for outpatient procedures.

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or Member Services or go to our website at **kp.org**.

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction
- Physician Specialist Visits to diagnose and treat hearing problems

Hearing aids

We provide an Allowance for each ear toward the purchase price of a hearing aid (including fitting, counseling, adjustment, cleaning, and inspection) when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later. Refer to "Hearing Services" in the "Cost Share Summary" section of this *EOC* for your Allowance amount.

We select the provider or vendor that will furnish the covered hearing aids. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

For the following Services, refer to these sections

- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to "Preventive Services")
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover home health care only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan 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
- The Services are provided inside our Service Area

We cover only part-time or intermittent home health care, as follows:

- 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)
- Up to 120 visits per Accumulation Period (counting all home health visits)

Note: 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.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Dialysis care (refer to "Dialysis Care")

- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice Services listed below only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient Services required at a level that cannot be provided at home

Hospital Inpatient Services

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units

- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Benefits" section)
- Behavioral Health Treatment for Autism Spectrum Disorder
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental and orthodontic procedures (refer to "Dental and Orthodontic Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services related to diagnosis and treatment of Infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Injury to Teeth

Services for accidental injury to teeth are not covered under this *EOC*.

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the prevention, diagnosis, or treatment of Mental Health Conditions. A "Mental Health Condition" is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment, including treatment of first episode psychosis
- Psychological testing when necessary to evaluate a Mental Health Condition
- Outpatient Services for the purpose of monitoring drug therapy
- Behavioral Health Treatment for Autism Spectrum Disorder
- Electroconvulsive therapy
- Transcranial magnetic stimulation

Intensive psychiatric treatment programs
We cover intensive psychiatric treatment programs at a Plan Facility, such as:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient or day-treatment program
- Psychiatric observation for an acute psychiatric crisis

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Gender-affirming Services

For covered Services you receive for treatment of gender dysphoria, you will pay the Cost Share you would pay if the Services were not related to gender dysphoria. For example:

- See "Administered Drugs" for administered drugs
- See "Office Visits" for consultations for gender dysphoria treatment, such as hormone therapy, and hair removal procedures
- See "Outpatient Laboratory, Imaging, and Other Diagnostic and Treatment Services" for laboratory and imaging Services
- See "Outpatient Prescription Drugs, Supplies and Supplements" for drugs, supplies, and supplements
- See "Reconstructive Surgery" for surgical Services
- See "Rehabilitative and Habilitative Services" for speech (voice) therapy

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory and sleep studies (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Telehealth Visits (refer to "Telehealth Visits")

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- 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)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Ostomy and Urological Supplies

We cover ostomy and urological supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Ostomy and urological supplies exclusions

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services only when part of care covered under other headings in this "Benefits" section. The Services must be prescribed by a Plan Provider.

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section and (2) the equipment is provided inside our Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)

We cover laboratory tests to diagnose or screen for COVID-19 from Plan Providers or Non-Plan Providers, including a provider visit for purposes of receiving the laboratory test.

We cover up to a total of eight FDA-authorized over-the-counter COVID-19 tests per calendar month from Plan Providers or Non-Plan Providers. Over-the-counter tests are self-administered tests that deliver results at home and are available without a prescription. For purposes of this section, "Plan Provider" means a Plan Pharmacy, mail order delivery through our website at **kp.org**, or a participating retail pharmacy. For purposes of this section, a "Non-Plan Provider" means a pharmacy or online retailer that isn't a Plan Provider. To find out more about coverage and limitations, including the

current list of Plan Providers, visit our website or call Member Services.

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient Surgery and Outpatient Procedures")
- Services related to diagnosis and treatment of Infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services exclusions

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers:
  - ♦ Dentists if the drug is for dental care
  - ♦ Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - ♦ Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
  - ♦ Non–Plan Providers that are not providers of Emergency Services or Out-of-Area Urgent Care if the prescription is for COVID-19 therapeutics (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Post-Service Claims and Appeals" section)

Note: If you obtain a prescription from a Non-Plan Provider related to dental care or for COVID-19 therapeutics as described above, we do not cover an office visit or any other services from the Non-Plan Provider.

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item from a Non-Plan Provider as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section or a Non-Plan Provider prescribes COVID-19 therapeutics for you.

For the locations of Plan Pharmacies, refer to our Provider Directory or call Member Services.

Refills

You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, item, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply (or 365-day supply if the item is a hormonal contraceptive) for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies,

and supplements" section of the "Cost Share Summary," you will receive the supply prescribed up to the day supply limit specified in this section or in the drug formulary for your plan (see "About the drug formulary" below). The maximum you may receive at one time of a covered item, other than a hormonal contraceptive, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

If your plan includes coverage for hormonal contraceptives, the maximum you may receive at one time of contraceptive drugs is a 365-day supply. To obtain a 365-day supply, talk to your prescribing provider. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for hormonal contraceptives.

If your plan includes coverage for sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for sexual dysfunction drugs.

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary" for any drug to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, please refer to the California Commercial HMO formulary on our website at **kp.org/formulary**. The formulary also discloses requirements or limitations that apply to specific drugs, such as whether there is a limit on the amount of the drug that can be dispensed and whether the drug must be obtained at certain specialty pharmacies. If you would like to request a copy of this drug formulary, please call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Formulary exception process

Drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the "Dispute Resolution" section.

Continuity drugs

If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.

About drug tiers

Drugs for your plan are categorized into tiers as described in the table below (your plan doesn't have a Tier 3). Your Cost Share for covered items may vary based on the tier. Refer to "Outpatient prescription drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC* for Cost Share for items covered under this section. Refer to the drug formulary to find out which tier a particular drug is on and for the definition of "generic drug," "brand-name drug," and "specialty drug."

Tier	Description
Tier 1	Most generic drugs, supplies and supplements (also includes certain brand-name drugs, supplies, and supplements)
Tier 2	Most brand-name drugs, supplies, and supplements (also includes certain generic drugs, supplies, and supplements)
Tier 4	High-cost brand-name or generic drugs, supplies, and supplements (sometimes called "specialty drugs")

These tiers apply to formulary and non-formulary drugs, supplies and supplements. If you need help determining

whether a formulary or non-formulary drug, supply, or supplement is categorized as Tier 1, Tier 2, or Tier 4, please call Member Services. Note: Non-formulary drugs are not covered unless Medically Necessary as described under "Formulary exception process" in the "About the drug formulary" section above.

General rules about coverage and your Cost Share

We cover the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Drugs for which a prescription is required by law. We also cover certain over-the-counter drugs and items (drugs and items that do not require a prescription by law) if they are listed on our drug formulary and prescribed by a Plan Physician, except a prescription is not required for over-the-counter contraceptives
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on Tier 4, not the Cost Share for drugs on Tier 2)

Schedule II drugs

You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service

Prescription refills can be mailed within 3 to 5 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail-order service in the following ways:

- To order online, visit **kp.org/rxrefill** (you can register for a secure account at **kp.org/registernow**) or use the KP app from your smartphone or other mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option
- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Restrictions and limitations apply. For example, not all drugs can be mailed and we cannot mail drugs to all states.

Manufacturer coupon program

For outpatient prescription drugs or items that are covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum if applicable. Refer to the "Cost Share Summary" section of this *EOC* to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Drug Deductible

In any Accumulation Period, you must pay Charges for any items covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section that are subject to the Drug Deductible until you meet the applicable Drug Deductible amount listed in the "Cost Share Summary" section of this *EOC*.

The only payments that count toward this Drug Deductible are those you make under this *EOC* for covered items that are subject to this Drug Deductible. After you reach the Drug Deductible, you pay the applicable Copayments or Coinsurance for these items for the remainder of the Accumulation Period.

Services that are subject to the Drug Deductible
The Cost Share that you must pay for covered Services is described in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the Services are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible. Note: When the Cost Share for the Services is described as "no charge," but the Services are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Base drugs, supplies, and supplements
Cost Share for the following items may be different than other drugs, supplies, and supplements. Refer to "Base drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC*:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis
- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

For the following Services, refer to these sections

- Drugs prescribed for abortion or abortion-related Services (refer to "Reproductive Health Services")
- Administered contraceptives (refer to "Reproductive Health Services")
- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment ("DME") for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment ("DME") for Home Use")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - ♦ insulin
  - ♦ over-the-counter drugs covered under "Preventive Services" in this "Benefits" section (this includes tobacco cessation drugs and contraceptive drugs)
  - ♦ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- Drugs when prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. We may require Members who are prescribed drugs for morbid obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug

Outpatient Surgery and Outpatient Procedures

We cover the following outpatient care Services:

- Outpatient surgery
- Outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient procedures (including imaging and diagnostic Services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Preventive Services

We cover a variety of Preventive Services from Plan Providers, as listed on our website at **kp.org/prevention**, including the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list of recommended immunizations can be found at **cdc.gov/vaccines/schedules**
- Preventive services recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at **hrsa.gov/womens-guidelines**

Note: We cover immunizations to prevent COVID-19 that are administered in a Plan Medical Office or by a Non-Plan Provider. If you obtain this immunization from a Non-Plan Provider (except for providers of Emergency Services or Out-of-Area Urgent Care), we do not cover an office visit or any other services from the Non-Plan Provider other than administration of the vaccine.

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

If you are enrolled in a grandfathered plan, certain preventive items listed on our website, such as over-the-counter drugs, may not be covered. Refer to the "Certain preventive items" table in the "Cost Share Summary" section of this *EOC* for coverage information. If you have questions about Preventive Services, please call Member Services.

Note: Preventive Services help you stay healthy, before you have symptoms. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services that are not Preventive Services before, during, or after a visit that includes Preventive Services, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

For the following Services, refer to these sections

- Milk pumps and lactation supplies (refer to "Lactation supplies" under "Durable Medical Equipment ("DME") for Home Use")
- Health education programs (refer to "Health Education")
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Family planning counseling, consultations, and sterilization Services (refer to "Reproductive Health Services")

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to

determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices

We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

For internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Surgery and Outpatient Procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for Outpatient Surgery.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast:
  - ♦ prostheses, including custom-made prostheses when Medically Necessary
  - ♦ up to three brassieres required to hold a prosthesis in any 12-month period
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses 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

Supplemental prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items:

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services for Adult Members" and "Vision Services for Pediatric Members")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered Drugs and Products")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss, theft, or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible

- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

For covered Services related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the Services were not related to reconstructive surgery. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services, and see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Office visits not described in the "Reconstructive Surgery" section (refer to "Office Visits")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Rehabilitative and Habilitative Services

We cover the Services described in this "Rehabilitative and Habilitative Services" section if all of the following requirements are met:

- The Services are to address a health condition
- The Services are to help you keep, learn, or improve skills and functioning for daily living
- You receive the Services at a Plan Facility unless a Plan Physician determines that it is Medically Necessary for you to receive the Services in another location

We cover the following Services:

- Individual outpatient physical, occupational, and speech therapy
- Group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")

Rehabilitative and habilitative Services exclusions

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Reproductive Health Services

Family planning Services

We cover the following Services when provided for family planning purposes:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy
- Sterilization procedures for Members assigned female at birth
- Sterilization procedures for Members assigned male at birth

Plan Doula services

If you are pregnant or were pregnant within the last 12 months and want Plan Doula services, talk to your care team. We cover the following Plan Doula services:

- One initial visit
- Up to eight one-hour visits that may be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery

Up to two additional postpartum visits may be available.

Abortion and abortion-related Services

We cover the following Services:

- Surgical abortion
- Prescription drugs, in accord with our drug formulary guidelines
- Abortion-related Services

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services to diagnose or treat Infertility (refer to "Fertility Services")
- Office visits related to injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") when provided for medical reasons other than to prevent pregnancy (refer to "Office Visits")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient surgery and outpatient procedures when provided for medical reasons other than to prevent pregnancy (refer to "Outpatient Surgery and Outpatient Procedures")

Reproductive health Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Plan Doula services exclusions:
  - Clinical or medical Services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care)
  - Assistance with activities of daily living
  - Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation)
  - Yoga
  - Birthing ceremonies
  - Over-the-counter supplies or drugs
  - Home birth

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - a Plan Provider makes this determination
  - you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the federal Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - the National Institutes of Health

- the Centers for Disease Control and Prevention
- the Agency for Health Care Research and Quality
- the Centers for Medicare & Medicaid Services
- a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
- a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
- the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Services in connection with a clinical trial exclusions

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral Health Treatment for Autism Spectrum Disorder
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the prevention, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment at a licensed treatment center approved by Medical Group

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Outpatient laboratory, including drug testing (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits, and you may choose to receive in-person Services from a Plan Provider instead. Some Plan Providers offer Services exclusively through a telehealth technology platform and have no physical location at which you can receive Services. If you receive covered Services from these Plan Providers, you may access your medical record of the Telehealth Visit and, unless you object, such information will be added to your Health Plan electronic medical record and shared with your Primary Care Physician.

We cover the following types of Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits
- Scheduled telephone visits

Transplant Services

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call Member Services for questions about donor Services

For covered transplant Services that you receive, you will pay the Cost Share you would pay if the Services were not related to a transplant. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge (not subject to the Plan Deductible)**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Vision Services for Adult Members

For the purpose of this "Vision Services for Adult Members" section, an "Adult Member" is a Member who is age 19 or older and is not a Pediatric Member, as defined under "Vision Services for Pediatric Members" in this "Benefits" section. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Adult Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Adult Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Adult Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Vision Services for Pediatric Members

For the purpose of this "Vision Services for Pediatric Members" section, a "Pediatric Member" is a Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Pediatric Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Pediatric Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Pediatric Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. These exclusions or limitations do not apply to Services that are Medically Necessary to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or

licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, including cosmetic surgery (surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or hospital inpatient Services.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to the following Services:

- Services covered under "Dental and Orthodontic Services" in the "Benefits" section
- Service described under "Injury to Teeth" in the "Benefits" section
- Pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, if any. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the federal Food and Drug Administration ("FDA") and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," "Hospital Inpatient Services," "Rehabilitative and Habilitative Services," or "Skilled Nursing Facility Care" in the "Benefits" section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, and services of massage therapists.

Oral nutrition and weight loss aids

Outpatient oral nutrition, such as dietary supplements, herbal supplements, formulas, food, and weight loss aids.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, or inpatient respite care covered in the "Hospice Care" section.

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration ("FDA") approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section
- COVID-19 Services granted emergency use authorization by the FDA (COVID-19 laboratory tests, therapeutics, and immunizations must be prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care)

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the

Member's condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to covered Plan Doula services.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Also, Services in connection with assisted reproductive technology ("ART") Services related to a Surrogacy Arrangement. Refer to "Surrogacy Arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Coordination of Benefits

The Services covered under this *EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *EOC*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *EOC* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, please call Member Services.

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call Member Services to find out which Medicare rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we

cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such Services we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by other parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain (1) against another party, and/or (2) from other types of coverage or sources of payment that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, and/or personal injury coverages, any other types of medical payments and all other first party types of coverages or sources of payment. The proceeds of any judgment or settlement that you or we obtain and/or payments that you receive shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

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

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-214-1137

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

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

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive monetary compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or

any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

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

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

You must send this information to:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-214-1137

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

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call Member Services.

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

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

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services from a Non–Plan Provider and you want us to pay for the Services
- You have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our grievance form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for Services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

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 follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call Member Services.

Submitting a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

You may file a claim (request for payment/reimbursement):

- By visiting **kp.org**, completing an electronic form and uploading supporting documentation;
- By mailing a paper form that can be obtained by visiting **kp.org** or calling Member Services; or
- If you are unable access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claim:
  - Member/Patient Name and Medical/Health Record Number
  - The date you received the Services
  - Where you received the Services
  - Who provided the Services
  - Why you think we should pay for the Services
  - A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services

Mailing address to submit your claim to Kaiser Permanente:

Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Please call Member Services if you need help filing your claim.

Submitting a claim for all other Services

If you have received any other Services from a Non–Plan Provider that we did not authorize, then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Please call Member Services if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- 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 need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call Member Services for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:

  Kaiser Foundation Health Plan, Inc.

Special Services Unit
P.O. Box 23280
Oakland, CA 94623

- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for all other Services from a Non-Plan Provider that we did not authorize

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to any Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- In person at any Member Services office at a Plan Facility or any Plan Provider (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, please include any information that clarifies or supports your position. 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. To make a request, you should call Member Services.

Additional information regarding claims for all other Services from a Non–Plan Provider that we did not authorize

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and 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 the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about the external review process, see "Independent Medical Review ("IMR")" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at most Plan Facilities, or you can call Member Services.

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received from a Non–Plan Provider, please follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received.

Standard Procedure

To file a grievance electronically, use the grievance form on **kp.org**.

To file a grievance orally, call Member Services toll free at **1-800-464-4000** (TTY users call **711**).

To file a grievance in writing, please use our grievance form, which is available on **kp.org** under "Forms & Publications," in person from any Member Services office at a Plan Facility, or from Plan Providers (for addresses, refer to our Provider Directory or call Member Services). You can submit the form in the following ways:

- In person at any Member Services office at a Plan Facility

- By mail to any Member Services office at a Plan Facility

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Please call Member Services if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary prescription drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Urgent procedure

If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance. Note: Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure 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
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary prescription drug and your grievance involves a request to refill a non-formulary prescription drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but no later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non- Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding pre-service requests for Medically Necessary Services
You may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization
You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment
Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Independent Review Organization for Non-Formulary Prescription Drug Requests

If you filed a grievance to obtain a non-formulary prescription drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization ("IRO"). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit

P.O. Box 1809
Pleasanton, CA 94566

- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

For urgent IRO reviews, we will forward to you the independent reviewer's decision within 24 hours. For non-urgent requests, we will forward the independent reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care ("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary Services
  - you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's IMR organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or investigational denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within three days after we received your request. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying their recommendation. We do not cover the Services of the Non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, go to **hhs.gov/civil-rights**.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered),

for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted

- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
1 Kaiser Plaza, 19th Floor
Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the

Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2026, your last minute of coverage was at 11:59 p.m. on December 31, 2025). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any

Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2026, your last minute of coverage was at 11:59 p.m. on December 31, 2025.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy Arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

If you believe that we have terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this

coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act ("Cal-COBRA"), you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Member Services within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA enrollment and Premiums

Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay Full Premiums within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, your Premium payment for the upcoming coverage month is due on the last day of the preceding month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments may be subject to a fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for nonpayment of Cal-COBRA Premiums" section.

Changes to Cal-COBRA coverage and Premiums

Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *EOC* is still in effect and give you a

current one if this *EOC* has expired or been amended. You can also request one from Member Services.

Cal-COBRA open enrollment or termination of another health plan

If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call Member Services. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage

You may terminate your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA Premiums

If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the last day of the preceding month. If we do not receive Full Premium payment by the due date, we will send a notice of nonreceipt of payment to the Subscriber's address of record. You will have a 30-day grace period to pay the required Premiums before we terminate your Cal-COBRA coverage for nonpayment. The notice will state when the grace period begins and when the memberships of the Subscriber and all Dependents will terminate if the required Premiums are not paid. Your coverage will continue during this grace period. If we do not receive Full Premium payment by the end of the grace period, we will mail a termination notice to the Subscriber's address of record. After termination of your membership for nonpayment of Cal-COBRA Premiums, you are still responsible for paying all amounts due, including Premiums for the grace period.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums

If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage

Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under

"Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities

If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

USERRA

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

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC,* including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **buykp.org** or call Member Services. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement,* including this *EOC*.

Advance Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services office at a Plan Facility. For more information about advance directives, refer to our website at **kp.org** or call Member Services.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee

Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

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

Group and Members Not Our Agents

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

No Waiver

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

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy Practices

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

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request

confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call Member Services. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **about.kp.org** or from Member Services. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling Member Services.

Provider Directory

Refer to the Provider Directory for your Home Region for the following information:

- A list of Plan Physicians
- The location of Plan Facilities and the types of covered Services that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at **kp.org**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our Services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

Document Delivery Preferences

Many Health Plan documents are available electronically, such as bills, statements, and notices. If you prefer to get documents in electronic format, go to **kp.org** or call Member Services. You can change delivery preference at any time. To get a copy of a specific Heath Plan document in printed format, call Member Services.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week:

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (closed holidays)

Visit Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Write Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Website **kp.org**

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-390-3507** (TTY users call **711**)

Monday through Friday 6 a.m. to 5 p.m.

Website **kp.org**

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

24 hours a day, seven days a week (closed holidays)

Website **kp.org/travel**

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section under "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (closed holidays)

Website **kp.org**

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section, under "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Text telephone access ("TTY")

If you use a text telephone device ("TTY," also known as "TDD") to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *EOC*. Payment responsibility is more fully described in other sections of the *EOC* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Cost Share for covered Services (refer to the "Cost Share Summary" section)
- If you receive Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or COVID-19 Services from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or another party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for noncovered Services

Important Notices

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, or materials translated into your language or alternative formats. You can also request auxiliary aids and devices at our facilities. Call our Member Service Contact Center for help, 24 hours a day, 7 days a week (closed holidays).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. اتصل مع مركز اتصال خدمة الأعضاء لدينا، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع (العطلات مغلق).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- جميع الآخرين: **1-800-464-4000** (TTY **711**)

Armenian: Ձեզ կարող է անվճար լեզվական աջակցություն տրամադրվել օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման կապի կենտրոն օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է):

- Medi-Cal՝ **1-855-839-7613** (TTY **711**)
- Այլ՝ **1-800-464-4000** (TTY **711**)

Chinese: 我们每周 7 天，每天 24 小时免费提供语言帮助。您可以要求提供口译员、或将材料翻译为您所用语言或其他格式。您还可以在我们的设施中要求使用辅助工具和设备。请打电话给我们的会员服务联络中心，服务时间为每周 7 天，每天 24 小时（节假日除外）。

- 所有会员：**1-800-757-7585** (TTY **711**)

Farsi: خدمات زبانی در 24 ساعت شبانه‌روز و 7 روز هفته به‌صورت رایگان در اختیار شماست. می‌توانید خدمات مترجم شفاهی، یا ترجمه مدارک به زبان خود یا به فرمت‌های دیگر را درخواست کنید. همچنین می‌توانید دستگاه‌ها و کمک‌های دیگر را در مراکز ما درخواست نمایید. برای دریافت کمک، در 24 ساعت شبانه‌روز و 7 روز هفته (به‌جز تعطیلات) با مرکز تماس خدمات اعضای ما تماس بگیرید.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- سایر: **1-800-464-4000** (TTY **711**)

Hindi: बिना किसी लागत के भाषा सहायता, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप दुभाषिये की सेवाओं के लिए, या बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों का अनुरोध कर सकते हैं। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं।सहायता के लिए हमारी सदस्य सेवाओं के सम्पर्क केंद्र को, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- बाकी दूसरे: **1-800-464-4000** (TTY **711**)

Hmong: Muaj kev pab txhais lus pub dawb rau koj, 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Hu rau peb Qhov Chaw Pab Cov Tswv Cuab 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg (cov hnub caiv kaw).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Dua lwm cov: **1-800-464-4000** (TTY **711**)

Japanese: 多言語による情報支援を無料で 24 時間年中無休でご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは別の形式による資料もご所望いただけます。また、当施設における補助的な支援や機器についてもご所望いただけます。お気軽にご連絡ください（祝祭日を除き 24 時間週 7 日）。

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- その他のご連絡先: **1-800-464-4000** (TTY **711**)

Khmer (Cambodian): ជំនួយភាសា គឺឥតគិតថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ ឬឯកសារដែលបានបកប្រែ ជាភាសាខ្មែរ ឬទម្រង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយ ទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ ទូរស័ព្ទទៅមជ្ឈមណ្ឌល ទំនាក់ទំនងសេវាកម្មសមាជិករបស់យើងសម្រាប់ជំនួយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (ថ្ងៃឈប់សម្រាកបិទ)។

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ផ្សេងទៀតទាំងអស់: **1-800-464-4000** (TTY **711**)

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스 또는 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 저희 가입자 서비스 연락 센터에 주 7 일, 하루 24 시간(공휴일 휴무) 전화하셔서 도움을 받으십시오.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- 기타 모든 경우: **1-800-464-4000** (TTY **711**)

Laotian: ມີການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ. ທ່ານຍັງສາມາດຂໍບໍລິການຜູ້ແປພາສາ ຫຼື ເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໄດ້. ທ່ານຍັງສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ເຄື່ອງມືຢູ່ສະຖານບໍລິການຂອງພວກເຮົາໄດ້. ໂທຫາສູນຕິດຕໍ່ບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ (ບໍ່ດໃນວັນພັກ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ອື່ນໆທັງໝົດ: **1-800-464-4000** (TTY **711**)

Mien: Mbenc nzoih liouh wangv-henh tengx nzie faan waac bun muangx meih maiv cingv, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm leiz baaix mbenc maaih 7 hnoi. Meih se haih tov heuc tengx faan benx meih nyei waac bun muangx, a'fai zoux benx nyungc horngh jaa-sic zoux benx meih nyei waac. Meih corc haih tov tengx nyungc horngh jaa-dorngx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Beiv hnangv qiemx zuqc longc mienh nzie weih nor douc waac lorx taux yie mbuo ziux goux baengc mienh nyei gorn zangc, yietc hnoi tengx duqv 24 norm ziangh hoc, yietc norm leiz baaix tengx duqv 7 hnoi (simv cuotv gingc nyei hnoi se guon oc).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yietc zungv da'nyeic deix: **1-800-464-4000** (TTY **711**)

Navajo: Díí hózhó nízhoní bee hane' dóó jíik'ah jóóní doonílwo'. Ndik'é yádi naaltsoos bee haz'áanii bee hane' dóó yádi nihookaa dóó nádááhágíí yádi nihookaa. Shí éí bee háídínii bibee' haz'áanii dóó bee t'ah kodí bízíkinii wo'da'gi doolyé. Ahéhee' bik'ehgo nohólǫǫn'ígíí, 24 t'áádawołíí, 7 t'áádawołíígo (t'áadoo t'áálwo').

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yadilzingo biłk'ehgo bee: **1-800-464-4000** (TTY **711**)

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਲਈ, ਜਾਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਮਦਦ ਲਈ ਸਾਡੀ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਕਾੱਲ ਕਰੋ।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ਹੋਰ ਸਾਰੇ: **1-800-464-4000** (TTY **711**)

Russian: Языковая помощь доступна для вас бесплатно круглосуточно, ежедневно. Вы можете запросить услуги переводчика или материалы, переведенные на ваш язык или в альтернативные форматы. Вы также можете заказать вспомогательные средства и приспособления. Для получения помощи позвоните в наш центр обслуживания участников ежедневно, круглосуточно (кроме праздничных дней).

- Medi-Cal: **1-855-839-7613** (линия TTY **711**)
- Все остальные: **1-800-464-4000** (линия TTY **711**)

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Usted puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Llame a nuestra Central de Llamadas de Servicio a los Miembros para recibir ayuda 24 horas al día, 7 días a la semana (excepto los días festivos).

- Para todos los demás: **1-800-788-0616** (TTY **711**)

Tagalog: May magagamit na tulong sa wika nang wala kayong babayaran, 24 na oras sa isang araw, 7 araw sa isang linggo. Maaari kayong humiling ng mga serbisyo ng interpreter, o mga babasahin na isinalin sa inyong wika o sa mga alternatibong format. Maaari rin kayong humiling ng mga pantulong na gamit at device sa aming mga pasilidad. Tawagan ang aming Center sa Pakikipag-ugnayan ng Serbisyo sa Miyembro para sa tulong, 24 na oras sa isang araw, 7 araw sa isang linggo (sarado sa mga pista opisyal).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Lahat ng iba pa: **1-800-464-4000** (TTY **711**)

Thai: มีบริการช่วยเหลือด้านภาษาตลอด 24 ชั่วโมงทุกวันโดยไม่มีค่าใช้จ่าย โดยคุณสามารถขอใช้บริการล่าม บริการแปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่นๆ ได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการของเราโดยโทรหาเราที่ศูนย์ติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือตลอด 24 ชั่วโมงทุกวัน (ปิดทำการในช่วงวันหยุด)

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ที่อื่นๆทั้งหมด: **1-800-464-4000** (TTY **711**)

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача або отримання матеріалів у перекладі мовою, якою володієте, чи в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Телефонуйте в наш контактний центр для обслуговування клієнтів цілодобово, 7 днів на тиждень (крім святкових днів).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Усі інші: **1-800-464-4000** (TTY **711**)

Vietnamese: Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, hoặc tài liệu được dịch ra ngôn ngữ của quý vị hoặc nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Gọi cho Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**)

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente[1] follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center, 24 hours a day, 7 days a week (closed holidays). The call is free:

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Medi-Cal members may call **1-855-839-7613** (TTY **711**). All other members may call **1-800-464-4000** (TTY **711**). Help is available 24 hours a day, 7 days a week (closed holidays)
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.

[1] Kaiser Permanente is inclusive of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Medical Group

- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at:
  https://www.hhs.gov/ocr/complaints/index.html

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

EOC #13 - Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO
Evidence of Coverage for
BMO FINANCIAL CORP.

Group ID: 1932 Contract: 1 Version: 96 *EOC* Number: 13 Issue Date: November 19, 2024

January 1, 2025, through December 31, 2025

Member Services
24 hours a day, seven days a week (closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

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Cost Share Summary

This "Cost Share Summary" is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductibles and Out-of-Pocket Maximums

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

If your Group's plan changes during an Accumulation Period, your deductibles and out-of-pocket maximums may increase or decrease, which may change the total amount you must accumulate to reach the deductibles or out-of-pocket maximums during that Accumulation Period.

Note: The Plan Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Deductible	$1,750	$3,300	$3,500
Drug Deductible	Not applicable	Not applicable	Not applicable
Plan Out-of-Pocket Maximum ("OOPM")	$3,425	$3,425	$6,850

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, refer to the same benefit heading in the "Benefits" section of this *EOC*.

- **Copayment / Coinsurance**. This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the "Deductibles and Out-of-Pocket Maximums" section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read "Not covered." If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible**. This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a "✓" or "D" in this column, depending on which deductible applies ("✓" for Plan Deductible, "D" for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, refer to "Plan Deductible" and "Drug Deductible" in the "Benefits" section of this *EOC*.
- **Applies to OOPM**. This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum ("OOPM") after you have met any applicable deductible. If the Services count toward the Plan

OOPM, there will be a "✓" in this column. If the Services do not count toward the Plan OOPM, this column will be blank. For a more detailed explanation of the Plan OOPM, refer to "Plan Out-of-Pocket Maximum" in the "Benefits" section of this *EOC*.

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge	✓	✓
Allergy antigens (including administration)	20% Coinsurance	✓	✓
Cancer chemotherapy drugs and adjuncts	No charge	✓	✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood	No charge	✓	✓
All other administered drugs and products	No charge	✓	✓
Drugs and products administered to you during a home visit	No charge	✓	✓

Ambulance Services

Description of Ambulance Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency ambulance Services	20% Coinsurance	✓	✓
Nonemergency ambulance and psychiatric transport van Services	20% Coinsurance	✓	✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge	✓	✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge	✓	✓
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	20% Coinsurance	✓	✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Blood glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance	✓	✓
Other Base DME Items as described in this *EOC*	20% Coinsurance	✓	✓
Supplemental DME items as described in this *EOC*	20% Coinsurance	✓	✓
Retail-grade milk pumps	No charge		✓
Hospital-grade milk pumps	No charge		✓

Emergency Services and Urgent Care

Description of Emergency Services and Urgent Care	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency department visits	20% Coinsurance	✓	✓
Urgent Care visits	20% Coinsurance	✓	✓

Note: If you are admitted to the hospital as an inpatient from the emergency department, the emergency department visits Cost Share above does not apply. Instead, the Services you received in the emergency department, including any observation stay, if applicable, will be considered part of your hospital inpatient stay. For the Cost Share for inpatient Services, refer to "Hospital inpatient Services" in this "Cost Share Summary." The emergency department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Fertility Services

Diagnosis and treatment of Infertility

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Artificial insemination

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Assisted reproductive technology ("ART") Services

Description of ART Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Assisted reproductive technology ("ART") Services lifetime maximum
Covered ART Services are limited to one treatment cycle per lifetime.

Health education

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to tobacco cessation	No charge		✓

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	20% Coinsurance	✓	✓
Physician Specialist Visits to diagnose and treat hearing problems	20% Coinsurance	✓	✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	Not covered		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care Services (120 visits per Accumulation Period)	20% Coinsurance	✓	✓

Hospice care

Description of Hospice Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospice Services	20% Coinsurance	✓	✓

Hospital inpatient Services

Description of Hospital Inpatient Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient stays	20% Coinsurance	✓	✓

Injury to teeth

Description of Injury to Teeth Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	20% Coinsurance	✓	✓
Individual mental health evaluation and treatment	20% Coinsurance	✓	✓
Group mental health treatment	20% Coinsurance	✓	✓
Partial hospitalization	20% Coinsurance	✓	✓
Other intensive psychiatric treatment programs	20% Coinsurance	✓	✓
Residential mental health treatment Services	20% Coinsurance	✓	✓
Behavioral Health Treatment for Autism Spectrum Disorder	20% Coinsurance	✓	✓
Electroconvulsive therapy	20% Coinsurance	✓	✓
Transcranial magnetic stimulation	20% Coinsurance	✓	✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	20% Coinsurance	✓	✓
Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	20% Coinsurance	✓	✓
Group appointments that are not described elsewhere in this "Cost Share Summary"	20% Coinsurance	✓	✓
Acupuncture Services	20% Coinsurance	✓	✓

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	20% Coinsurance	✓	✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	20% Coinsurance	✓	✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	20% Coinsurance	✓	✓
Nuclear medicine	20% Coinsurance	✓	✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge	✓	✓
Over-the-counter COVID-19 tests obtained from Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month)	No charge	✓	✓
Over-the-counter COVID-19 tests obtained from Non-Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month, not to exceed $12 per test, including all fees and taxes, if you obtain the test from a Non-Plan Provider)	50% Coinsurance	✓	
Laboratory tests to diagnose or screen for COVID-19 obtained from Plan Providers	No charge	✓	✓
Laboratory tests to diagnose or screen for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance	✓	
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	20% Coinsurance	✓	✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	20% Coinsurance	✓	✓

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Radiation therapy	No charge	✓	✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge	✓	✓

Outpatient prescription drugs, supplies, and supplements

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on Tier 1 not described elsewhere in this "Cost Share Summary"	$10 for up to a 30-day supply	$20 for up to a 100-day supply	✓	✓
Items on Tier 2 not described elsewhere in this "Cost Share Summary"	30% Coinsurance (not to exceed $100) for up to a 100-day supply	30% Coinsurance (not to exceed $100) for up to a 100-day supply	✓	✓
Items on Tier 4 not described elsewhere in this "Cost Share Summary"	30% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available	✓	✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available	✓	✓
All other items on Tier 1 as described in this *EOC*	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
All other items on Tier 2 as described in this *EOC*	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
All other items on Tier 4 as described in this *EOC*	30% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Oral anticancer drugs on Tier 2	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Oral anticancer drugs on Tier 4	30% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Non-oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Non-oral anticancer drugs on Tier 2	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Non-oral anticancer drugs on Tier 4	30% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

Home infusion drugs

Description of Home Infusion Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available	✓	✓
Supplies necessary for administration of home infusion drugs	No charge	No charge	✓	✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Certain state-mandated items

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available	✓	✓
Therapeutics for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Therapeutics for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance for up to a 30-day supply	Not available	✓	
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available	✓	✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, refer to the "Most items" table above. For insulin pumps, refer to the "Durable Medical Equipment ("DME") for home use" table above.

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items on Tier 1: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 1: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items on Tier 2: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 2: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms, cervical caps, and up to a 30-day supply of condoms	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓
Items on our preventive items list on Tier 1	No charge for up to a 100-day supply	No charge for up to a 100-day supply		✓

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our preventive items list on Tier 2 and Tier 4	No charge for up to a 100-day supply	No charge for up to a 100-day supply		✓

Items on our preventive items list are covered at the Cost Share indicated when prescribed to prevent the onset of disease or illness (to get the current list, call Member Services).

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on Tier 1 prescribed to treat Infertility or in connection with covered artificial insemination Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	✓	✓
Drugs on Tier 2 and Tier 4 prescribed to treat Infertility or in connection with covered artificial insemination Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	✓	✓
Drugs on Tier 1 prescribed in connection with covered assisted reproductive technology ("ART") Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	✓	✓
Drugs on Tier 2 and Tier 4 prescribed in connection with covered assisted reproductive technology ("ART") Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	✓	✓
Drugs on Tier 1 prescribed for sexual dysfunction disorders	$10 for up to a 30-day supply	$20 for up to a 100-day supply	✓	✓
Drugs on Tier 2 and Tier 4 prescribed for sexual dysfunction disorders	30% Coinsurance (not to exceed $100) for up to a 100-day supply	30% Coinsurance (not to exceed $100) for up to a 100-day supply	✓	✓

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman, postpartum follow-up, and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Immunizations (including the vaccine) for COVID-19 administered by Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance	✓	
Tuberculosis skin tests	No charge		✓
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection ("STI") tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
External prosthetic and orthotic devices as described in this *EOC*	20% Coinsurance	✓	✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	20% Coinsurance	✓	✓

Rehabilitative and habilitative Services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	20% Coinsurance	✓	✓
Group outpatient physical, occupational, and speech therapy	20% Coinsurance	✓	✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	20% Coinsurance	✓	✓

Reproductive Health Services

Family planning Services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		✓
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		✓

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Sterilization procedures for Members assigned female at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned female at birth	No charge		✓
Sterilization procedures for Members assigned male at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge	✓	✓
All other sterilization procedures for Members assigned male at birth	No charge	✓	✓

Abortion and abortion-related Services

Description of abortion and abortion-related Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Surgical abortion	No charge	✓	✓
Prescription drugs, in accord with our drug formulary guidelines	No charge	✓	✓
Other abortion-related Services	No charge	✓	✓

Plan Doula services

Description of Plan Doula services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Initial, prenatal, or postpartum visits	No charge		✓
Support during labor and delivery	No charge		✓

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility Services up to 60 days per benefit period*	20% Coinsurance	✓	✓

*A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled

level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	20% Coinsurance	✓	✓
Individual substance use disorder evaluation and treatment	20% Coinsurance	✓	✓
Group substance use disorder treatment	20% Coinsurance	✓	✓
Intensive outpatient and day-treatment programs	20% Coinsurance	✓	✓
Methadone maintenance treatment	20% Coinsurance	✓	✓
Residential substance use disorder treatment	20% Coinsurance	✓	✓

Telehealth visits

Interactive video visits

Description of Interactive Video Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge	✓	✓
Physician Specialist Visits	No charge	✓	✓

Scheduled telephone visits

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge	✓	✓
Physician Specialist Visits	No charge	✓	✓

Vision Services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	20% Coinsurance		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	20% Coinsurance	✓	✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	20% Coinsurance	✓	✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge	✓	✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge	✓	✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	20% Coinsurance		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	20% Coinsurance	✓	✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	20% Coinsurance	✓	✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge	✓	✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge	✓	✓
Low vision devices (including fitting and dispensing)	Not covered		

CARE Plan

The California Community Assistance, Recovery, and Empowerment ("CARE") Act established a system for individuals with severe mental illness to be evaluated and given a treatment plan developed by a county behavioral health agency ("CARE Plan"). If a Member has a court-approved CARE Plan, we cover the Services required under that plan when provided by Plan Providers or Non-Plan Providers at **no charge subject to the Plan Deductible**, with the exception of prescription drugs and Preventive Services. Prescription drugs required under a court-approved CARE Plan are subject to the same Cost Share as drugs prescribed by Plan Providers, as described in this Cost Share Summary, and are also subject to prior authorization by Health Plan. Preventive Services are covered at **no charge (not subject to the Plan Deductible)**. To inform us that you have a court-approved CARE Plan, please call Member Services.

Introduction

This *Evidence of Coverage* (*"EOC"*) describes the health care coverage of this Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO provided under the *Group Agreement* (*"Agreement"*) between Kaiser Foundation Health Plan, Inc. ("Health Plan") and the entity with which Health Plan has entered into the *Agreement* (your "Group").

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan's evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

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

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The coverage information in this *EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Your Plan

Your plan is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in this *EOC* is designed to be compatible for

use with a Health Savings Account ("HSA") under federal tax law.

The tax references contained in this *EOC* relate to federal income tax only. The tax treatment of Health Savings Account contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Health Plan does not provide tax advice. You should consult with your financial or tax advisor for tax advice or more information, including information about your eligibility for a Health Savings Account.

Please be aware that enrollment in a High Deductible Health Plan that is compatible for use with a Health Savings Account is only one of the eligibility requirements for establishing and contributing to a Health Savings Account. For example, you will not be eligible to establish or contribute to a Health Savings Account if any of the following are true:

- You have other health care coverage in addition to the coverage under this *EOC*, unless both coverages qualify as High Deductible Health Plans, with certain exceptions
- You have Medicare coverage
- You can be claimed as a dependent on another person's tax return

If your Group provides a Health Reimbursement Arrangement ("HRA"), Health Incentive Account ("HIA"), or Flexible Spending Account ("FSA"), you may be able to use funds in the HRA, HIA, or FSA to pay Copayments, Coinsurance, and deductibles under this plan. However, most HRAs, HIAs, and FSAs provided through your Group are considered another health coverage plan for HSA purposes and will make you ineligible to establish or contribute to a Health Savings Account. Contact your Group or your tax advisor for more information.

Term of this *EOC*

This *EOC* is for the period January 1, 2025, through December 31, 2025, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC.* If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Behavioral Health Treatment for Autism Spectrum Disorder: 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 a person with autism spectrum disorder (or treat mental health conditions other than autism spectrum disorder when this treatment is clinically indicated) that meet the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is administered by a Plan Provider who is a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional, as defined in California Health and Safety Code section 1374.73(c)

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's

benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)

- For air ambulance Services received from Non-Plan Providers when you have an Emergency Medical Condition, the amount required to be paid by Health Plan pursuant to federal law
- For other Emergency Services received from Non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law
- For all other Services received from Non-Plan Providers (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Plan Provider and Health Plan or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Health Plan based on objective criteria
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Cigna Healthcare PPO Network: The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of a shared administration network arrangement called Cigna Healthcare PPO for Shared Administration.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Intellectual Property, Inc.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Disclosure Form ("DF"): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

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

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

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

- A medical screening exam that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the facility, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post-Stabilization Care and not Emergency Services)
- Post-Stabilization Care furnished by a Non-Plan Provider is covered as Emergency Services when federal law applies, as described under "Post-Stabilization Care" in the "Emergency Services" section

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO" under Health Plan's *Agreement* with your Group.

Family: A Subscriber and all of their Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *EOC* sometimes refers to Health Plan as "we" or "us."

Health Savings Account ("HSA"): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law eligibility requirements.

Health Plan does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

High Deductible Health Plan ("HDHP"): A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The health care coverage under this *EOC* has been designed to be a HDHP compatible for use with a Health Savings Account.

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Infertility: A person's inability to conceive a pregnancy or carry a pregnancy to live birth either as an individual or with their partner; or, a Plan Physician's determination of Infertility, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Kaiser Permanente State: California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, a Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under "Dental and Orthodontic Services" in the "Benefits" section, non-physician specialists include dentists and orthodontists.

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Doula: A contracted birth worker who provides physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth.

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities**. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call Member Services.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Refer to the "Cost Share Summary" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services.

Plan Physician: Any licensed physician who is an employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the emergency department), an independent freestanding emergency department, or a skilled nursing facility after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from an emergency department and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC,* except that you are responsible for paying Premiums if you have Cal-COBRA coverage. "Full Premiums" means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the "Premiums" section of Health Plan's *Agreement* with your Group.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at **kp.org/facilities** for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services.

Service Area: The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501-02, 94505, 94514, 94536-46, 94550-52, 94555, 94557, 94560, 94566, 94568, 94577-80, 94586-88, 94601-15, 94617-21, 94622-24, 94649, 94659-62, 94666, 94701-10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Northern California Service Area: 94505-07, 94509, 94511, 94513-14, 94516-31, 94547-49, 94551, 94553, 94556, 94561, 94563-65, 94569-70, 94572, 94575, 94582-83, 94595-98, 94706-08, 94801-08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903-04, 94912-15, 94920, 94924-25, 94929-30, 94933, 94937-42, 94945-50, 94952, 94956-57, 94960, 94963-66, 94970-71, 94973-74, 94976-79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- The following ZIP codes in Monterey County are inside our Northern California Service Area: 93901,

93902, 93905, 93906, 93907, 93912, 93915, 93933, 93955, 93962, 95004, 95012, 95039, 95076

- All ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203-09, 94211, 94229-30, 94232, 94234-37, 94239-40, 94244-45, 94247-50, 94252, 94254, 94256-59, 94261-63, 94267-69, 94271, 94273-74, 94277-80, 94282-85, 94287-91, 94293-98, 94571, 95608-11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638-39, 95641, 95652, 95655, 95660, 95662, 95670-71, 95673, 95678, 95680, 95683, 95690, 95693, 95741-42, 95757-59, 95763, 95811-38, 95840-43, 95851-53, 95860, 95864-67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Northern California Service Area: 94102-05, 94107-12, 94114-34, 94137, 94139-47, 94151, 94158-61, 94163-64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Northern California Service Area: 94514, 95201-15, 95219-20, 95227, 95230-31, 95234, 95236-37, 95240-42, 95253, 95258, 95267, 95269, 95296-97, 95304, 95320, 95330, 95336-37, 95361, 95366, 95376-78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Northern California Service Area: 94002, 94005, 94010-11, 94014-21, 94025-28, 94030, 94037-38, 94044, 94060-66, 94070, 94074, 94080, 94083, 94128, 94303, 94401-04, 94497
- The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, 95196
- All ZIP codes in Santa Cruz County are inside our Northern California Service Area: 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77
- All ZIP codes in Solano County are inside our Northern California Service Area: 94503, 94510, 94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Northern California Service Area: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- All ZIP codes in Stanislaus County are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397
- The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95836-7
- The following ZIP codes in Tulare County are inside our Northern California Service Area: 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95615-18, 95620, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in our Service Area, please call Member Services.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes physical health care, mental health care, and substance use disorder treatment), and Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities

for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

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

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children). The person may be impregnated in any manner including, but not limited to, artificial insemination, intrauterine insemination, in vitro fertilization, or through the surgical implantation of a fertilized egg of another person. For the purposes of this *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Full Premiums, except that you are responsible for paying Full Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *EOC*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) they live inside or move to the service area of another Region and do not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside our Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another

Region, please contact your Group to learn about your Group health care options:

- **Regions outside California**. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Southern California Region's service area**. Your Group may have an arrangement with us that permits membership in the Southern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Northern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the service areas of the other Regions, please call Member Services.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - ♦ biological children
  - ♦ stepchildren
  - ♦ adopted children
  - ♦ children placed with you for adoption
  - ♦ foster children if you or your Spouse have the legal authority to direct their care
  - ♦ children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care), if they meet all of the following requirements:
  - ♦ they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - ♦ they meet the requirements described under "Age limit of Dependent children"
  - ♦ they receive all of their support and maintenance from you or your Spouse
  - ♦ they permanently reside with you or your Spouse
- Certain Dependents may continue their memberships for a limited time after membership would otherwise terminate as a result of the Subscriber's death if permitted by your Group (please ask your Group for details)

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth).

Age limit of Dependent children

Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit

- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as a disabled Dependent. If we request it, the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Members with Medicare and retirees

This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *EOC* if permitted by your Group (please ask your Group for details).

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *EOC* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

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

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, placement for adoption, or placement for foster care by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments of newly acquired Dependent children are effective as follows:

- Enrollments due to birth are effective on the date of birth
- Enrollments due to adoption are effective on the date of adoption
- Enrollments due to placement for adoption or foster care are effective on the date you or your Spouse have newly assumed a legal right to control health care

Special enrollment due to loss of other coverage

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

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - ♦ exhaustion of COBRA coverage
  - ♦ termination of employer contributions for non-COBRA coverage
  - ♦ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ♦ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - ♦ reaching a lifetime maximum on all benefits

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order

Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible

Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service

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

Other special enrollment events

You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
  - a qualified individual was not enrolled in a qualified health plan
  - a qualified individual was not enrolled in the qualified health plan that the individual selected
  - a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

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

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in this "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)

- Other care that is not Urgent Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call Member Services. To request an appointment online, go to our website at **kp.org**.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

For information about Out-of-Area Urgent Care, refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

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 Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside our Service Area

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call Member Services). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Benefits" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org** or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a

referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy.

Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment

Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Medical Group's decision time frames

The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or

specialist that is needed, and the date that the Medical Group expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Completion of Services from Non–Plan Providers

New Member

If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility

The cases that are subject to this completion of Services provision are:

- Acute conditions, which are 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. We may cover these Services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Services
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date

- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area (the requirement that the provider agree to providing Services inside our Service Area doesn't apply if you were receiving covered Services from the provider outside our Service Area when the provider's contract terminated)
- The Services to be provided to you would be covered Services under this *EOC* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information
For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call Member Services.

Travel and Lodging for Certain Services

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside your Home Region Service Area for certain specialty Services such as a transplant or transgender surgery
- If you are outside of California and you need an abortion on an emergency or urgent basis, and the abortion can't be obtained in a timely manner due to a near total or total ban on health care providers' ability to provide such Services

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital Services for Members, please visit our website at **kp.org** or call Member Services.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals

If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Receiving Care Outside of Your Home Region Service Area

For information about your coverage when you are away from home, visit our website at **kp.org/travel**. You can also call the Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

Receiving care in another Kaiser Permanente service area

If you are visiting in another Kaiser Permanente service area, you may receive certain covered Services from designated providers in that other Kaiser Permanente service area, subject to exclusions, limitations, prior authorization or approval requirements, and reductions. For more information about receiving covered Services in another Kaiser Permanente service area, including provider and facility locations, please visit **kp.org/travel** or call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

For covered Services you receive in another Kaiser Permanente service area, you pay the Cost Share required for Services provided by a Plan Provider inside our Service Area as described in this *EOC*.

Receiving care outside of any Kaiser Permanente service area

If you are traveling outside of any Kaiser Permanente service area, we cover Emergency Services and Urgent Care as described in the "Emergency Services and Urgent Care" section.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent care appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days
- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. Except as specified above for mental health care and substance use disorder treatment, the standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Access to mental health Services and substance use disorder treatment

State law requires evidence of coverage documents to include the following notice:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Plan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card;

2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at http://www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call	**1-800-464-4000 (**English and more than 150 languages using interpreter services**)** **1-800-788-0616 (**Spanish**)** **1-800-757-7585 (**Chinese dialects**)** TTY users call **711** 24 hours a day, seven days a week (closed holidays)
Visit	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Write	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Website	kp.org

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at kp.org/facilities. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital emergency departments (for emergency department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)

Note: State law requires evidence of coverage documents to include the following notice:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract 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 enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Kaiser Permanente Member Services, to ensure that you can obtain the health care services that you need.

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

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

Post-Stabilization Care

When you receive Post-Stabilization Care from a Non-Plan Provider inside of California, or from a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State

When you receive Emergency Services, we cover Post-Stabilization Care from a Non–Plan Provider only if prior authorization for the care is obtained as described below, or if otherwise required by applicable law ("prior authorization" means that the Services must be approved in advance).

- **Post-Stabilization Care authorization at a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State:** If you are outside of a Kaiser Permanente state and you were treated at a Cigna Healthcare PPO Network facility for an Emergency Medical Condition, Cigna Payer Solutions is responsible for authorizing any Post-Stabilization Care
- **Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State):** To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered

  Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non–Plan Hospital or independent freestanding emergency department, please notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card

When you receive Post-Stabilization Care from a Non-Plan Provider that is not a Cigna Healthcare PPO Network provider outside of California

After you receive Emergency Services from Non-Plan Providers and your condition is Stabilized, Post-Stabilization Care is considered Emergency Services under federal law if either of the following are true:

- Your treating physician determines that you are not able to travel using nonemergency transportation to an available Plan Provider located within a reasonable travel distance, taking into account your medical condition; or
- Your treating physician, using appropriate medical judgment, determines that you are not in a condition to receive, and/or to provide consent to, the Non-Plan Provider's notice and consent form, in accordance with applicable state informed consent law

If the Post-Stabilization Care is considered Emergency Services under the criteria above, prior authorization for Post-Stabilization Care at a Non-Plan Provider will not be required.

If the Post-Stabilization Care is not considered Emergency Services, the Services are not covered unless you have received prior authorization from Health Plan as described under "Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State)" above. Non-Plan Providers outside of California may provide notice and seek your consent to waive your balance billing protections under the federal No Surprises Act, if such consent is permissible under applicable state informed consent law. If you consent to

waive your balance billing protections and receive Services from the Non-Plan Provider, you will have to pay the full cost of the Services.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Cost Share Summary" section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the emergency department of a Non–Plan Hospital, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient Services as described in the "Cost Share Summary" under "Hospital inpatient Services"
- If we gave prior authorization for durable medical equipment after discharge from a Non–Plan Hospital, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"
- If you receive COVID-19 laboratory testing or immunizations in the emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If you obtain a prescription in the emergency department related to your Emergency Medical Condition, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient prescription drugs, supplies, and supplements" in addition to the Cost Share for the emergency department visit

Urgent Care

Inside our Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Getting a Referral" in the "How to Obtain Services" section.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the "Cost Share Summary" section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If the Out-of-Area Urgent Care you receive includes a COVID-19 test, you may have to pay the Cost Share for a COVID-19 test as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in

addition to the Cost Share for the Urgent Care evaluation

- If you obtain a prescription as part of an Out-of-Area Urgent Care visit related to the condition for which you obtained Urgent Care, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient prescription drugs, supplies, and supplements" in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits" section, you are not responsible for any amounts beyond your Cost Share for covered Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" below
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" below
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" below
  - emergency ambulance Services, as described under "Ambulance Services" below

- ♦ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
- ♦ hospice care, as described under "Hospice Care" below

- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance.

If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Refer to the "Cost Share Summary" section of this *EOC* for the amount you will pay for Services.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered hospital inpatient or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Cost Share for Services received by newborn children of a Member

During the 31 days of automatic coverage for newborn children described under "If you have a baby" under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, the parent or guardian of the newborn must pay the Cost Share indicated in the "Cost Share Summary" section of this *EOC* for any Services that the newborn receives, whether or not the newborn is enrolled. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem

with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services

- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Share, or your Plan Provider is not able to collect Cost Share, if any, for Telehealth Visits you receive at home).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Please refer to the "Emergency Services and Urgent Care" section for more information about when you may be billed for Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care.

Reimbursement for COVID-19 Services from Non-Plan Providers

If you receive covered COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see "Initial Claims" in the "the "Post-Service Claims and Appeals" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services

If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services

do not apply to any deductible or out-of-pocket maximum.

Benefit limits

Some benefits may include a limit on the number of visits, days, treatment cycles, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the "Cost Share Summary" section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Services you receive during the benefit limit period toward the benefit limit, including Services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count Services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer group's plan, when you move from group to individual plan coverage (or vice versa), or when you received Services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company ("KPIC").

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m. Refer to the "Cost Share Summary" section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Drug Deductible

This *EOC* does not include a Drug Deductible.

Plan Deductible

In any Accumulation Period, you must pay Charges for Services subject to the Plan Deductible until you reach one of the Plan Deductible amounts listed in the "Cost Share Summary" section of this *EOC*.

If you are a Member in a Family of two or more Members, you reach the Plan Deductible either when you reach the amount for any one Member, or when your entire Family reaches the Family amount. For example, suppose you have reached the deductible amount for any one Member. For Services subject to the Plan Deductible, you will not pay Charges during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Charges during the remainder of the Accumulation Period until either they reach the deductible amount for any one Member, or the entire Family reaches the Family amount.

After you reach the Plan Deductible and for the remainder of the Accumulation Period, you pay the applicable Copayment or Coinsurance subject to the limits described under "Plan Out-of-Pocket Maximum" in this "Benefits" section.

Services that are subject to the Plan Deductible

All covered Services are subject to the Plan Deductible, except for certain preventive Services, as indicated in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Note: When the Cost Share for the Services is "no charge" and the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Also, if you pay a Plan Deductible amount for a Service that has a limit, such as a visit limit, the Services count toward reaching the limit.

The only payments that count toward the Plan Deductible are those you make for covered Services that are subject to this Plan Deductible under this *EOC*.

Increasing the Plan Deductible

If the U.S. Department of the Treasury increases the minimum deductible required in High Deductible Health Plans, we will increase the Plan Deductible if necessary to meet the new minimum deductible requirement, and we will notify your Group.

Changes to your Family

When your Family changes during the Accumulation Period from self-only coverage to two or more Members

(or vice versa), your Plan Deductible will change and the only Plan Deductible payments that will count in the new Family are those for Services that Members in the new Family received in that Accumulation Period under this *EOC*. For example:

- If you are a Family of one Member (self-only coverage) and then add Dependents during the Accumulation Period, the amounts that had been applied toward the Plan Deductible under your self-only coverage will be applied toward the new Plan Deductible required for the expanded Family of two or more Members. Each Member in your expanded Family, including you, must pay Charges for covered Services until they reach the Plan Deductible required for each Member in a Family of two or more Members (if applicable) or until your Family reaches the Plan Deductible required for a Family of two or more Members, even if you had met your Plan Deductible (for a Family of one Member) before you added the Dependents
- If all of your Dependents cease to be Members in your Family so that your Family becomes a Family of one Member, only the amounts that had been applied toward the Plan Deductible for Services that you received during the Accumulation Period will be applied toward the Plan Deductible required for self-only coverage. You must pay Charges for covered Services you receive on or after the date you become a Family of one Member until you reach the Plan Deductible required for self-only coverage, even if the Family had previously met the Plan Deductible for a Family of two or more Members

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. Refer to the "Cost Share Summary" section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the Plan Out-of-Pocket Maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either they reach the maximum for any one Member or your Family reaches the Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for covered Services apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a covered Service will apply to the maximum refer to the "Cost Share Summary" section of this *EOC*.

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, those Services will apply toward the maximum. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org** or call Member Services. We will provide you with accrual balance information for every month that you receive Services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

We will provide accrual balance information by mail unless you have opted to receive notices electronically. You can change your document delivery preferences at any time at **kp.org** or by calling Member Services.

Administered Drugs and Products

Administered drugs and products are medications and products that require administration or observation by medical personnel, such as:

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood
- Other administered drugs and products

We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

Certain administered drugs are Preventive Services. Refer to "Reproductive Health Services" for information about administered contraceptives and refer to "Preventive Services" for information on immunizations.

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient Services related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

For covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Share you would pay if the Services were not related to a bariatric surgical procedure. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

For the following Services, refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services under this *EOC*, but we do cover some dental and

orthodontic Services as described in this "Dental and Orthodontic Services" section.

For covered dental and orthodontic procedures that you may receive, you will pay the Cost Share you would pay if the Services were not related to dental and orthodontic Services. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services.

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

For the following Services, refer to these sections

- Accidental injury to teeth (refer to "Injury to Teeth")
- Office visits not described in the "Dental and Orthodontic Services" section (refer to "Office Visits")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- The Services are provided inside our Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient Services (refer to "Hospital Inpatient Services")
- Office visits not described in the "Dialysis Care" section (refer to "Office Visits")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

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

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

We cover DME that is not described under "Base DME Items" or "Lactation supplies," including repair and replacement of covered equipment, if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met.

Lactation supplies

We cover one retail-grade milk pump (also known as a breast pump) per pregnancy and associated supplies, as listed on our website at **kp.org/prevention**. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

If you or your baby has a medical condition that requires the use of a milk pump, we cover a hospital-grade milk pump and the necessary supplies to operate it, in accord with the coverage rules described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to an Emergency Medical Condition or Urgent Care episode (refer to "Post-Stabilization Care" and "Out-of-Area Urgent Care")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusions

- Comfort, convenience, or luxury equipment or features except for retail-grade milk pumps as described under "Lactation supplies" in this "Durable Medical Equipment ("DME") for Home Use" section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse

Emergency Services and Urgent Care

We cover the following Services:

- Emergency department visits
- Urgent Care consultations, evaluations, and treatment

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Diagnosis and treatment of Infertility

We cover the following Services for the diagnosis and treatment of Infertility:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services

- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stay directly related to diagnosis and treatment of Infertility

Artificial insemination

We cover the following Services for artificial insemination:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stays directly related to diagnosis and treatment of Infertility

Assisted reproductive technology ("ART") Services

We cover the following ART Services:

- Gamete intrafallopian transfer ("GIFT")
- In vitro fertilization ("IVF")
- Zygote intrafallopian transfer ("ZIFT")
- Transfer of cryopreserved embryos

Covered ART Services are limited to one treatment cycle per lifetime under any Health Plan evidence of coverage offered by your Group. If you reach the treatment cycle limit, we will not cover any more treatment cycles for as long as you are covered under this or any other Health Plan evidence of coverage offered by your Group.

A covered treatment cycle includes cryopreservation and storage of embryos for up to 6 months.

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Fertility Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Services related to the procurement and storage of semen and eggs, except if the retrieval is part of your covered ART treatment cycle
- Services related to the procurement and storage of embryos, except for storage of embryos that is part of your covered ART treatment cycle

Fertility Preservation Services for Iatrogenic Infertility

Standard fertility preservation Services are covered for Members undergoing treatment or receiving covered Services that may directly or indirectly cause iatrogenic Infertility. Fertility preservation Services do not include diagnosis or treatment of Infertility.

For covered fertility preservation Services that you receive, you will pay the Cost Share you would pay if the Services were not related to fertility preservation. For example, see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for outpatient procedures.

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or Member Services or go to our website at **kp.org**.

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction
- Physician Specialist Visits to diagnose and treat hearing problems

Hearing aids

Hearing aids and related Services are not covered under this *EOC*. For internally implanted devices, see "Prosthetic and Orthotic Devices" in this "Benefits" section.

For the following Services, refer to these sections

- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to "Preventive Services")
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover home health care only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan 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
- The Services are provided inside our Service Area

We cover only part-time or intermittent home health care, as follows:

- 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)
- Up to 120 visits per Accumulation Period (counting all home health visits)

Note: 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.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover

the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility

- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice Services listed below only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient Services required at a level that cannot be provided at home

Hospital Inpatient Services

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans

- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Benefits" section)
- Behavioral Health Treatment for Autism Spectrum Disorder
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental and orthodontic procedures (refer to "Dental and Orthodontic Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services related to diagnosis and treatment of Infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Injury to Teeth

Services for accidental injury to teeth are not covered under this *EOC*.

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the prevention, diagnosis, or treatment of Mental Health Conditions. A "Mental Health Condition" is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment, including treatment of first episode psychosis
- Psychological testing when necessary to evaluate a Mental Health Condition
- Outpatient Services for the purpose of monitoring drug therapy
- Behavioral Health Treatment for Autism Spectrum Disorder
- Electroconvulsive therapy
- Transcranial magnetic stimulation

Intensive psychiatric treatment programs

We cover intensive psychiatric treatment programs at a Plan Facility, such as:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient or day-treatment program
- Psychiatric observation for an acute psychiatric crisis

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment

facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Gender-affirming Services

For covered Services you receive for treatment of gender dysphoria, you will pay the Cost Share you would pay if the Services were not related to gender dysphoria. For example:

- See "Administered Drugs" for administered drugs
- See "Office Visits" for consultations for gender dysphoria treatment, such as hormone therapy, and hair removal procedures
- See "Outpatient Laboratory, Imaging, and Other Diagnostic and Treatment Services" for laboratory and imaging Services
- See "Outpatient Prescription Drugs, Supplies and Supplements" for drugs, supplies, and supplements
- See "Reconstructive Surgery" for surgical Services
- See "Rehabilitative and Habilitative Services" for speech (voice) therapy

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory and sleep studies (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Telehealth Visits (refer to "Telehealth Visits")

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- 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)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Ostomy and Urological Supplies

We cover ostomy and urological supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Ostomy and urological supplies exclusions

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services only when part of care covered under other headings in this "Benefits" section. The Services must be prescribed by a Plan Provider.

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section and (2) the equipment is provided inside our Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)

We cover laboratory tests to diagnose or screen for COVID-19 from Plan Providers or Non-Plan Providers, including a provider visit for purposes of receiving the laboratory test.

We cover up to a total of eight FDA-authorized over-the-counter COVID-19 tests per calendar month from Plan Providers or Non-Plan Providers. Over-the-counter tests are self-administered tests that deliver results at home and are available without a prescription. For purposes of this section, "Plan Provider" means a Plan Pharmacy, mail order delivery through our website at **kp.org**, or a participating retail pharmacy. For purposes of this section, a "Non-Plan Provider" means a pharmacy or online retailer that isn't a Plan Provider. To find out more about coverage and limitations, including the current list of Plan Providers, visit our website or call Member Services.

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient Surgery and Outpatient Procedures")
- Services related to diagnosis and treatment of Infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services exclusions

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features

- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
  - Non–Plan Providers that are not providers of Emergency Services or Out-of-Area Urgent Care if the prescription is for COVID-19 therapeutics (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Post-Service Claims and Appeals" section)

Note: If you obtain a prescription from a Non-Plan Provider related to dental care or for COVID-19 therapeutics as described above, we do not cover an office visit or any other services from the Non-Plan Provider.

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item from a Non-Plan Provider as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section or a Non-Plan Provider prescribes COVID-19 therapeutics for you.

For the locations of Plan Pharmacies, refer to our Provider Directory or call Member Services.

Refills

You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, item, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply (or 365-day supply if the item is a hormonal contraceptive) for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary," you will receive the supply prescribed up to the day supply limit specified in this section or in the drug formulary for your plan (see "About the drug formulary" below). The maximum you may receive at one time of a covered item, other than a hormonal contraceptive, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

If your plan includes coverage for hormonal contraceptives, the maximum you may receive at one time of contraceptive drugs is a 365-day supply. To obtain a 365-day supply, talk to your prescribing provider. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for hormonal contraceptives.

If your plan includes coverage for sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period. Refer to the

"Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for sexual dysfunction drugs.

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary" for any drug to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, please refer to the California Commercial HMO formulary on our website at **kp.org/formulary**. The formulary also discloses requirements or limitations that apply to specific drugs, such as whether there is a limit on the amount of the drug that can be dispensed and whether the drug must be obtained at certain specialty pharmacies. If you would like to request a copy of this drug formulary, please call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Formulary exception process

Drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the "Dispute Resolution" section.

Continuity drugs

If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.

About drug tiers

Drugs for your plan are categorized into tiers as described in the table below (your plan doesn't have a Tier 3). Your Cost Share for covered items may vary based on the tier. Refer to "Outpatient prescription drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC* for Cost Share for items covered under this section. Refer to the drug formulary to find out which tier a particular drug is on and for the definition of "generic drug," "brand-name drug," and "specialty drug."

Tier	Description
Tier 1	Most generic drugs, supplies and supplements (also includes certain brand-name drugs, supplies, and supplements)
Tier 2	Most brand-name drugs, supplies, and supplements (also includes certain generic drugs, supplies, and supplements)
Tier 4	High-cost brand-name or generic drugs, supplies, and supplements (sometimes called "specialty drugs")

These tiers apply to formulary and non-formulary drugs, supplies and supplements. If you need help determining whether a formulary or non-formulary drug, supply, or supplement is categorized as Tier 1, Tier 2, or Tier 4, please call Member Services. Note: Non-formulary drugs are not covered unless Medically Necessary as described under "Formulary exception process" in the "About the drug formulary" section above.

General rules about coverage and your Cost Share

We cover the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Drugs for which a prescription is required by law. We also cover certain over-the-counter drugs and items (drugs and items that do not require a prescription by law) if they are listed on our drug formulary and prescribed by a Plan Physician, except a prescription is not required for over-the-counter contraceptives
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on Tier 4, not the Cost Share for drugs on Tier 2)

Schedule II drugs

You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service

Prescription refills can be mailed within 3 to 5 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail-order service in the following ways:

- To order online, visit **kp.org/rxrefill** (you can register for a secure account at **kp.org/registernow**) or use the KP app from your smartphone or other mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option
- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Restrictions and limitations apply. For example, not all drugs can be mailed and we cannot mail drugs to all states.

Manufacturer coupon program

For outpatient prescription drugs or items that are covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, after reaching your applicable deductible amount and as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum if applicable. Refer to the "Cost Share Summary" section of this *EOC* to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Base drugs, supplies, and supplements

Cost Share for the following items may be different than other drugs, supplies, and supplements. Refer to "Base drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC*:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis
- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

For the following Services, refer to these sections

- Drugs prescribed for abortion or abortion-related Services (refer to "Reproductive Health Services")
- Administered contraceptives (refer to "Reproductive Health Services")
- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment ("DME") for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")

- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment ("DME") for Home Use")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - ♦ insulin
  - ♦ over-the-counter drugs covered under "Preventive Services" in this "Benefits" section (this includes tobacco cessation drugs and contraceptive drugs)
  - ♦ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- Drugs when prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. We may require Members who are prescribed drugs for morbid obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug

Outpatient Surgery and Outpatient Procedures

We cover the following outpatient care Services:

- Outpatient surgery
- Outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient procedures (including imaging and diagnostic Services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Preventive Services

We cover a variety of Preventive Services from Plan Providers, as listed on our website at **kp.org/prevention**, including the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list of recommended immunizations can be found at **cdc.gov/vaccines/schedules**
- Preventive services recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at **hrsa.gov/womens-guidelines**

Note: We cover immunizations to prevent COVID-19 that are administered in a Plan Medical Office or by a Non-Plan Provider. If you obtain this immunization from a Non-Plan Provider (except for providers of Emergency Services or Out-of-Area Urgent Care), we do not cover an office visit or any other services from the Non-Plan Provider other than administration of the vaccine.

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

If you are enrolled in a grandfathered plan, certain preventive items listed on our website, such as over-the-counter drugs, may not be covered. Refer to the "Certain preventive items" table in the "Cost Share Summary" section of this *EOC* for coverage information. If you have questions about Preventive Services, please call Member Services.

Note: Preventive Services help you stay healthy, before you have symptoms. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services that are not Preventive Services before, during, or after a visit that includes Preventive Services, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

For the following Services, refer to these sections

- Milk pumps and lactation supplies (refer to "Lactation supplies" under "Durable Medical Equipment ("DME") for Home Use")
- Health education programs (refer to "Health Education")
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Family planning counseling, consultations, and sterilization Services (refer to "Reproductive Health Services")

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices

We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

For internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Surgery and Outpatient Procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for Outpatient Surgery.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast:
  - ♦ prostheses, including custom-made prostheses when Medically Necessary
  - ♦ up to three brassieres required to hold a prosthesis in any 12-month period
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies

- Prostheses 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

Supplemental prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items:

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services for Adult Members" and "Vision Services for Pediatric Members")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered Drugs and Products")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss, theft, or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

For covered Services related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the Services were not related to reconstructive surgery. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services, and see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Office visits not described in the "Reconstructive Surgery" section (refer to "Office Visits")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Rehabilitative and Habilitative Services

We cover the Services described in this "Rehabilitative and Habilitative Services" section if all of the following requirements are met:

- The Services are to address a health condition
- The Services are to help you keep, learn, or improve skills and functioning for daily living

- You receive the Services at a Plan Facility unless a Plan Physician determines that it is Medically Necessary for you to receive the Services in another location

We cover the following Services:

- Individual outpatient physical, occupational, and speech therapy
- Group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")

Rehabilitative and habilitative Services exclusions

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Reproductive Health Services

Family planning Services

We cover the following Services when provided for family planning purposes:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy
- Sterilization procedures for Members assigned female at birth
- Sterilization procedures for Members assigned male at birth

Plan Doula services

If you are pregnant or were pregnant within the last 12 months and want Plan Doula services, talk to your care team. We cover the following Plan Doula services:

- One initial visit
- Up to eight one-hour visits that may be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery

Up to two additional postpartum visits may be available.

Abortion and abortion-related Services

We cover the following Services:

- Surgical abortion
- Prescription drugs, in accord with our drug formulary guidelines
- Abortion-related Services

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services to diagnose or treat Infertility (refer to "Fertility Services")
- Office visits related to injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") when provided for medical reasons other than to prevent pregnancy (refer to "Office Visits")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient surgery and outpatient procedures when provided for medical reasons other than to prevent pregnancy (refer to "Outpatient Surgery and Outpatient Procedures")

Reproductive health Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Plan Doula services exclusions:
  - Clinical or medical Services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care)
  - Assistance with activities of daily living
  - Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation)
  - Yoga
  - Birthing ceremonies
  - Over-the-counter supplies or drugs
  - Home birth

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - a Plan Provider makes this determination
  - you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the federal Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - the National Institutes of Health
  - the Centers for Disease Control and Prevention
  - the Agency for Health Care Research and Quality
  - the Centers for Medicare & Medicaid Services
  - a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Services in connection with a clinical trial exclusions

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services

- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral Health Treatment for Autism Spectrum Disorder
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the prevention, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment at a licensed treatment center approved by Medical Group

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use

disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Outpatient laboratory, including drug testing (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits, and you may choose to receive in-person Services from a Plan Provider instead. Some Plan Providers offer Services exclusively through a telehealth technology platform and have no physical location at which you can receive Services. If you receive covered Services from these Plan Providers, you may access your medical record of the Telehealth Visit and, unless you object, such information will be added to your Health Plan electronic medical record and shared with your Primary Care Physician.

We cover the following types of Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits
- Scheduled telephone visits

Transplant Services

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call Member Services for questions about donor Services

For covered transplant Services that you receive, you will pay the Cost Share you would pay if the Services were not related to a transplant. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge subject to the Plan Deductible**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Vision Services for Adult Members

For the purpose of this "Vision Services for Adult Members" section, an "Adult Member" is a Member who is age 19 or older and is not a Pediatric Member, as defined under "Vision Services for Pediatric Members"

in this "Benefits" section. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Adult Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Adult Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Adult Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Vision Services for Pediatric Members

For the purpose of this "Vision Services for Pediatric Members" section, a "Pediatric Member" is a Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Pediatric Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Pediatric Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Pediatric Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. These exclusions or limitations do not apply to Services that are Medically Necessary to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, including cosmetic surgery (surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or hospital inpatient Services.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to the following Services:

- Services covered under "Dental and Orthodontic Services" in the "Benefits" section
- Service described under "Injury to Teeth" in the "Benefits" section
- Pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, if any. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the federal Food and Drug Administration ("FDA") and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," "Hospital Inpatient Services," "Rehabilitative and Habilitative Services," or "Skilled Nursing Facility Care" in the "Benefits" section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, and services of massage therapists.

Oral nutrition and weight loss aids

Outpatient oral nutrition, such as dietary supplements, herbal supplements, formulas, food, and weight loss aids.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section

- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, or inpatient respite care covered in the "Hospice Care" section.

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration ("FDA") approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section
- COVID-19 Services granted emergency use authorization by the FDA (COVID-19 laboratory tests, therapeutics, and immunizations must be prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care)

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to covered Plan Doula services.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Also, Services in connection with assisted reproductive technology ("ART") Services related to a Surrogacy Arrangement. Refer to "Surrogacy Arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services" in the "Emergency Services and Urgent Care"

section, and we will provide coverage and reimbursement as described in that section.

Coordination of Benefits

The Services covered under this *EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *EOC*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *EOC* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, please call Member Services.

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call Member Services to find out which Medicare rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such Services we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by other parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain (1) against another party, and/or (2) from other types of coverage or sources of payment that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, and/or personal injury coverages, any other types of medical payments and all other first party types of coverages or sources of payment. The proceeds of any judgment or settlement that you or we obtain and/or payments that you receive shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

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

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-214-1137

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

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

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive monetary compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

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

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

You must send this information to:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-214-1137

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

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call Member Services.

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

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

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services from a Non–Plan Provider and you want us to pay for the Services
- You have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our grievance form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for Services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

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 follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call Member Services.

Submitting a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

You may file a claim (request for payment/reimbursement):

- By visiting **kp.org**, completing an electronic form and uploading supporting documentation;
- By mailing a paper form that can be obtained by visiting **kp.org** or calling Member Services; or
- If you are unable access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claim:
  - Member/Patient Name and Medical/Health Record Number
  - The date you received the Services
  - Where you received the Services
  - Who provided the Services
  - Why you think we should pay for the Services
  - A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services

Mailing address to submit your claim to Kaiser Permanente:

Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Please call Member Services if you need help filing your claim.

Submitting a claim for all other Services

If you have received any other Services from a Non–Plan Provider that we did not authorize, then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Please call Member Services if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- 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 need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call Member Services for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:

  Kaiser Foundation Health Plan, Inc.
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for all other Services from a Non-Plan Provider that we did not authorize

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to any Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- In person at any Member Services office at a Plan Facility or any Plan Provider (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, please include any information that clarifies or supports your position. 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. To make a request, you should call Member Services.

Additional information regarding claims for all other Services from a Non–Plan Provider that we did not authorize

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and 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 the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will

review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about the external review process, see "Independent Medical Review ("IMR")" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at most Plan Facilities, or you can call Member Services.

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received from a Non–Plan Provider, please follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself

- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received.

Standard Procedure

To file a grievance electronically, use the grievance form on **kp.org**.

To file a grievance orally, call Member Services toll free at **1-800-464-4000** (TTY users call **711**).

To file a grievance in writing, please use our grievance form, which is available on **kp.org** under "Forms & Publications," in person from any Member Services office at a Plan Facility, or from Plan Providers (for addresses, refer to our Provider Directory or call Member Services). You can submit the form in the following ways:

- In person at any Member Services office at a Plan Facility
- By mail to any Member Services office at a Plan Facility

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Please call Member Services if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary prescription drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Urgent procedure

If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance. Note: Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit

P.O. Box 1809
Pleasanton, CA 94566

- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure 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
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary prescription drug and your grievance involves a request to refill a non-formulary prescription drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but no later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non- Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding pre-service requests for Medically Necessary Services

You may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization

You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address

mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment

Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Independent Review Organization for Non-Formulary Prescription Drug Requests

If you filed a grievance to obtain a non-formulary prescription drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization ("IRO"). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

For urgent IRO reviews, we will forward to you the independent reviewer's decision within 24 hours. For non-urgent requests, we will forward the independent reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care ("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  - ♦ you have a recommendation from a provider requesting Medically Necessary Services
  - ♦ you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - ♦ you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's IMR organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or investigational denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within three days after we received your request. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying their recommendation. We do not cover the Services of the Non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the

United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, go to **hhs.gov/civil-rights**.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a

Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

> Kaiser Foundation Health Plan, Inc.
> Legal Department, Professional & Public Liability
> 1 Kaiser Plaza, 19th Floor
> Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as

to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2026, your last minute of coverage was at 11:59 p.m. on December 31, 2025). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2026, your last minute of coverage was at 11:59 p.m. on December 31, 2025.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy Arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may

also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

If you believe that we have terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act ("Cal-COBRA"), you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Member Services within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA enrollment and Premiums
Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay Full Premiums within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, your Premium payment for the upcoming coverage month is due on the last day of the preceding month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments may be subject to a fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for nonpayment of Cal-COBRA Premiums" section.

Changes to Cal-COBRA coverage and Premiums
Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended. You can also request one from Member Services.

Cal-COBRA open enrollment or termination of another health plan
If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call Member Services. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage
You may terminate your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA Premiums
If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under

"How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the last day of the preceding month. If we do not receive Full Premium payment by the due date, we will send a notice of nonreceipt of payment to the Subscriber's address of record. You will have a 30-day grace period to pay the required Premiums before we terminate your Cal-COBRA coverage for nonpayment. The notice will state when the grace period begins and when the memberships of the Subscriber and all Dependents will terminate if the required Premiums are not paid. Your coverage will continue during this grace period. If we do not receive Full Premium payment by the end of the grace period, we will mail a termination notice to the Subscriber's address of record. After termination of your membership for nonpayment of Cal-COBRA Premiums, you are still responsible for paying all amounts due, including Premiums for the grace period.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums

If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage

Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities

If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

USERRA

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

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and

your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC,* including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **buykp.org** or call Member Services. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement,* including this *EOC*.

Advance Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services office at a Plan Facility. For more information about advance directives, refer to our website at **kp.org** or call Member Services.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

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

Group and Members Not Our Agents

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

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or

impair our right thereafter to require your strict performance of any provision.

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy Practices

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

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call Member Services. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **about.kp.org** or from Member Services. If you would like to provide input about Health Plan public policy for

consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling Member Services.

Provider Directory

Refer to the Provider Directory for your Home Region for the following information:

- A list of Plan Physicians
- The location of Plan Facilities and the types of covered Services that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at **kp.org**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our Services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

Document Delivery Preferences

Many Health Plan documents are available electronically, such as bills, statements, and notices. If you prefer to get documents in electronic format, go to **kp.org** or call Member Services. You can change delivery preference at any time. To get a copy of a specific Heath Plan document in printed format, call Member Services.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week:

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (closed holidays)

Visit Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Write Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Website **kp.org**

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-390-3507** (TTY users call **711**)

Monday through Friday 6 a.m. to 5 p.m.

Website kp.org

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

24 hours a day, seven days a week (closed holidays)

Website kp.org/travel

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section under "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (closed holidays)

Website kp.org

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section, under "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Text telephone access ("TTY")

If you use a text telephone device ("TTY," also known as "TDD") to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *EOC*. Payment responsibility is more fully described in other sections of the *EOC* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Cost Share for covered Services (refer to the "Cost Share Summary" section)

- If you receive Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or COVID-19 Services from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or another party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for noncovered Services

Important Notices

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, or materials translated into your language or alternative formats. You can also request auxiliary aids and devices at our facilities. Call our Member Service Contact Center for help, 24 hours a day, 7 days a week (closed holidays).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. اتصل مع مركز اتصال خدمة الأعضاء لدينا، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع (العطلات مغلق).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- جميع الآخرين: **1-800-464-4000** (TTY **711**)

Armenian: Ձեզ կարող է անվճար լեզվական աջակցություն տրամադրվել օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման կապի կենտրոն օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է):

- Medi-Cal՝ **1-855-839-7613** (TTY **711**)
- Այլ՝ **1-800-464-4000** (TTY **711**)

Chinese: 我们每周 7 天，每天 24 小时免费提供语言帮助。您可以要求提供口译员、或将材料翻译为您所用语言或其他格式。您还可以在我们的设施中要求使用辅助工具和设备。请打电话给我们的会员服务联络中心，服务时间为每周 7 天，每天 24 小时（节假日除外）。

- 所有会员：**1-800-757-7585** (TTY **711**)

Farsi: خدمات زبانی در 24 ساعت شبانه‌روز و 7 روز هفته به‌صورت رایگان در اختیار شماست. می‌توانید خدمات مترجم شفاهی، یا ترجمه مدارک به زبان خود یا به فرمت‌های دیگر را درخواست کنید. همچنین می‌توانید دستگاه‌ها و کمک‌های دیگر را در مراکز ما درخواست نمایید. برای دریافت کمک، در 24 ساعت شبانه‌روز و 7 روز هفته (به‌جز تعطیلات) با مرکز تماس خدمات اعضای ما تماس بگیرید.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- سایر: **1-800-464-4000** (TTY **711**)

Hindi: बिना किसी लागत के भाषा सहायता, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप दुभाषिये की सेवाओं के लिए, या बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों का अनुरोध कर सकते हैं। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं।सहायता के लिए हमारी सदस्य सेवाओं के सम्पर्क केंद्र को, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- बाकी दूसरे: **1-800-464-4000** (TTY **711**)

Hmong: Muaj kev pab txhais lus pub dawb rau koj, 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Hu rau peb Qhov Chaw Pab Cov Tswv Cuab 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg (cov hnub caiv kaw).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Dua lwm cov: **1-800-464-4000** (TTY **711**)

Japanese: 多言語による情報支援を無料で 24 時間年中無休でご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは別の形式による資料もご所望いただけます。また、当施設における補助的な支援や機器についてもご所望いただけます。お気軽にご連絡ください（祝祭日を除き 24 時間週 7 日）。

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- その他のご連絡先: **1-800-464-4000** (TTY **711**)

Khmer (Cambodian): ជំនួយភាសា គឺឥតគិតថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ ឬឯកសារដែលបានបកប្រែ ជាភាសាខ្មែរ ឬទម្រង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយ ទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ ទូរស័ព្ទទៅមជ្ឈមណ្ឌល ទំនាក់ទំនងសេវាកម្មសមាជិករបស់យើងសម្រាប់ជំនួយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (ថ្ងៃឈប់សម្រាកបិទ)។

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ផ្សេងទៀតទាំងអស់: **1-800-464-4000** (TTY **711**)

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스 또는 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 저희 가입자 서비스 연락 센터에 주 7 일, 하루 24 시간(공휴일 휴무) 전화하셔서 도움을 받으십시오.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- 기타 모든 경우: **1-800-464-4000** (TTY **711**)

Laotian: ມີການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ. ທ່ານຍັງສາມາດຂໍບໍລິການຜູ້ແປພາສາ ຫຼື ເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໄດ້. ທ່ານຍັງສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ເຄື່ອງມືຢູ່ສະຖານບໍລິການຂອງພວກເຮົາໄດ້. ໂທຫາສູນຕິດຕໍ່ບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ (ບໍ່ດໃນວັນພັກ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ອື່ນໆທັງໝົດ: **1-800-464-4000** (TTY **711**)

Mien: Mbenc nzoih liouh wangv-henh tengx nzie faan waac bun muangx meih maiv cingv, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm leiz baaix mbenc maaih 7 hnoi. Meih se haih tov heuc tengx faan benx meih nyei waac bun muangx, a'fai zoux benx nyungc horngh jaa-sic zoux benx meih nyei waac. Meih corc haih tov tengx nyungc horngh jaa-dorngx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Beiv hnangv qiemx zuqc longc mienh nzie weih nor douc waac lorx taux yie mbuo ziux goux baengc mienh nyei gorn zangc, yietc hnoi tengx duqv 24 norm ziangh hoc, yietc norm leiz baaix tengx duqv 7 hnoi (simv cuotv gingc nyei hnoi se guon oc).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yietc zungv da'nyeic deix: **1-800-464-4000** (TTY **711**)

Navajo: Díí hózhó nízhoní bee hane' dóó jíik'ah jóóní doonílwo'. Ndik'é yádi naaltsoos bee haz'áanii bee hane' dóó yádi nihookaa dóó nádááhágíí yádi nihookaa. Shí éí bee háídínii bibee' haz'áanii dóó bee t'ah kodí bízíkinii wo'da'gi doolyé. Ahéhee' bik'ehgo nohólǫǫn'ígíí, 24 t'áádawołíí, 7 t'áádawołíígo (t'áadoo t'áálwo').

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yadilzingo biłk'ehgo bee: **1-800-464-4000** (TTY **711**)

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਲਈ, ਜਾਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਮਦਦ ਲਈ ਸਾਡੀ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਕਾੱਲ ਕਰੋ।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ਹੋਰ ਸਾਰੇ: **1-800-464-4000** (TTY **711**)

Russian: Языковая помощь доступна для вас бесплатно круглосуточно, ежедневно. Вы можете запросить услуги переводчика или материалы, переведенные на ваш язык или в альтернативные форматы. Вы также можете заказать вспомогательные средства и приспособления. Для получения помощи позвоните в наш центр обслуживания участников ежедневно, круглосуточно (кроме праздничных дней).

- Medi-Cal: **1-855-839-7613** (линия TTY **711**)
- Все остальные: **1-800-464-4000** (линия TTY **711**)

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Usted puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Llame a nuestra Central de Llamadas de Servicio a los Miembros para recibir ayuda 24 horas al día, 7 días a la semana (excepto los días festivos).

- Para todos los demás: **1-800-788-0616** (TTY **711**)

Tagalog: May magagamit na tulong sa wika nang wala kayong babayaran, 24 na oras sa isang araw, 7 araw sa isang linggo. Maaari kayong humiling ng mga serbisyo ng interpreter, o mga babasahin na isinalin sa inyong wika o sa mga alternatibong format. Maaari rin kayong humiling ng mga pantulong na gamit at device sa aming mga pasilidad. Tawagan ang aming Center sa Pakikipag-ugnayan ng Serbisyo sa Miyembro para sa tulong, 24 na oras sa isang araw, 7 araw sa isang linggo (sarado sa mga pista opisyal).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Lahat ng iba pa: **1-800-464-4000** (TTY **711**)

Thai: มีบริการช่วยเหลือด้านภาษาตลอด 24 ชั่วโมงทุกวันโดยไม่มีค่าใช้จ่าย โดยคุณสามารถขอใช้บริการล่าม บริการแปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่นๆ ได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการของเราโดยโทรหาเราที่ศูนย์ติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือตลอด 24 ชั่วโมงทุกวัน (ปิดทำการในช่วงวันหยุด)

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ที่อื่นๆทั้งหมด: **1-800-464-4000** (TTY **711**)

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача або отримання матеріалів у перекладі мовою, якою володієте, чи в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Телефонуйте в наш контактний центр для обслуговування клієнтів цілодобово, 7 днів на тиждень (крім святкових днів).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Усі інші: **1-800-464-4000** (TTY **711**)

Vietnamese: Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, hoặc tài liệu được dịch ra ngôn ngữ của quý vị hoặc nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Gọi cho Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**)

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente[1] follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center, 24 hours a day, 7 days a week (closed holidays). The call is free:

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Medi-Cal members may call **1-855-839-7613** (TTY **711**). All other members may call **1-800-464-4000** (TTY **711**). Help is available 24 hours a day, 7 days a week (closed holidays)
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.

[1] Kaiser Permanente is inclusive of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Medical Group

- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at:
  https://www.hhs.gov/ocr/complaints/index.html

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

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Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation

EOC #46 - Kaiser Permanente Deductible HMO Plan
Evidence of Coverage for
BMO FINANCIAL CORP.

Group ID: 102000 Contract: 1 Version: 89 *EOC* Number: 46 Issue Date: December 8, 2024

January 1, 2025, through December 31, 2025

Member Services
24 hours a day, seven days a week (closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

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Cost Share Summary

This "Cost Share Summary" is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductibles and Out-of-Pocket Maximums

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

If your Group's plan changes during an Accumulation Period, your deductibles and out-of-pocket maximums may increase or decrease, which may change the total amount you must accumulate to reach the deductibles or out-of-pocket maximums during that Accumulation Period.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Deductible	$750	$750	$1,500
Drug Deductible	$250	$250	Not applicable
Plan Out-of-Pocket Maximum ("OOPM")	$3,000	$3,000	$6,000

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, refer to the same benefit heading in the "Benefits" section of this *EOC*.

- **Copayment / Coinsurance**. This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the "Deductibles and Out-of-Pocket Maximums" section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read "Not covered." If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible**. This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a "✓" or "D" in this column, depending on which deductible applies ("✓" for Plan Deductible, "D" for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, refer to "Plan Deductible" and "Drug Deductible" in the "Benefits" section of this *EOC*.
- **Applies to OOPM**. This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum ("OOPM") after you have met any applicable deductible. If the Services count toward the Plan OOPM, there will be a "✓" in this column. If the Services do not count toward the Plan OOPM, this column will be

blank. For a more detailed explanation of the Plan OOPM, refer to "Plan Out-of-Pocket Maximum" in the "Benefits" section of this *EOC*.

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge	✓	✓
Allergy antigens (including administration)	No charge	✓	✓
Cancer chemotherapy drugs and adjuncts	No charge		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood	No charge		✓
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance Services

Description of Ambulance Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency ambulance Services	20% Coinsurance	✓	✓
Nonemergency ambulance and psychiatric transport van Services	20% Coinsurance	✓	✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge	✓	✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	$40 per visit	✓	✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Blood glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance		✓
Other Base DME Items as described in this *EOC*	20% Coinsurance		✓
Supplemental DME items as described in this *EOC*	20% Coinsurance		
Retail-grade milk pumps	No charge		✓
Hospital-grade milk pumps	No charge		✓

Emergency Services and Urgent Care

Description of Emergency Services and Urgent Care	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency department visits	$300 per visit	✓	✓
Urgent Care visits	$25 per visit		✓

Note: If you are admitted to the hospital as an inpatient from the emergency department, the emergency department visits Cost Share above does not apply. Instead, the Services you received in the emergency department, including any observation stay, if applicable, will be considered part of your hospital inpatient stay. For the Cost Share for inpatient Services, refer to "Hospital inpatient Services" in this "Cost Share Summary." The emergency department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Fertility Services

Diagnosis and treatment of Infertility

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Artificial insemination

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Assisted reproductive technology ("ART") Services

Description of ART Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Assisted reproductive technology ("ART") Services lifetime maximum
Covered ART Services are limited to one treatment cycle per lifetime.

Health education

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to tobacco cessation	No charge		✓

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	$25 per visit		✓
Physician Specialist Visits to diagnose and treat hearing problems	$40 per visit		✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	We provide a $2,000 Allowance for each ear every 36 months		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care Services (120 visits per Accumulation Period)	No charge		✓

Hospice care

Description of Hospice Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospice Services	No charge		✓

Hospital inpatient Services

Description of Hospital Inpatient Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient stays	20% Coinsurance	✓	✓

Injury to teeth

Description of Injury to Teeth Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	20% Coinsurance	✓	✓
Individual mental health evaluation and treatment	$25 per visit		✓
Group mental health treatment	$12 per visit		✓
Partial hospitalization	20% Coinsurance	✓	✓
Other intensive psychiatric treatment programs	20% Coinsurance	✓	✓
Residential mental health treatment Services	20% Coinsurance	✓	✓
Behavioral Health Treatment for Autism Spectrum Disorder	20% Coinsurance up to a maximum of $25 per day		✓
Electroconvulsive therapy	$25 per visit		✓
Transcranial magnetic stimulation	$25 per visit		✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	$25 per visit		✓
Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	$40 per visit		✓
Group appointments that are not described elsewhere in this “Cost Share Summary”	$12 per visit		✓

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Acupuncture Services	$25 per visit		✓

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	No charge		✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	20% Coinsurance	✓	✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	20% Coinsurance	✓	✓
Nuclear medicine	20% Coinsurance	✓	✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge	✓	✓
Over-the-counter COVID-19 tests obtained from Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month)	No charge		✓
Over-the-counter COVID-19 tests obtained from Non-Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month, not to exceed $12 per test, including all fees and taxes, if you obtain the test from a Non-Plan Provider)	50% Coinsurance	✓	
Laboratory tests to diagnose or screen for COVID-19 obtained from Plan Providers	No charge		✓
Laboratory tests to diagnose or screen for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance	✓	

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	20% Coinsurance	✓	✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	20% Coinsurance	✓	✓
Radiation therapy	No charge	✓	✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge		✓

Outpatient prescription drugs, supplies, and supplements

If an item in this section is subject to a deductible there will be a "✓" or "D" in the "Subject to Deductible" column. "✓" indicates the item is subject to the Plan Deductible. "D" indicates the item is subject to the Drug Deductible.

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on Tier 1 not described elsewhere in this "Cost Share Summary"	$10 for up to a 30-day supply	$20 for up to a 100-day supply	D	✓
Items on Tier 2 not described elsewhere in this "Cost Share Summary"	30% Coinsurance (not to exceed $100) for up to a 100-day supply	30% Coinsurance (not to exceed $100) for up to a 100-day supply	D	✓
Items on Tier 4 not described elsewhere in this "Cost Share Summary"	30% Coinsurance (not to exceed $100) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓
All other items on Tier 1 as described in this *EOC*	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓
All other items on Tier 2 as described in this *EOC*	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓
All other items on Tier 4 as described in this *EOC*	30% Coinsurance (not to exceed $100) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 2	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 4	30% Coinsurance (not to exceed $100) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Non-oral anticancer drugs on Tier 2	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓
Non-oral anticancer drugs on Tier 4	30% Coinsurance (not to exceed $100) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

Home infusion drugs

Description of Home Infusion Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available		✓
Supplies necessary for administration of home infusion drugs	No charge	No charge		✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Certain state-mandated items

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Therapeutics for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Therapeutics for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance for up to a 30-day supply	Not available	✓	
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available		✓

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	D	✓

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, refer to the "Most items" table above. For insulin pumps, refer to the "Durable Medical Equipment ("DME") for home use" table above.

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items on Tier 1: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 1: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items on Tier 2: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 2: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms, cervical caps, and up to a 30-day supply of condoms	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓
Items on our preventive items list on Tier 1	No charge for up to a 100-day supply	No charge for up to a 100-day supply		✓
Items on our preventive items list on Tier 2 and Tier 4	No charge for up to a 100-day supply	No charge for up to a 100-day supply		✓

Items on our preventive items list are covered at the Cost Share indicated when prescribed to prevent the onset of disease or illness (to get the current list, call Member Services).

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on Tier 1 prescribed to treat Infertility or in connection with covered artificial insemination Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	D	
Drugs on Tier 2 and Tier 4 prescribed to treat Infertility or in connection with covered artificial insemination Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	D	
Drugs on Tier 1 prescribed in connection with covered assisted reproductive technology (“ART”) Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	D	
Drugs on Tier 2 and Tier 4 prescribed in connection with covered assisted reproductive technology (“ART”) Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	D	
Drugs on Tier 1 prescribed for sexual dysfunction disorders	$10 for up to a 30-day supply	$20 for up to a 100-day supply	D	✓
Drugs on Tier 2 and Tier 4 prescribed for sexual dysfunction disorders	30% Coinsurance (not to exceed $100) for up to a 100-day supply	30% Coinsurance (not to exceed $100) for up to a 100-day supply	D	✓

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$40 per procedure		✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman, postpartum follow-up, and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Immunizations (including the vaccine) for COVID-19 administered by Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance	✓	
Tuberculosis skin tests	No charge		✓
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection ("STI") tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
External prosthetic and orthotic devices as described in this *EOC*	No charge		✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	No charge		✓

Rehabilitative and habilitative Services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	$25 per visit	✓	✓
Group outpatient physical, occupational, and speech therapy	$12 per visit	✓	✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	$25 per day	✓	✓

Reproductive Health Services

Family planning Services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		✓

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		✓
Sterilization procedures for Members assigned female at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned female at birth	No charge		✓
Sterilization procedures for Members assigned male at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned male at birth	No charge		✓

Abortion and abortion-related Services

Description of abortion and abortion-related Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Surgical abortion	No charge		✓
Prescription drugs, in accord with our drug formulary guidelines	No charge		✓
Other abortion-related Services	No charge		✓

Plan Doula services

Description of Plan Doula services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Initial, prenatal, or postpartum visits	No charge		✓
Support during labor and delivery	No charge		✓

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility Services up to 100 days per benefit period*	20% Coinsurance	✓	✓

*A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	20% Coinsurance	✓	✓
Individual substance use disorder evaluation and treatment	$25 per visit		✓
Group substance use disorder treatment	$12 per visit		✓
Intensive outpatient and day-treatment programs	20% Coinsurance		✓
Methadone maintenance treatment	No charge		✓
Residential substance use disorder treatment	20% Coinsurance	✓	✓

Telehealth visits

Interactive video visits

Description of Interactive Video Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Scheduled telephone visits

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Physician Specialist Visits	No charge		✓

Vision Services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$40 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$25 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$40 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$25 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Low vision devices (including fitting and dispensing)	Not covered		

CARE Plan

The California Community Assistance, Recovery, and Empowerment ("CARE") Act established a system for individuals with severe mental illness to be evaluated and given a treatment plan developed by a county behavioral health agency ("CARE Plan"). If a Member has a court-approved CARE Plan, we cover the Services required under that plan when provided by Plan Providers or Non-Plan Providers at **no charge (not subject to the Plan Deductible)**, with the exception of prescription drugs. Prescription drugs required under a court-approved CARE Plan are subject to the same Cost Share as drugs prescribed by Plan Providers, as described in this Cost Share Summary, and are also subject to prior authorization by Health Plan. To inform us that you have a court-approved CARE Plan, please call Member Services.

Introduction

This *Evidence of Coverage* (*"EOC"*) describes the health care coverage of this Kaiser Permanente Deductible HMO Plan provided under the *Group Agreement* (*"Agreement"*) between Kaiser Foundation Health Plan, Inc. ("Health Plan") and the entity with which Health Plan has entered into the *Agreement* (your "Group").

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan's evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

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

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The coverage information in this *EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Term of this *EOC*

This *EOC* is for the period January 1, 2025, through December 31, 2025, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC*. If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Behavioral Health Treatment for Autism Spectrum Disorder: 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 a person with autism spectrum disorder (or treat mental health conditions other than autism spectrum disorder when this treatment is clinically indicated) that meet the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is administered by a Plan Provider who is a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional, as defined in California Health and Safety Code section 1374.73(c)

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For air ambulance Services received from Non-Plan Providers when you have an Emergency Medical Condition, the amount required to be paid by Health Plan pursuant to federal law
- For other Emergency Services received from Non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law
- For all other Services received from Non-Plan Providers (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Plan Provider and Health Plan or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Health Plan based on objective criteria
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Cigna Healthcare PPO Network: The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of a shared administration network arrangement called Cigna Healthcare PPO for Shared Administration.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare

name, logo, and other marks are owned by Cigna Intellectual Property, Inc.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Disclosure Form ("DF"): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

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

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

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

- A medical screening exam that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the facility, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post-Stabilization Care and not Emergency Services)
- Post-Stabilization Care furnished by a Non-Plan Provider is covered as Emergency Services when federal law applies, as described under "Post-Stabilization Care" in the "Emergency Services" section

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" under Health Plan's *Agreement* with your Group.

Family: A Subscriber and all of their Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Infertility: A person's inability to conceive a pregnancy or carry a pregnancy to live birth either as an individual or with their partner; or, a Plan Physician's determination of Infertility, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Kaiser Permanente State: California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

Medically Necessary: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, a Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under "Dental and Orthodontic Services" in the "Benefits" section, non-physician specialists include dentists and orthodontists.

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Doula: A contracted birth worker who provides physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth.

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities**. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices

may change. If you have questions, please call Member Services.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call Member Services.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Refer to the "Cost Share Summary" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the emergency department), an independent freestanding emergency department, or a skilled nursing facility after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from an emergency department and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC,* except that you are responsible for paying Premiums if you have Cal-COBRA coverage. "Full Premiums" means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the "Premiums" section of Health Plan's *Agreement* with your Group.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at **kp.org/facilities** for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services.

Service Area: The ZIP codes below for each county are in our Service Area:

- The following ZIP codes in Imperial County are inside our Southern California Service Area: 92274-75
- The following ZIP codes in Kern County are inside our Southern California Service Area: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238,

93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581

- The following ZIP codes in Los Angeles County are inside our Southern California Service Area: 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-28, 91330-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91526, 91601-10, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- All ZIP codes in Orange County are inside our Southern California Service Area: 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711-12, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92850, 92856-57, 92859, 92861-71, 92885-87, 92899
- The following ZIP codes in Riverside County are inside our Southern California Service Area: 91752, 92028, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
- The following ZIP codes in San Bernardino County are inside our Southern California Service Area: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in San Diego County are inside our Southern California Service Area: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99
- The following ZIP codes in Tulare County are inside our Southern California Service Area: 93238, 93261
- The following ZIP codes in Ventura County are inside our Southern California Service Area: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in our Service Area, please call Member Services.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes physical health care, mental health care, and substance use disorder treatment), and Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section

within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

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

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children). The person may be impregnated in any manner including, but not limited to, artificial insemination, intrauterine insemination, in vitro fertilization, or through the surgical implantation of a fertilized egg of another person. For the purposes of this *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Full Premiums, except that you are responsible for paying Full Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *EOC*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) they live inside or move to the service area of another Region and do not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside our Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another

Region, please contact your Group to learn about your Group health care options:

- **Regions outside California**. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Northern California Region's service area**. Your Group may have an arrangement with us that permits membership in the Northern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Southern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the service areas of the other Regions, please call Member Services.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - ♦ biological children
  - ♦ stepchildren
  - ♦ adopted children
  - ♦ children placed with you for adoption
  - ♦ foster children if you or your Spouse have the legal authority to direct their care
  - ♦ children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care), if they meet all of the following requirements:
  - ♦ they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - ♦ they meet the requirements described under "Age limit of Dependent children"
  - ♦ they receive all of their support and maintenance from you or your Spouse
  - ♦ they permanently reside with you or your Spouse
- Certain Dependents may continue their memberships for a limited time after membership would otherwise terminate as a result of the Subscriber's death if permitted by your Group (please ask your Group for details)

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth).

Age limit of Dependent children

Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit

- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as a disabled Dependent. If we request it, the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Members with Medicare and retirees

This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *EOC* if permitted by your Group (please ask your Group for details).

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *EOC* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

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

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, placement for adoption, or placement for foster care by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments of newly acquired Dependent children are effective as follows:

- Enrollments due to birth are effective on the date of birth
- Enrollments due to adoption are effective on the date of adoption
- Enrollments due to placement for adoption or foster care are effective on the date you or your Spouse have newly assumed a legal right to control health care

Special enrollment due to loss of other coverage

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

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - ♦ exhaustion of COBRA coverage
  - ♦ termination of employer contributions for non-COBRA coverage
  - ♦ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - ♦ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - ♦ reaching a lifetime maximum on all benefits

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order

Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible

Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service

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

Other special enrollment events

You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
  - a qualified individual was not enrolled in a qualified health plan
  - a qualified individual was not enrolled in the qualified health plan that the individual selected
  - a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

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

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in this "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)

- Other care that is not Urgent Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call Member Services. To request an appointment online, go to our website at **kp.org**.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

For information about Out-of-Area Urgent Care, refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

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 Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside our Service Area

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call Member Services). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Benefits" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org** or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a

referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy.

Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment

Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Medical Group's decision time frames

The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or

specialist that is needed, and the date that the Medical Group expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Completion of Services from Non–Plan Providers

New Member

If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility

The cases that are subject to this completion of Services provision are:

- Acute conditions, which are 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. We may cover these Services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - ♦ it persists without full cure
  - ♦ it worsens over an extended period of time
  - ♦ it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Services
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date

- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area (the requirement that the provider agree to providing Services inside our Service Area doesn't apply if you were receiving covered Services from the provider outside our Service Area when the provider's contract terminated)
- The Services to be provided to you would be covered Services under this *EOC* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information
For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call Member Services.

Travel and Lodging for Certain Services

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside your Home Region Service Area for certain specialty Services such as a transplant or transgender surgery
- If you are outside of California and you need an abortion on an emergency or urgent basis, and the abortion can't be obtained in a timely manner due to a near total or total ban on health care providers' ability to provide such Services

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital Services for Members, please visit our website at **kp.org** or call Member Services.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals

If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Receiving Care Outside of Your Home Region Service Area

For information about your coverage when you are away from home, visit our website at **kp.org/travel**. You can also call the Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

Receiving care in another Kaiser Permanente service area

If you are visiting in another Kaiser Permanente service area, you may receive certain covered Services from designated providers in that other Kaiser Permanente service area, subject to exclusions, limitations, prior authorization or approval requirements, and reductions. For more information about receiving covered Services in another Kaiser Permanente service area, including provider and facility locations, please visit **kp.org/travel** or call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

For covered Services you receive in another Kaiser Permanente service area, you pay the Cost Share required for Services provided by a Plan Provider inside our Service Area as described in this *EOC*.

Receiving care outside of any Kaiser Permanente service area

If you are traveling outside of any Kaiser Permanente service area, we cover Emergency Services and Urgent Care as described in the "Emergency Services and Urgent Care" section.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent care appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days
- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. Except as specified above for mental health care and substance use disorder treatment, the standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Access to mental health Services and substance use disorder treatment

State law requires evidence of coverage documents to include the following notice:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Plan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card;

2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at http://www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call	**1-800-464-4000 (**English and more than 150 languages using interpreter services**)** **1-800-788-0616 (**Spanish**)** **1-800-757-7585 (**Chinese dialects**)** TTY users call **711** 24 hours a day, seven days a week (closed holidays)
Visit	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Write	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Website	kp.org

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at kp.org/facilities. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital emergency departments (for emergency department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)

Note: State law requires evidence of coverage documents to include the following notice:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract 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 enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Kaiser Permanente Member Services, to ensure that you can obtain the health care services that you need.

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

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

Post-Stabilization Care

When you receive Post-Stabilization Care from a Non-Plan Provider inside of California, or from a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State

When you receive Emergency Services, we cover Post-Stabilization Care from a Non–Plan Provider only if prior authorization for the care is obtained as described below, or if otherwise required by applicable law ("prior authorization" means that the Services must be approved in advance).

- **Post-Stabilization Care authorization at a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State:** If you are outside of a Kaiser Permanente state and you were treated at a Cigna Healthcare PPO Network facility for an Emergency Medical Condition, Cigna Payer Solutions is responsible for authorizing any Post-Stabilization Care
- **Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State):** To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered

  Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non–Plan Hospital or independent freestanding emergency department, please notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card

When you receive Post-Stabilization Care from a Non-Plan Provider that is not a Cigna Healthcare PPO Network provider outside of California

After you receive Emergency Services from Non-Plan Providers and your condition is Stabilized, Post-Stabilization Care is considered Emergency Services under federal law if either of the following are true:

- Your treating physician determines that you are not able to travel using nonemergency transportation to an available Plan Provider located within a reasonable travel distance, taking into account your medical condition; or
- Your treating physician, using appropriate medical judgment, determines that you are not in a condition to receive, and/or to provide consent to, the Non-Plan Provider's notice and consent form, in accordance with applicable state informed consent law

If the Post-Stabilization Care is considered Emergency Services under the criteria above, prior authorization for Post-Stabilization Care at a Non-Plan Provider will not be required.

If the Post-Stabilization Care is not considered Emergency Services, the Services are not covered unless you have received prior authorization from Health Plan as described under "Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State)" above. Non-Plan Providers outside of California may provide notice and seek your consent to waive your balance billing protections under the federal No Surprises Act, if such consent is permissible under applicable state informed consent law. If you consent to

waive your balance billing protections and receive Services from the Non-Plan Provider, you will have to pay the full cost of the Services.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Cost Share Summary" section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the emergency department of a Non–Plan Hospital, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient Services as described in the "Cost Share Summary" under "Hospital inpatient Services"
- If we gave prior authorization for durable medical equipment after discharge from a Non–Plan Hospital, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"
- If you receive COVID-19 laboratory testing or immunizations in the emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If you obtain a prescription in the emergency department related to your Emergency Medical Condition, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient prescription drugs, supplies, and supplements" in addition to the Cost Share for the emergency department visit

Urgent Care

Inside our Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Getting a Referral" in the "How to Obtain Services" section.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the "Cost Share Summary" section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If the Out-of-Area Urgent Care you receive includes a COVID-19 test, you may have to pay the Cost Share for a COVID-19 test as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in

addition to the Cost Share for the Urgent Care evaluation

- If you obtain a prescription as part of an Out-of-Area Urgent Care visit related to the condition for which you obtained Urgent Care, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient prescription drugs, supplies, and supplements" in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits" section, you are not responsible for any amounts beyond your Cost Share for covered Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" below
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" below
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" below
  - emergency ambulance Services, as described under "Ambulance Services" below

- ♦ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
- ♦ hospice care, as described under "Hospice Care" below

- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance.

If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Refer to the "Cost Share Summary" section of this *EOC* for the amount you will pay for Services.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered hospital inpatient or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Cost Share for Services received by newborn children of a Member

During the 31 days of automatic coverage for newborn children described under "If you have a baby" under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, the parent or guardian of the newborn must pay the Cost Share indicated in the "Cost Share Summary" section of this *EOC* for any Services that the newborn receives, whether or not the newborn is enrolled. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem

with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services

- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Share, or your Plan Provider is not able to collect Cost Share, if any, for Telehealth Visits you receive at home).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Please refer to the "Emergency Services and Urgent Care" section for more information about when you may be billed for Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care.

Reimbursement for COVID-19 Services from Non-Plan Providers

If you receive covered COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see "Initial Claims" in the "the "Post-Service Claims and Appeals" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services

If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services

do not apply to any deductible or out-of-pocket maximum.

Benefit limits

Some benefits may include a limit on the number of visits, days, treatment cycles, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the "Cost Share Summary" section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Services you receive during the benefit limit period toward the benefit limit, including Services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count Services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer group's plan, when you move from group to individual plan coverage (or vice versa), or when you received Services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company ("KPIC").

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m. Refer to the "Cost Share Summary" section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Drug Deductible

Refer to the "Cost Share Summary" section of this *EOC* for Services that are subject to the Drug Deductible and the Drug Deductible amount. When the Cost Share for the Services is described as "subject to the Drug Deductible," your Cost Share for those Services will be Charges until you reach the Drug Deductible. Note: When the Cost Share for the Services is described as "no charge subject to the Drug Deductible," your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Plan Deductible

In any Accumulation Period, you must pay Charges for Services subject to the Plan Deductible until you reach one of the Plan Deductible amounts listed in the "Cost Share Summary" section of this *EOC*.

If you are a Member in a Family of two or more Members, you reach the Plan Deductible either when you reach the amount for any one Member, or when your entire Family reaches the Family amount. For example, suppose you have reached the deductible amount for any one Member. For Services subject to the Plan Deductible, you will not pay Charges during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Charges during the remainder of the Accumulation Period until either they reach the deductible amount for any one Member, or the entire Family reaches the Family amount.

After you reach the Plan Deductible and for the remainder of the Accumulation Period, you pay the applicable Copayment or Coinsurance subject to the limits described under "Plan Out-of-Pocket Maximum" in this "Benefits" section.

Services that are subject to the Plan Deductible

The Cost Share that you must pay for covered Services is described in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Note: When the Cost Share for the Services is "no charge" and the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Also, if you pay a Plan Deductible amount for a Service that has a limit, such as a visit limit, the Services count toward reaching the limit.

The only payments that count toward the Plan Deductible are those you make for covered Services that are subject to this Plan Deductible under this *EOC*.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. Refer to the "Cost Share Summary" section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the Plan Out-of-Pocket Maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either they reach the maximum for any one Member or your Family reaches the Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for covered Services apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a covered Service will apply to the maximum refer to the "Cost Share Summary" section of this *EOC*.

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, those Services will apply toward the maximum. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org** or call Member Services. We will provide you with accrual balance information for every month that you receive Services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

We will provide accrual balance information by mail unless you have opted to receive notices electronically. You can change your document delivery preferences at any time at **kp.org** or by calling Member Services.

Administered Drugs and Products

Administered drugs and products are medications and products that require administration or observation by medical personnel, such as:

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood
- Other administered drugs and products

We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

Certain administered drugs are Preventive Services. Refer to "Reproductive Health Services" for information about administered contraceptives and refer to "Preventive Services" for information on immunizations.

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient Services related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

For covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Share you would pay if the Services were not related to a bariatric surgical procedure. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

For the following Services, refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services under this *EOC*, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

For covered dental and orthodontic procedures that you may receive, you will pay the Cost Share you would pay if the Services were not related to dental and orthodontic Services. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services.

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

For the following Services, refer to these sections

- Accidental injury to teeth (refer to "Injury to Teeth")
- Office visits not described in the "Dental and Orthodontic Services" section (refer to "Office Visits")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- The Services are provided inside our Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient Services (refer to "Hospital Inpatient Services")
- Office visits not described in the "Dialysis Care" section (refer to "Office Visits")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

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

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

We cover DME that is not described under "Base DME Items" or "Lactation supplies," including repair and replacement of covered equipment, if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met.

Lactation supplies

We cover one retail-grade milk pump (also known as a breast pump) per pregnancy and associated supplies, as listed on our website at **kp.org/prevention**. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

If you or your baby has a medical condition that requires the use of a milk pump, we cover a hospital-grade milk pump and the necessary supplies to operate it, in accord with the coverage rules described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to an Emergency Medical Condition or Urgent Care episode (refer to "Post-Stabilization Care" and "Out-of-Area Urgent Care")

- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusions

- Comfort, convenience, or luxury equipment or features except for retail-grade milk pumps as described under "Lactation supplies" in this "Durable Medical Equipment ("DME") for Home Use" section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse

Emergency Services and Urgent Care

We cover the following Services:

- Emergency department visits
- Urgent Care consultations, evaluations, and treatment

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Diagnosis and treatment of Infertility

We cover the following Services for the diagnosis and treatment of Infertility:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stay directly related to diagnosis and treatment of Infertility

Artificial insemination

We cover the following Services for artificial insemination:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stays directly related to diagnosis and treatment of Infertility

Assisted reproductive technology ("ART") Services

We cover the following ART Services:

- Gamete intrafallopian transfer ("GIFT")
- In vitro fertilization ("IVF")
- Zygote intrafallopian transfer ("ZIFT")
- Transfer of cryopreserved embryos

Covered ART Services are limited to one treatment cycle per lifetime under any Health Plan evidence of coverage offered by your Group. If you reach the treatment cycle limit, we will not cover any more treatment cycles for as long as you are covered under this or any other Health Plan evidence of coverage offered by your Group.

A covered treatment cycle includes cryopreservation and storage of embryos for up to 6 months.

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Fertility Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Services related to the procurement and storage of semen and eggs, except if the retrieval is part of your covered ART treatment cycle
- Services related to the procurement and storage of embryos, except for storage of embryos that is part of your covered ART treatment cycle

Fertility Preservation Services for Iatrogenic Infertility

Standard fertility preservation Services are covered for Members undergoing treatment or receiving covered Services that may directly or indirectly cause iatrogenic Infertility. Fertility preservation Services do not include diagnosis or treatment of Infertility.

For covered fertility preservation Services that you receive, you will pay the Cost Share you would pay if the Services were not related to fertility preservation. For example, see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for outpatient procedures.

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or Member Services or go to our website at **kp.org**.

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction
- Physician Specialist Visits to diagnose and treat hearing problems

Hearing aids

We provide an Allowance for each ear toward the purchase price of a hearing aid (including fitting, counseling, adjustment, cleaning, and inspection) when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later. Refer to "Hearing Services" in the "Cost Share Summary" section of this *EOC* for your Allowance amount.

We select the provider or vendor that will furnish the covered hearing aids. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

For the following Services, refer to these sections

- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to "Preventive Services")
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover home health care only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan 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
- The Services are provided inside our Service Area

We cover only part-time or intermittent home health care, as follows:

- 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)
- Up to 120 visits per Accumulation Period (counting all home health visits)

Note: 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.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice Services listed below only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient Services required at a level that cannot be provided at home

Hospital Inpatient Services

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Benefits" section)
- Behavioral Health Treatment for Autism Spectrum Disorder
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental and orthodontic procedures (refer to "Dental and Orthodontic Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services related to diagnosis and treatment of Infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Injury to Teeth

Services for accidental injury to teeth are not covered under this *EOC*.

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the prevention, diagnosis, or treatment of Mental Health Conditions. A "Mental Health Condition" is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment, including treatment of first episode psychosis
- Psychological testing when necessary to evaluate a Mental Health Condition
- Outpatient Services for the purpose of monitoring drug therapy
- Behavioral Health Treatment for Autism Spectrum Disorder
- Electroconvulsive therapy
- Transcranial magnetic stimulation

Intensive psychiatric treatment programs

We cover intensive psychiatric treatment programs at a Plan Facility, such as:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient or day-treatment program
- Psychiatric observation for an acute psychiatric crisis

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Gender-affirming Services

For covered Services you receive for treatment of gender dysphoria, you will pay the Cost Share you would pay if the Services were not related to gender dysphoria. For example:

- See "Administered Drugs" for administered drugs
- See "Office Visits" for consultations for gender dysphoria treatment, such as hormone therapy, and hair removal procedures
- See "Outpatient Laboratory, Imaging, and Other Diagnostic and Treatment Services" for laboratory and imaging Services
- See "Outpatient Prescription Drugs, Supplies and Supplements" for drugs, supplies, and supplements
- See "Reconstructive Surgery" for surgical Services
- See "Rehabilitative and Habilitative Services" for speech (voice) therapy

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory and sleep studies (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Telehealth Visits (refer to "Telehealth Visits")

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- 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)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Ostomy and Urological Supplies

We cover ostomy and urological supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain

referrals" under "Getting a Referral" in the "How to Obtain Services" section

- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Ostomy and urological supplies exclusions

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services only when part of care covered under other headings in this "Benefits" section. The Services must be prescribed by a Plan Provider.

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section and (2) the equipment is provided inside our Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)

We cover laboratory tests to diagnose or screen for COVID-19 from Plan Providers or Non-Plan Providers, including a provider visit for purposes of receiving the laboratory test.

We cover up to a total of eight FDA-authorized over-the-counter COVID-19 tests per calendar month from Plan Providers or Non-Plan Providers. Over-the-counter tests are self-administered tests that deliver results at home and are available without a prescription. For purposes of this section, "Plan Provider" means a Plan Pharmacy, mail order delivery through our website at **kp.org**, or a participating retail pharmacy. For purposes of this section, a "Non-Plan Provider" means a pharmacy or online retailer that isn't a Plan Provider. To find out more about coverage and limitations, including the current list of Plan Providers, visit our website or call Member Services.

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient Surgery and Outpatient Procedures")
- Services related to diagnosis and treatment of Infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services exclusions

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice

- Items prescribed by the following Non–Plan Providers:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
  - Non–Plan Providers that are not providers of Emergency Services or Out-of-Area Urgent Care if the prescription is for COVID-19 therapeutics (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Post-Service Claims and Appeals" section)

Note: If you obtain a prescription from a Non-Plan Provider related to dental care or for COVID-19 therapeutics as described above, we do not cover an office visit or any other services from the Non-Plan Provider.

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item from a Non-Plan Provider as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section or a Non-Plan Provider prescribes COVID-19 therapeutics for you.

For the locations of Plan Pharmacies, refer to our Provider Directory or call Member Services.

Refills

You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, item, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply (or 365-day supply if the item is a hormonal contraceptive) for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary," you will receive the supply prescribed up to the day supply limit specified in this section or in the drug formulary for your plan (see "About the drug formulary" below). The maximum you may receive at one time of a covered item, other than a hormonal contraceptive, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

If your plan includes coverage for hormonal contraceptives, the maximum you may receive at one time of contraceptive drugs is a 365-day supply. To obtain a 365-day supply, talk to your prescribing provider. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for hormonal contraceptives.

If your plan includes coverage for sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for sexual dysfunction drugs.

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary" for any drug to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for

our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, please refer to the California Commercial HMO formulary on our website at **kp.org/formulary**. The formulary also discloses requirements or limitations that apply to specific drugs, such as whether there is a limit on the amount of the drug that can be dispensed and whether the drug must be obtained at certain specialty pharmacies. If you would like to request a copy of this drug formulary, please call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Formulary exception process

Drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the "Dispute Resolution" section.

Continuity drugs

If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.

About drug tiers

Drugs for your plan are categorized into tiers as described in the table below (your plan doesn't have a Tier 3). Your Cost Share for covered items may vary based on the tier. Refer to "Outpatient prescription drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC* for Cost Share for items covered under this section. Refer to the drug formulary to find out which tier a particular drug is on and for the definition of "generic drug," "brand-name drug," and "specialty drug."

Tier	Description
Tier 1	Most generic drugs, supplies and supplements (also includes certain brand-name drugs, supplies, and supplements)
Tier 2	Most brand-name drugs, supplies, and supplements (also includes certain generic drugs, supplies, and supplements)
Tier 4	High-cost brand-name or generic drugs, supplies, and supplements (sometimes called "specialty drugs")

These tiers apply to formulary and non-formulary drugs, supplies and supplements. If you need help determining whether a formulary or non-formulary drug, supply, or supplement is categorized as Tier 1, Tier 2, or Tier 4, please call Member Services. Note: Non-formulary drugs are not covered unless Medically Necessary as described under "Formulary exception process" in the "About the drug formulary" section above.

General rules about coverage and your Cost Share

We cover the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Drugs for which a prescription is required by law. We also cover certain over-the-counter drugs and items (drugs and items that do not require a prescription by law) if they are listed on our drug formulary and prescribed by a Plan Physician, except a prescription is not required for over-the-counter contraceptives
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on Tier 4, not the Cost Share for drugs on Tier 2)

Schedule II drugs
You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service
Prescription refills can be mailed within 3 to 5 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail-order service in the following ways:

- To order online, visit **kp.org/rxrefill** (you can register for a secure account at **kp.org/registernow**) or use the KP app from your smartphone or other mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option
- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Restrictions and limitations apply. For example, not all drugs can be mailed and we cannot mail drugs to all states.

Manufacturer coupon program
For outpatient prescription drugs or items that are covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum if applicable. Refer to the "Cost Share Summary" section of this *EOC* to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Drug Deductible
In any Accumulation Period, you must pay Charges for any items covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section that are subject to the Drug Deductible until you meet the applicable Drug Deductible amount listed in the "Cost Share Summary" section of this *EOC*.

The only payments that count toward this Drug Deductible are those you make under this *EOC* for covered items that are subject to this Drug Deductible. After you reach the Drug Deductible, you pay the applicable Copayments or Coinsurance for these items for the remainder of the Accumulation Period.

Services that are subject to the Drug Deductible
The Cost Share that you must pay for covered Services is described in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the Services are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible. Note: When the Cost Share for the Services is described as "no charge," but the Services are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Base drugs, supplies, and supplements
Cost Share for the following items may be different than other drugs, supplies, and supplements. Refer to "Base drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC*:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis
- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

For the following Services, refer to these sections

- Drugs prescribed for abortion or abortion-related Services (refer to "Reproductive Health Services")
- Administered contraceptives (refer to "Reproductive Health Services")
- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment ("DME") for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment ("DME") for Home Use")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - ♦ insulin
  - ♦ over-the-counter drugs covered under "Preventive Services" in this "Benefits" section (this includes tobacco cessation drugs and contraceptive drugs)
  - ♦ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- Drugs when prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. We may require Members who are prescribed drugs for morbid obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug

Outpatient Surgery and Outpatient Procedures

We cover the following outpatient care Services:

- Outpatient surgery
- Outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient procedures (including imaging and diagnostic Services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Preventive Services

We cover a variety of Preventive Services from Plan Providers, as listed on our website at **kp.org/prevention**, including the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list of recommended immunizations can be found at **cdc.gov/vaccines/schedules**
- Preventive services recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at **hrsa.gov/womens-guidelines**

Note: We cover immunizations to prevent COVID-19 that are administered in a Plan Medical Office or by a Non-Plan Provider. If you obtain this immunization from a Non-Plan Provider (except for providers of Emergency Services or Out-of-Area Urgent Care), we do not cover an office visit or any other services from the Non-Plan Provider other than administration of the vaccine.

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

If you are enrolled in a grandfathered plan, certain preventive items listed on our website, such as over-the-counter drugs, may not be covered. Refer to the "Certain preventive items" table in the "Cost Share Summary" section of this *EOC* for coverage information. If you have questions about Preventive Services, please call Member Services.

Note: Preventive Services help you stay healthy, before you have symptoms. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services that are not Preventive Services before, during, or after a visit that includes Preventive Services, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

For the following Services, refer to these sections

- Milk pumps and lactation supplies (refer to "Lactation supplies" under "Durable Medical Equipment ("DME") for Home Use")
- Health education programs (refer to "Health Education")
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Family planning counseling, consultations, and sterilization Services (refer to "Reproductive Health Services")

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices

We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

For internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Surgery and Outpatient Procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for Outpatient Surgery.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not

include electronic voice-producing machines, which are not prosthetic devices)

- After Medically Necessary removal of all or part of a breast:
  - ♦ prostheses, including custom-made prostheses when Medically Necessary
  - ♦ up to three brassieres required to hold a prosthesis in any 12-month period
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses 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

Supplemental prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items:

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services for Adult Members" and "Vision Services for Pediatric Members")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered Drugs and Products")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss, theft, or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

For covered Services related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the Services were not related to reconstructive surgery. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services, and see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Office visits not described in the "Reconstructive Surgery" section (refer to "Office Visits")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Rehabilitative and Habilitative Services

We cover the Services described in this "Rehabilitative and Habilitative Services" section if all of the following requirements are met:

- The Services are to address a health condition
- The Services are to help you keep, learn, or improve skills and functioning for daily living
- You receive the Services at a Plan Facility unless a Plan Physician determines that it is Medically Necessary for you to receive the Services in another location

We cover the following Services:

- Individual outpatient physical, occupational, and speech therapy
- Group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")

Rehabilitative and habilitative Services exclusions

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Reproductive Health Services

Family planning Services

We cover the following Services when provided for family planning purposes:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy
- Sterilization procedures for Members assigned female at birth
- Sterilization procedures for Members assigned male at birth

Plan Doula services

If you are pregnant or were pregnant within the last 12 months and want Plan Doula services, talk to your care team. We cover the following Plan Doula services:

- One initial visit
- Up to eight one-hour visits that may be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery

Up to two additional postpartum visits may be available.

Abortion and abortion-related Services

We cover the following Services:

- Surgical abortion
- Prescription drugs, in accord with our drug formulary guidelines
- Abortion-related Services

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services to diagnose or treat Infertility (refer to "Fertility Services")

- Office visits related to injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") when provided for medical reasons other than to prevent pregnancy (refer to "Office Visits")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient surgery and outpatient procedures when provided for medical reasons other than to prevent pregnancy (refer to "Outpatient Surgery and Outpatient Procedures")

Reproductive health Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Plan Doula services exclusions:
  - Clinical or medical Services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care)
  - Assistance with activities of daily living
  - Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation)
  - Yoga
  - Birthing ceremonies
  - Over-the-counter supplies or drugs
  - Home birth

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - a Plan Provider makes this determination
  - you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the federal Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - the National Institutes of Health
  - the Centers for Disease Control and Prevention
  - the Agency for Health Care Research and Quality
  - the Centers for Medicare & Medicaid Services
  - a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section

of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Services in connection with a clinical trial exclusions

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral Health Treatment for Autism Spectrum Disorder
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the prevention, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment at a licensed treatment center approved by Medical Group

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)

- Discharge planning

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Outpatient laboratory, including drug testing (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits, and you may choose to receive in-person Services from a Plan Provider instead. Some Plan Providers offer Services exclusively through a telehealth technology platform and have no physical location at which you can receive Services. If you receive covered Services from these Plan Providers, you may access your medical record of the Telehealth Visit and, unless you object, such information will be added to your Health Plan electronic medical record and shared with your Primary Care Physician.

We cover the following types of Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits
- Scheduled telephone visits

Transplant Services

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call Member Services for questions about donor Services

For covered transplant Services that you receive, you will pay the Cost Share you would pay if the Services were not related to a transplant. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with

our guidelines for donor Services at **no charge (not subject to the Plan Deductible)**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Vision Services for Adult Members

For the purpose of this "Vision Services for Adult Members" section, an "Adult Member" is a Member who is age 19 or older and is not a Pediatric Member, as defined under "Vision Services for Pediatric Members" in this "Benefits" section. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Adult Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Adult Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Adult Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Vision Services for Pediatric Members

For the purpose of this "Vision Services for Pediatric Members" section, a "Pediatric Member" is a Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Pediatric Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Pediatric Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Pediatric Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. These exclusions or limitations do not apply to Services that are Medically Necessary to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, including cosmetic surgery (surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or hospital inpatient Services.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to the following Services:

- Services covered under "Dental and Orthodontic Services" in the "Benefits" section
- Service described under "Injury to Teeth" in the "Benefits" section
- Pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, if any. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the federal Food and Drug Administration ("FDA") and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered

under “Home Health Care,” “Hospice Services,” “Hospital Inpatient Services,” “Rehabilitative and Habilitative Services,” or “Skilled Nursing Facility Care” in the “Benefits” section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, and services of massage therapists.

Oral nutrition and weight loss aids

Outpatient oral nutrition, such as dietary supplements, herbal supplements, formulas, food, and weight loss aids.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under “Outpatient Prescription Drugs, Supplies, and Supplements” in the “Benefits” section
- Enteral formula covered under “Prosthetic and Orthotic Devices” in the “Benefits” section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, or inpatient respite care covered in the “Hospice Care” section.

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration (“FDA”) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the “Emergency Services and Urgent Care” section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under “Services in Connection with a Clinical Trial” in the “Benefits” section
- COVID-19 Services granted emergency use authorization by the FDA (COVID-19 laboratory tests, therapeutics, and immunizations must be prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care)

Refer to the “Dispute Resolution” section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member’s condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to covered Plan Doula services.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Also, Services in connection with assisted reproductive technology (“ART”) Services related to a Surrogacy Arrangement. Refer to “Surrogacy Arrangements” under “Reductions” in this “Exclusions, Limitations, Coordination of Benefits, and Reductions” section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information

about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Coordination of Benefits

The Services covered under this *EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *EOC*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *EOC* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, please call Member Services.

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call Member Services to find out which Medicare rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such Services we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by other parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written

notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain (1) against another party, and/or (2) from other types of coverage or sources of payment that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, and/or personal injury coverages, any other types of medical payments and all other first party types of coverages or sources of payment. The proceeds of any judgment or settlement that you or we obtain and/or payments that you receive shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

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

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-753-7064

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

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

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive monetary compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

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

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

You must send this information to:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-753-7064

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are

reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy Arrangements" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call Member Services.

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

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

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services from a Non–Plan Provider and you want us to pay for the Services
- You have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our grievance form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for Services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

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 follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call Member Services.

Submitting a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

You may file a claim (request for payment/reimbursement):

- By visiting **kp.org**, completing an electronic form and uploading supporting documentation;
- By mailing a paper form that can be obtained by visiting **kp.org** or calling Member Services; or
- If you are unable access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claim:
  - Member/Patient Name and Medical/Health Record Number
  - The date you received the Services
  - Where you received the Services
  - Who provided the Services
  - Why you think we should pay for the Services
  - A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services

Mailing address to submit your claim to Kaiser Permanente:

Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

Please call Member Services if you need help filing your claim.

Submitting a claim for all other Services

If you have received any other Services from a Non–Plan Provider that we did not authorize, then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Please call Member Services if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- 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 need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call Member Services for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:

  Kaiser Foundation Health Plan, Inc.
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for all other Services from a Non-Plan Provider that we did not authorize

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to any Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- In person at any Member Services office at a Plan Facility or any Plan Provider (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, please include any information that clarifies or supports your position. 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. To make a request, you should call Member Services.

Additional information regarding claims for all other Services from a Non–Plan Provider that we did not authorize

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and 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 the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about the external review process, see "Independent Medical Review ("IMR")" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at most Plan Facilities, or you can call Member Services.

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received from a Non–Plan Provider, please follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- You received a written denial for a second opinion or we did not respond to your request for a second

opinion in an expeditious manner, as appropriate for your condition

- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services.

Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received.

Standard Procedure

To file a grievance electronically, use the grievance form on **kp.org**.

To file a grievance orally, call Member Services toll free at **1-800-464-4000** (TTY users call **711**).

To file a grievance in writing, please use our grievance form, which is available on **kp.org** under "Forms & Publications," in person from any Member Services office at a Plan Facility, or from Plan Providers (for addresses, refer to our Provider Directory or call Member Services). You can submit the form in the following ways:

- In person at any Member Services office at a Plan Facility
- By mail to any Member Services office at a Plan Facility

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Please call Member Services if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary prescription drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your

favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Urgent procedure

If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance. Note: Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure 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
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary prescription drug and your grievance involves a request to refill a non-formulary prescription drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but no later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non- Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding pre-service requests for Medically Necessary Services

You may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization
You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment
Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Independent Review Organization for Non-Formulary Prescription Drug Requests

If you filed a grievance to obtain a non-formulary prescription drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization ("IRO"). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

For urgent IRO reviews, we will forward to you the independent reviewer's decision within 24 hours. For non-urgent requests, we will forward the independent reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your

health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care ("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  - ♦ you have a recommendation from a provider requesting Medically Necessary Services
  - ♦ you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - ♦ you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's IMR organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or investigational denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within three days after we received your request. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation

- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying their recommendation. We do not cover the Services of the Non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, go to **hhs.gov/civil-rights**.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
393 E. Walnut St.
Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and

expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2026, your last minute of coverage was at 11:59 p.m. on December 31, 2025). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2026, your last minute of coverage was at 11:59 p.m. on December 31, 2025.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days

from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy Arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

If you believe that we have terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act ("Cal-COBRA"), you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Member Services within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA enrollment and Premiums

Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay Full Premiums within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, your Premium payment for the upcoming coverage month is due on the last day of the preceding month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments may be subject to a fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for nonpayment of Cal-COBRA Premiums" section.

Changes to Cal-COBRA coverage and Premiums

Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended. You can also request one from Member Services.

Cal-COBRA open enrollment or termination of another health plan

If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call Member Services. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill.

You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage
You may terminate your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA Premiums
If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the last day of the preceding month. If we do not receive Full Premium payment by the due date, we will send a notice of nonreceipt of payment to the Subscriber's address of record. You will have a 30-day grace period to pay the required Premiums before we terminate your Cal-COBRA coverage for nonpayment. The notice will state when the grace period begins and when the memberships of the Subscriber and all Dependents will terminate if the required Premiums are not paid. Your coverage will continue during this grace period. If we do not receive Full Premium payment by the end of the grace period, we will mail a termination notice to the Subscriber's address of record. After termination of your membership for nonpayment of Cal-COBRA Premiums, you are still responsible for paying all amounts due, including Premiums for the grace period.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums
If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage
Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities
If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to

send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

USERRA

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

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC,* including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **buykp.org** or call Member Services. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement,* including this *EOC*.

Advance Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services office at a Plan Facility. For more information about advance directives, refer to our website at **kp.org** or call Member Services.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy

was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

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

Group and Members Not Our Agents

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

No Waiver

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

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy Practices

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

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice*

of Privacy Practices (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call Member Services. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **about.kp.org** or from Member Services. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling Member Services.

Provider Directory

Refer to the Provider Directory for your Home Region for the following information:

- A list of Plan Physicians
- The location of Plan Facilities and the types of covered Services that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at **kp.org**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our Services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

Document Delivery Preferences

Many Health Plan documents are available electronically, such as bills, statements, and notices. If you prefer to get documents in electronic format, go to **kp.org** or call Member Services. You can change delivery preference at any time. To get a copy of a specific Heath Plan document in printed format, call Member Services.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care

professionals available to assist you by phone 24 hours a day, seven days a week:

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (closed holidays)

Visit Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Write Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Website kp.org

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-390-3507** (TTY users call **711**)

Monday through Friday 6 a.m. to 5 p.m.

Website kp.org

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

24 hours a day, seven days a week (closed holidays)

Website kp.org/travel

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section under "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (closed holidays)

Website kp.org

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section, under "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

Text telephone access ("TTY")

If you use a text telephone device ("TTY," also known as "TDD") to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *EOC*. Payment responsibility is more fully described in other sections of the *EOC* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Cost Share for covered Services (refer to the "Cost Share Summary" section)
- If you receive Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or COVID-19 Services from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or another party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for noncovered Services

Important Notices

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, or materials translated into your language or alternative formats. You can also request auxiliary aids and devices at our facilities. Call our Member Service Contact Center for help, 24 hours a day, 7 days a week (closed holidays).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. اتصل مع مركز اتصال خدمة الأعضاء لدينا، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع (العطلات مغلق).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- جميع الآخرين: **1-800-464-4000** (TTY **711**)

Armenian: Ձեզ կարող է անվճար լեզվական աջակցություն տրամադրվել օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման կապի կենտրոն օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է):

- Medi-Cal՝ **1-855-839-7613** (TTY **711**)
- Այլ՝ **1-800-464-4000** (TTY **711**)

Chinese: 我们每周 7 天，每天 24 小时免费提供语言帮助。您可以要求提供口译员、或将材料翻译为您所用语言或其他格式。您还可以在我们的设施中要求使用辅助工具和设备。请打电话给我们的会员服务联络中心，服务时间为每周 7 天，每天 24 小时（节假日除外）。

- 所有会员：**1-800-757-7585** (TTY **711**)

Farsi: خدمات زبانی در 24 ساعت شبانه‌روز و 7 روز هفته به‌صورت رایگان در اختیار شماست. می‌توانید خدمات مترجم شفاهی، یا ترجمه مدارک به زبان خود یا به فرمت‌های دیگر را درخواست کنید. همچنین می‌توانید دستگاه‌ها و کمک‌های دیگر را در مراکز ما درخواست نمایید. برای دریافت کمک، در 24 ساعت شبانه‌روز و 7 روز هفته (به‌جز تعطیلات) با مرکز تماس خدمات اعضای ما تماس بگیرید.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- سایر: **1-800-464-4000** (TTY **711**)

Hindi: बिना किसी लागत के भाषा सहायता, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप दुभाषिये की सेवाओं के लिए, या बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों का अनुरोध कर सकते हैं। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं।सहायता के लिए हमारी सदस्य सेवाओं के सम्पर्क केंद्र को, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- बाकी दूसरे: **1-800-464-4000** (TTY **711**)

Hmong: Muaj kev pab txhais lus pub dawb rau koj, 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Hu rau peb Qhov Chaw Pab Cov Tswv Cuab 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg (cov hnub caiv kaw).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Dua lwm cov: **1-800-464-4000** (TTY **711**)

Japanese: 多言語による情報支援を無料で 24 時間年中無休でご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは別の形式による資料もご所望いただけます。また、当施設における補助的な支援や機器についてもご所望いただけます。お気軽にご連絡ください（祝祭日を除き 24 時間週 7 日）。

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- その他のご連絡先: **1-800-464-4000** (TTY **711**)

Khmer (Cambodian): ជំនួយភាសា គឺឥតគិតថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ ឬឯកសារដែលបានបកប្រែ ជាភាសាខ្មែរ ឬទម្រង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយ ទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ ទូរស័ព្ទទៅមជ្ឈមណ្ឌល ទំនាក់ទំនងសេវាកម្មសមាជិករបស់យើងសម្រាប់ជំនួយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (ថ្ងៃឈប់សម្រាកបិទ)។

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ផ្សេងទៀតទាំងអស់: **1-800-464-4000** (TTY **711**)

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스 또는 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 저희 가입자 서비스 연락 센터에 주 7 일, 하루 24 시간(공휴일 휴무) 전화하셔서 도움을 받으십시오.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- 기타 모든 경우: **1-800-464-4000** (TTY **711**)

Laotian: ມີການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ. ທ່ານຍັງສາມາດຂໍບໍລິການຜູ້ແປພາສາ ຫຼື ເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໄດ້. ທ່ານຍັງສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ເຄື່ອງມືຢູ່ສະຖານບໍລິການຂອງພວກເຮົາໄດ້. ໂທຫາສູນຕິດຕໍ່ບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ (ບໍ່ດໃນວັນພັກ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ອື່ນໆທັງໝົດ: **1-800-464-4000** (TTY **711**)

Mien: Mbenc nzoih liouh wangv-henh tengx nzie faan waac bun muangx meih maiv cingv, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm leiz baaix mbenc maaih 7 hnoi. Meih se haih tov heuc tengx faan benx meih nyei waac bun muangx, a'fai zoux benx nyungc horngh jaa-sic zoux benx meih nyei waac. Meih corc haih tov tengx nyungc horngh jaa-dorngx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Beiv hnangv qiemx zuqc longc mienh nzie weih nor douc waac lorx taux yie mbuo ziux goux baengc mienh nyei gorn zangc, yietc hnoi tengx duqv 24 norm ziangh hoc, yietc norm leiz baaix tengx duqv 7 hnoi (simv cuotv gingc nyei hnoi se guon oc).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yietc zungv da'nyeic deix: **1-800-464-4000** (TTY **711**)

Navajo: Díí hózhó nízhoní bee hane' dóó jíik'ah jóóní doonílwo'. Ndik'é yádi naaltsoos bee haz'áanii bee hane' dóó yádi nihookaa dóó nádááhágíí yádi nihookaa. Shí éí bee háídínii bibee' haz'áanii dóó bee t'ah kodí bízíkinii wo'da'gi doolyé. Ahéhee' bik'ehgo nohólǫǫn'ígíí, 24 t'áádawołíí, 7 t'áádawołíígo (t'áadoo t'áálwo').

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yadilzingo biłk'ehgo bee: **1-800-464-4000** (TTY **711**)

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਲਈ, ਜਾਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਮਦਦ ਲਈ ਸਾਡੀ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਕਾੱਲ ਕਰੋ।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ਹੋਰ ਸਾਰੇ: **1-800-464-4000** (TTY **711**)

Russian: Языковая помощь доступна для вас бесплатно круглосуточно, ежедневно. Вы можете запросить услуги переводчика или материалы, переведенные на ваш язык или в альтернативные форматы. Вы также можете заказать вспомогательные средства и приспособления. Для получения помощи позвоните в наш центр обслуживания участников ежедневно, круглосуточно (кроме праздничных дней).

- Medi-Cal: **1-855-839-7613** (линия TTY **711**)
- Все остальные: **1-800-464-4000** (линия TTY **711**)

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Usted puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Llame a nuestra Central de Llamadas de Servicio a los Miembros para recibir ayuda 24 horas al día, 7 días a la semana (excepto los días festivos).

- Para todos los demás: **1-800-788-0616** (TTY **711**)

Tagalog: May magagamit na tulong sa wika nang wala kayong babayaran, 24 na oras sa isang araw, 7 araw sa isang linggo. Maaari kayong humiling ng mga serbisyo ng interpreter, o mga babasahin na isinalin sa inyong wika o sa mga alternatibong format. Maaari rin kayong humiling ng mga pantulong na gamit at device sa aming mga pasilidad. Tawagan ang aming Center sa Pakikipag-ugnayan ng Serbisyo sa Miyembro para sa tulong, 24 na oras sa isang araw, 7 araw sa isang linggo (sarado sa mga pista opisyal).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Lahat ng iba pa: **1-800-464-4000** (TTY **711**)

Thai: มีบริการช่วยเหลือด้านภาษาตลอด 24 ชั่วโมงทุกวันโดยไม่มีค่าใช้จ่าย โดยคุณสามารถขอใช้บริการล่าม บริการแปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่นๆ ได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการของเราโดยโทรหาเราที่ศูนย์ติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือตลอด 24 ชั่วโมงทุกวัน (ปิดทำการในช่วงวันหยุด)

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ที่อื่นๆทั้งหมด: **1-800-464-4000** (TTY **711**)

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача або отримання матеріалів у перекладі мовою, якою володієте, чи в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Телефонуйте в наш контактний центр для обслуговування клієнтів цілодобово, 7 днів на тиждень (крім святкових днів).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Усі інші: **1-800-464-4000** (TTY **711**)

Vietnamese: Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, hoặc tài liệu được dịch ra ngôn ngữ của quý vị hoặc nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Gọi cho Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**)

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente[1] follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center, 24 hours a day, 7 days a week (closed holidays). The call is free:

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Medi-Cal members may call **1-855-839-7613** (TTY **711**). All other members may call **1-800-464-4000** (TTY **711**). Help is available 24 hours a day, 7 days a week (closed holidays)
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.

[1] Kaiser Permanente is inclusive of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Medical Group

- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at:
  https://www.hhs.gov/ocr/complaints/index.html

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation

EOC #23 - Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO
Evidence of Coverage for
BMO FINANCIAL CORP.

Group ID: 102000 Contract: 1 Version: 89 *EOC* Number: 23 Issue Date: December 8, 2024

January 1, 2025, through December 31, 2025

Member Services
24 hours a day, seven days a week (closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

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Cost Share Summary

This "Cost Share Summary" is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductibles and Out-of-Pocket Maximums

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

If your Group's plan changes during an Accumulation Period, your deductibles and out-of-pocket maximums may increase or decrease, which may change the total amount you must accumulate to reach the deductibles or out-of-pocket maximums during that Accumulation Period.

Note: The Plan Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Deductible	$1,750	$3,300	$3,500
Drug Deductible	Not applicable	Not applicable	Not applicable
Plan Out-of-Pocket Maximum ("OOPM")	$3,425	$3,425	$6,850

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, refer to the same benefit heading in the "Benefits" section of this *EOC*.

- **Copayment / Coinsurance**. This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the "Deductibles and Out-of-Pocket Maximums" section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read "Not covered." If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible**. This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a "✓" or "D" in this column, depending on which deductible applies ("✓" for Plan Deductible, "D" for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, refer to "Plan Deductible" and "Drug Deductible" in the "Benefits" section of this *EOC*.
- **Applies to OOPM**. This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum ("OOPM") after you have met any applicable deductible. If the Services count toward the Plan

OOPM, there will be a "✓" in this column. If the Services do not count toward the Plan OOPM, this column will be blank. For a more detailed explanation of the Plan OOPM, refer to "Plan Out-of-Pocket Maximum" in the "Benefits" section of this *EOC*.

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge	✓	✓
Allergy antigens (including administration)	20% Coinsurance	✓	✓
Cancer chemotherapy drugs and adjuncts	No charge	✓	✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood	No charge	✓	✓
All other administered drugs and products	No charge	✓	✓
Drugs and products administered to you during a home visit	No charge	✓	✓

Ambulance Services

Description of Ambulance Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency ambulance Services	20% Coinsurance	✓	✓
Nonemergency ambulance and psychiatric transport van Services	20% Coinsurance	✓	✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge	✓	✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge	✓	✓
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	20% Coinsurance	✓	✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Blood glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance	✓	✓
Other Base DME Items as described in this *EOC*	20% Coinsurance	✓	✓
Supplemental DME items as described in this *EOC*	20% Coinsurance	✓	✓
Retail-grade milk pumps	No charge		✓
Hospital-grade milk pumps	No charge		✓

Emergency Services and Urgent Care

Description of Emergency Services and Urgent Care	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency department visits	20% Coinsurance	✓	✓
Urgent Care visits	20% Coinsurance	✓	✓

Note: If you are admitted to the hospital as an inpatient from the emergency department, the emergency department visits Cost Share above does not apply. Instead, the Services you received in the emergency department, including any observation stay, if applicable, will be considered part of your hospital inpatient stay. For the Cost Share for inpatient Services, refer to "Hospital inpatient Services" in this "Cost Share Summary." The emergency department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Fertility Services

Diagnosis and treatment of Infertility

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Artificial insemination

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Assisted reproductive technology ("ART") Services

Description of ART Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	20% Coinsurance	✓	✓
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓
Outpatient imaging	20% Coinsurance	✓	✓
Outpatient laboratory	20% Coinsurance	✓	✓
Outpatient administered drugs	20% Coinsurance	✓	✓
Hospital inpatient Services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	20% Coinsurance	✓	✓

Assisted reproductive technology ("ART") Services lifetime maximum
Covered ART Services are limited to one treatment cycle per lifetime.

Health education

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to tobacco cessation	No charge		✓

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	20% Coinsurance	✓	✓
Physician Specialist Visits to diagnose and treat hearing problems	20% Coinsurance	✓	✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	Not covered		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care Services (120 visits per Accumulation Period)	20% Coinsurance	✓	✓

Hospice care

Description of Hospice Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospice Services	20% Coinsurance	✓	✓

Hospital inpatient Services

Description of Hospital Inpatient Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient stays	20% Coinsurance	✓	✓

Injury to teeth

Description of Injury to Teeth Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	20% Coinsurance	✓	✓
Individual mental health evaluation and treatment	20% Coinsurance	✓	✓
Group mental health treatment	20% Coinsurance	✓	✓
Partial hospitalization	20% Coinsurance	✓	✓
Other intensive psychiatric treatment programs	20% Coinsurance	✓	✓
Residential mental health treatment Services	20% Coinsurance	✓	✓
Behavioral Health Treatment for Autism Spectrum Disorder	20% Coinsurance	✓	✓
Electroconvulsive therapy	20% Coinsurance	✓	✓
Transcranial magnetic stimulation	20% Coinsurance	✓	✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	20% Coinsurance	✓	✓
Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	20% Coinsurance	✓	✓
Group appointments that are not described elsewhere in this “Cost Share Summary”	20% Coinsurance	✓	✓
Acupuncture Services	20% Coinsurance	✓	✓

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	20% Coinsurance	✓	✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	20% Coinsurance	✓	✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	20% Coinsurance	✓	✓
Nuclear medicine	20% Coinsurance	✓	✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge	✓	✓
Over-the-counter COVID-19 tests obtained from Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month)	No charge	✓	✓
Over-the-counter COVID-19 tests obtained from Non-Plan Providers as described in this EOC (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month, not to exceed $12 per test, including all fees and taxes, if you obtain the test from a Non-Plan Provider)	50% Coinsurance	✓	
Laboratory tests to diagnose or screen for COVID-19 obtained from Plan Providers	No charge	✓	✓
Laboratory tests to diagnose or screen for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance	✓	
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	20% Coinsurance	✓	✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	20% Coinsurance	✓	✓

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Radiation therapy	No charge	✓	✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge	✓	✓

Outpatient prescription drugs, supplies, and supplements

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on Tier 1 not described elsewhere in this "Cost Share Summary"	$10 for up to a 30-day supply	$20 for up to a 100-day supply	✓	✓
Items on Tier 2 not described elsewhere in this "Cost Share Summary"	30% Coinsurance (not to exceed $100) for up to a 100-day supply	30% Coinsurance (not to exceed $100) for up to a 100-day supply	✓	✓
Items on Tier 4 not described elsewhere in this "Cost Share Summary"	30% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available	✓	✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available	✓	✓
All other items on Tier 1 as described in this *EOC*	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
All other items on Tier 2 as described in this *EOC*	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
All other items on Tier 4 as described in this *EOC*	30% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Oral anticancer drugs on Tier 2	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Oral anticancer drugs on Tier 4	30% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Non-oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Non-oral anticancer drugs on Tier 2	30% Coinsurance (not to exceed $100) for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Non-oral anticancer drugs on Tier 4	30% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

Home infusion drugs

Description of Home Infusion Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available	✓	✓
Supplies necessary for administration of home infusion drugs	No charge	No charge	✓	✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Certain state-mandated items

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available	✓	✓
Therapeutics for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓
Therapeutics for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance for up to a 30-day supply	Not available	✓	
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available	✓	✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy	✓	✓

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, refer to the "Most items" table above. For insulin pumps, refer to the "Durable Medical Equipment ("DME") for home use" table above.

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items on Tier 1: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 1: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items on Tier 2: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 2: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms, cervical caps, and up to a 30-day supply of condoms	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓
Items on our preventive items list on Tier 1	No charge for up to a 100-day supply	No charge for up to a 100-day supply		✓

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our preventive items list on Tier 2 and Tier 4	No charge for up to a 100-day supply	No charge for up to a 100-day supply		✓

Items on our preventive items list are covered at the Cost Share indicated when prescribed to prevent the onset of disease or illness (to get the current list, call Member Services).

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on Tier 1 prescribed to treat Infertility or in connection with covered artificial insemination Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	✓	✓
Drugs on Tier 2 and Tier 4 prescribed to treat Infertility or in connection with covered artificial insemination Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	✓	✓
Drugs on Tier 1 prescribed in connection with covered assisted reproductive technology (“ART”) Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	✓	✓
Drugs on Tier 2 and Tier 4 prescribed in connection with covered assisted reproductive technology (“ART”) Services	20% Coinsurance for up to a 100-day supply	20% Coinsurance for up to a 100-day supply	✓	✓
Drugs on Tier 1 prescribed for sexual dysfunction disorders	$10 for up to a 30-day supply	$20 for up to a 100-day supply	✓	✓
Drugs on Tier 2 and Tier 4 prescribed for sexual dysfunction disorders	30% Coinsurance (not to exceed $100) for up to a 100-day supply	30% Coinsurance (not to exceed $100) for up to a 100-day supply	✓	✓

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	20% Coinsurance	✓	✓

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	20% Coinsurance	✓	✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman, postpartum follow-up, and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Immunizations (including the vaccine) for COVID-19 administered by Non-Plan Providers (except for providers of Emergency Services or Out-of-Area Urgent Care)	50% Coinsurance	✓	
Tuberculosis skin tests	No charge		✓
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection ("STI") tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
External prosthetic and orthotic devices as described in this *EOC*	20% Coinsurance	✓	✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	20% Coinsurance	✓	✓

Rehabilitative and habilitative Services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	20% Coinsurance	✓	✓
Group outpatient physical, occupational, and speech therapy	20% Coinsurance	✓	✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	20% Coinsurance	✓	✓

Reproductive Health Services

Family planning Services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		✓
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		✓

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Sterilization procedures for Members assigned female at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned female at birth	No charge		✓
Sterilization procedures for Members assigned male at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge	✓	✓
All other sterilization procedures for Members assigned male at birth	No charge	✓	✓

Abortion and abortion-related Services

Description of abortion and abortion-related Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Surgical abortion	No charge	✓	✓
Prescription drugs, in accord with our drug formulary guidelines	No charge	✓	✓
Other abortion-related Services	No charge	✓	✓

Plan Doula services

Description of Plan Doula services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Initial, prenatal, or postpartum visits	No charge		✓
Support during labor and delivery	No charge		✓

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility Services up to 60 days per benefit period*	20% Coinsurance	✓	✓

*A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled

level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	20% Coinsurance	✓	✓
Individual substance use disorder evaluation and treatment	20% Coinsurance	✓	✓
Group substance use disorder treatment	20% Coinsurance	✓	✓
Intensive outpatient and day-treatment programs	20% Coinsurance	✓	✓
Methadone maintenance treatment	20% Coinsurance	✓	✓
Residential substance use disorder treatment	20% Coinsurance	✓	✓

Telehealth visits

Interactive video visits

Description of Interactive Video Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge	✓	✓
Physician Specialist Visits	No charge	✓	✓

Scheduled telephone visits

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge	✓	✓
Physician Specialist Visits	No charge	✓	✓

Vision Services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	20% Coinsurance		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	20% Coinsurance	✓	✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	20% Coinsurance	✓	✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge	✓	✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge	✓	✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	20% Coinsurance		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	20% Coinsurance	✓	✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	20% Coinsurance	✓	✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge	✓	✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge	✓	✓
Low vision devices (including fitting and dispensing)	Not covered		

CARE Plan

The California Community Assistance, Recovery, and Empowerment ("CARE") Act established a system for individuals with severe mental illness to be evaluated and given a treatment plan developed by a county behavioral health agency ("CARE Plan"). If a Member has a court-approved CARE Plan, we cover the Services required under that plan when provided by Plan Providers or Non-Plan Providers at **no charge subject to the Plan Deductible**, with the exception of prescription drugs and Preventive Services. Prescription drugs required under a court-approved CARE Plan are subject to the same Cost Share as drugs prescribed by Plan Providers, as described in this Cost Share Summary, and are also subject to prior authorization by Health Plan. Preventive Services are covered at **no charge (not subject to the Plan Deductible)**. To inform us that you have a court-approved CARE Plan, please call Member Services.

Introduction

This *Evidence of Coverage* (*"EOC"*) describes the health care coverage of this Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO provided under the *Group Agreement* (*"Agreement"*) between Kaiser Foundation Health Plan, Inc. ("Health Plan") and the entity with which Health Plan has entered into the *Agreement* (your "Group").

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan's evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

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

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The coverage information in this *EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Your Plan

Your plan is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in this *EOC* is designed to be compatible for

use with a Health Savings Account ("HSA") under federal tax law.

The tax references contained in this *EOC* relate to federal income tax only. The tax treatment of Health Savings Account contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Health Plan does not provide tax advice. You should consult with your financial or tax advisor for tax advice or more information, including information about your eligibility for a Health Savings Account.

Please be aware that enrollment in a High Deductible Health Plan that is compatible for use with a Health Savings Account is only one of the eligibility requirements for establishing and contributing to a Health Savings Account. For example, you will not be eligible to establish or contribute to a Health Savings Account if any of the following are true:

- You have other health care coverage in addition to the coverage under this *EOC*, unless both coverages qualify as High Deductible Health Plans, with certain exceptions
- You have Medicare coverage
- You can be claimed as a dependent on another person's tax return

If your Group provides a Health Reimbursement Arrangement ("HRA"), Health Incentive Account ("HIA"), or Flexible Spending Account ("FSA"), you may be able to use funds in the HRA, HIA, or FSA to pay Copayments, Coinsurance, and deductibles under this plan. However, most HRAs, HIAs, and FSAs provided through your Group are considered another health coverage plan for HSA purposes and will make you ineligible to establish or contribute to a Health Savings Account. Contact your Group or your tax advisor for more information.

Term of this *EOC*

This *EOC* is for the period January 1, 2025, through December 31, 2025, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC.* If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Behavioral Health Treatment for Autism Spectrum Disorder: 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 a person with autism spectrum disorder (or treat mental health conditions other than autism spectrum disorder when this treatment is clinically indicated) that meet the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is administered by a Plan Provider who is a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional, as defined in California Health and Safety Code section 1374.73(c)

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's

benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)

- For air ambulance Services received from Non-Plan Providers when you have an Emergency Medical Condition, the amount required to be paid by Health Plan pursuant to federal law
- For other Emergency Services received from Non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law
- For all other Services received from Non-Plan Providers (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Plan Provider and Health Plan or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Health Plan based on objective criteria
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Cigna Healthcare PPO Network: The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of a shared administration network arrangement called Cigna Healthcare PPO for Shared Administration.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Intellectual Property, Inc.

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Disclosure Form ("DF"): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

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

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

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

- A medical screening exam that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the facility, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post-Stabilization Care and not Emergency Services)
- Post-Stabilization Care furnished by a Non-Plan Provider is covered as Emergency Services when federal law applies, as described under "Post-Stabilization Care" in the "Emergency Services" section

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente HSA-Qualified High Deductible Health Plan ("HDHP") HMO" under Health Plan's *Agreement* with your Group.

Family: A Subscriber and all of their Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *EOC* sometimes refers to Health Plan as "we" or "us."

Health Savings Account ("HSA"): A tax-exempt trust or custodial account established under Section 223(d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law eligibility requirements.

Health Plan does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

High Deductible Health Plan ("HDHP"): A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The health care coverage under this *EOC* has been designed to be a HDHP compatible for use with a Health Savings Account.

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Infertility: A person's inability to conceive a pregnancy or carry a pregnancy to live birth either as an individual or with their partner; or, a Plan Physician's determination of Infertility, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Kaiser Permanente State: California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

Medically Necessary: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, a Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under "Dental and Orthodontic Services" in the "Benefits" section, non-physician specialists include dentists and orthodontists.

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Doula: A contracted birth worker who provides physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth.

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities**. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities**. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call Member Services.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Refer to the "Cost Share Summary" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the emergency department), an independent freestanding emergency department, or a skilled nursing facility after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from an emergency department and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC,* except that you are responsible for paying Premiums if you have Cal-COBRA coverage. "Full Premiums" means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the "Premiums" section of Health Plan's *Agreement* with your Group.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at **kp.org/facilities** for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at **kp.org** or call Member Services.

Service Area: The ZIP codes below for each county are in our Service Area:

- The following ZIP codes in Imperial County are inside our Southern California Service Area: 92274-75
- The following ZIP codes in Kern County are inside our Southern California Service Area: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- The following ZIP codes in Los Angeles County are inside our Southern California Service Area: 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-28, 91330-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91526, 91601-10, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- All ZIP codes in Orange County are inside our Southern California Service Area: 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711-12, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92850, 92856-57, 92859, 92861-71, 92885-87, 92899

- The following ZIP codes in Riverside County are inside our Southern California Service Area: 91752, 92028, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
- The following ZIP codes in San Bernardino County are inside our Southern California Service Area: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in San Diego County are inside our Southern California Service Area: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99
- The following ZIP codes in Tulare County are inside our Southern California Service Area: 93238, 93261
- The following ZIP codes in Ventura County are inside our Southern California Service Area: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in our Service Area, please call Member Services.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes physical health care, mental health care, and substance use disorder treatment), and Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

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

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children). The person may be impregnated in any manner including, but not limited to, artificial insemination, intrauterine insemination, in vitro fertilization, or through the surgical implantation of a fertilized egg of another person. For the purposes of this *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Full Premiums, except that you are responsible for paying Full Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *EOC*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) they live inside or move to the service area of another Region and do not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside our Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another Region, please contact your Group to learn about your Group health care options:

- **Regions outside California**. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Northern California Region's service area**. Your Group may have an arrangement with us that permits membership in the Northern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Southern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the service areas of the other Regions, please call Member Services.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - ♦ biological children

- stepchildren
- adopted children
- children placed with you for adoption
- foster children if you or your Spouse have the legal authority to direct their care
- children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)

- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care), if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they meet the requirements described under "Age limit of Dependent children"
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse
- Certain Dependents may continue their memberships for a limited time after membership would otherwise terminate as a result of the Subscriber's death if permitted by your Group (please ask your Group for details)

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth).

Age limit of Dependent children

Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as a disabled Dependent. If we request it, the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and

dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Members with Medicare and retirees

This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *EOC* if permitted by your Group (please ask your Group for details).

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *EOC* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

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

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

Special enrollment due to new Dependents

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, placement for adoption, or placement for foster care by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments of newly acquired Dependent children are effective as follows:

- Enrollments due to birth are effective on the date of birth
- Enrollments due to adoption are effective on the date of adoption
- Enrollments due to placement for adoption or foster care are effective on the date you or your Spouse have newly assumed a legal right to control health care

Special enrollment due to loss of other coverage

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

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - ♦ exhaustion of COBRA coverage

- ♦ termination of employer contributions for non-COBRA coverage
- ♦ loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
- ♦ loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
- ♦ reaching a lifetime maximum on all benefits

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order

Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service

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

Other special enrollment events

You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
  - ♦ a qualified individual was not enrolled in a qualified health plan
  - ♦ a qualified individual was not enrolled in the qualified health plan that the individual selected
  - ♦ a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes

effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

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

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" in this "How to Obtain Services" section
- COVID-19 Services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital Services, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call Member Services. To request an appointment online, go to our website at **kp.org**.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services.

For information about Out-of-Area Urgent Care, refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

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 Services or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside our Service Area

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call Member Services). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Benefits" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org** or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Benefits" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call Member Services to request a printed copy.

Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment

Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Medical Group's decision time frames

The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or specialist that is needed, and the date that the Medical Group expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Completion of Services from Non–Plan Providers

New Member

If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider

If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility

The cases that are subject to this completion of Services provision are:

- Acute conditions, which are 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. We may cover these Services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the

termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:

- ♦ it persists without full cure
- ♦ it worsens over an extended period of time
- ♦ it requires ongoing treatment to maintain remission or prevent deterioration

- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Services
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area (the requirement that the provider agree to providing Services inside our Service Area doesn't apply if you were receiving covered Services from the provider outside our Service Area when the provider's contract terminated)
- The Services to be provided to you would be covered Services under this *EOC* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information
For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call Member Services.

Travel and Lodging for Certain Services

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside your Home Region Service Area for certain specialty Services such as a transplant or transgender surgery
- If you are outside of California and you need an abortion on an emergency or urgent basis, and the abortion can't be obtained in a timely manner due to a near total or total ban on health care providers' ability to provide such Services

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and

lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital Services for Members, please visit our website at **kp.org** or call Member Services.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals

If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Receiving Care Outside of Your Home Region Service Area

For information about your coverage when you are away from home, visit our website at **kp.org/travel**. You can also call the Away from Home Travel Line at

1-951-268-3900 24 hours a day, seven days a week (closed holidays).

Receiving care in another Kaiser Permanente service area

If you are visiting in another Kaiser Permanente service area, you may receive certain covered Services from designated providers in that other Kaiser Permanente service area, subject to exclusions, limitations, prior authorization or approval requirements, and reductions. For more information about receiving covered Services in another Kaiser Permanente service area, including provider and facility locations, please visit **kp.org/travel** or call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

For covered Services you receive in another Kaiser Permanente service area, you pay the Cost Share required for Services provided by a Plan Provider inside our Service Area as described in this *EOC*.

Receiving care outside of any Kaiser Permanente service area

If you are traveling outside of any Kaiser Permanente service area, we cover Emergency Services and Urgent Care as described in the "Emergency Services and Urgent Care" section.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent care appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days
- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. Except as specified above for mental health care and substance use disorder treatment, the standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information

on the interpreter services we offer, please call Member Services.

Access to mental health Services and substance use disorder treatment

State law requires evidence of coverage documents to include the following notice:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Health Plan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at http://www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call	**1-800-464-4000 (**English and more than 150 languages using interpreter services**)** **1-800-788-0616 (**Spanish**)** **1-800-757-7585 (**Chinese dialects**)** TTY users call **711** 24 hours a day, seven days a week (closed holidays)
Visit	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Write	Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
Website	**kp.org**

Cost Share estimates

For information about estimates, see “Getting an estimate of your Cost Share” under “Your Cost Share” in the “Benefits” section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital emergency departments (for emergency department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)

Note: State law requires evidence of coverage documents to include the following notice:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract 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 enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Kaiser Permanente Member Services, to ensure that you can obtain the health care services that you need.

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

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

Post-Stabilization Care

When you receive Post-Stabilization Care from a Non-Plan Provider inside of California, or from a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State

When you receive Emergency Services, we cover Post-Stabilization Care from a Non–Plan Provider only if prior authorization for the care is obtained as described below, or if otherwise required by applicable law ("prior authorization" means that the Services must be approved in advance).

- **Post-Stabilization Care authorization at a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State:** If you are outside of a Kaiser Permanente state and you were treated at a Cigna Healthcare PPO Network facility for an Emergency Medical Condition, Cigna Payer Solutions is responsible for authorizing any Post-Stabilization Care
- **Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State):** To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider

(or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non–Plan Hospital or independent freestanding emergency department, please notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card

When you receive Post-Stabilization Care from a Non-Plan Provider that is not a Cigna Healthcare PPO Network provider outside of California

After you receive Emergency Services from Non-Plan Providers and your condition is Stabilized, Post-Stabilization Care is considered Emergency Services under federal law if either of the following are true:

- Your treating physician determines that you are not able to travel using nonemergency transportation to an available Plan Provider located within a reasonable travel distance, taking into account your medical condition; or
- Your treating physician, using appropriate medical judgment, determines that you are not in a condition to receive, and/or to provide consent to, the Non-Plan Provider's notice and consent form, in accordance with applicable state informed consent law

If the Post-Stabilization Care is considered Emergency Services under the criteria above, prior authorization for Post-Stabilization Care at a Non-Plan Provider will not be required.

If the Post-Stabilization Care is not considered Emergency Services, the Services are not covered unless you have received prior authorization from Health Plan as described under "Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State)" above. Non-Plan Providers outside of California may provide notice and seek your consent to waive your balance billing protections under the federal No Surprises Act, if such consent is permissible under applicable state informed consent law. If you consent to waive your balance billing protections and receive Services from the Non-Plan Provider, you will have to pay the full cost of the Services.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Cost Share Summary" section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the emergency department of a Non–Plan Hospital, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient Services as described in the "Cost Share Summary" under "Hospital inpatient Services"
- If we gave prior authorization for durable medical equipment after discharge from a Non–Plan Hospital, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"
- If you receive COVID-19 laboratory testing or immunizations in the emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If you obtain a prescription in the emergency department related to your Emergency Medical Condition, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient prescription drugs, supplies, and supplements" in addition to the Cost Share for the emergency department visit

Urgent Care

Inside our Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an

existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Getting a Referral" in the "How to Obtain Services" section.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the "Cost Share Summary" section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency Services and Urgent Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If the Out-of-Area Urgent Care you receive includes a COVID-19 test, you may have to pay the Cost Share for a COVID-19 test as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If you obtain a prescription as part of an Out-of-Area Urgent Care visit related to the condition for which you obtained Urgent Care, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient prescription drugs, supplies, and supplements" in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Urgent Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits" section, you are not responsible for any amounts beyond your Cost Share for covered Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" below
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" below
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" in the "How to Obtain Services" section
  - COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" below
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - hospice care, as described under "Hospice Care" below
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance.

If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Refer to the "Cost Share Summary" section of this *EOC* for the amount you will pay for Services.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered hospital inpatient or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services

- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Cost Share for Services received by newborn children of a Member

During the 31 days of automatic coverage for newborn children described under "If you have a baby" under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, the parent or guardian of the newborn must pay the Cost Share indicated in the "Cost Share Summary" section of this *EOC* for any Services that the newborn receives, whether or not the newborn is enrolled. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Share, or your Plan Provider is not able to collect Cost Share, if any, for Telehealth Visits you receive at home).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you

receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Please refer to the "Emergency Services and Urgent Care" section for more information about when you may be billed for Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care.

Reimbursement for COVID-19 Services from Non-Plan Providers

If you receive covered COVID-19 Services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see "Initial Claims" in the "the "Post-Service Claims and Appeals" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services

If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Benefit limits

Some benefits may include a limit on the number of visits, days, treatment cycles, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the "Cost Share Summary" section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Services you receive during the benefit limit period toward the benefit limit, including Services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count Services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer group's plan, when you move from group to individual plan coverage (or vice versa), or when you received Services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company ("KPIC").

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org** to use our cost estimate tool or call Member Services.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m. Refer to the "Cost Share Summary" section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Drug Deductible

This *EOC* does not include a Drug Deductible.

Plan Deductible

In any Accumulation Period, you must pay Charges for Services subject to the Plan Deductible until you reach one of the Plan Deductible amounts listed in the "Cost Share Summary" section of this *EOC*.

If you are a Member in a Family of two or more Members, you reach the Plan Deductible either when you reach the amount for any one Member, or when your entire Family reaches the Family amount. For example, suppose you have reached the deductible amount for any one Member. For Services subject to the Plan Deductible, you will not pay Charges during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Charges during the remainder of the Accumulation Period until either they reach the deductible amount for any one Member, or the entire Family reaches the Family amount.

After you reach the Plan Deductible and for the remainder of the Accumulation Period, you pay the applicable Copayment or Coinsurance subject to the limits described under "Plan Out-of-Pocket Maximum" in this "Benefits" section.

Services that are subject to the Plan Deductible

All covered Services are subject to the Plan Deductible, except for certain preventive Services, as indicated in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Note: When the Cost Share for the Services is "no charge" and the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Also, if you pay a Plan Deductible amount for a Service that has a limit, such as a visit limit, the Services count toward reaching the limit.

The only payments that count toward the Plan Deductible are those you make for covered Services that are subject to this Plan Deductible under this *EOC*.

Increasing the Plan Deductible

If the U.S. Department of the Treasury increases the minimum deductible required in High Deductible Health Plans, we will increase the Plan Deductible if necessary to meet the new minimum deductible requirement, and we will notify your Group.

Changes to your Family

When your Family changes during the Accumulation Period from self-only coverage to two or more Members (or vice versa), your Plan Deductible will change and the only Plan Deductible payments that will count in the new Family are those for Services that Members in the new Family received in that Accumulation Period under this *EOC*. For example:

- If you are a Family of one Member (self-only coverage) and then add Dependents during the Accumulation Period, the amounts that had been applied toward the Plan Deductible under your self-only coverage will be applied toward the new Plan Deductible required for the expanded Family of two or more Members. Each Member in your expanded Family, including you, must pay Charges for covered Services until they reach the Plan Deductible required for each Member in a Family of two or more Members (if applicable) or until your Family reaches the Plan Deductible required for a Family of two or more Members, even if you had met your Plan Deductible (for a Family of one Member) before you added the Dependents
- If all of your Dependents cease to be Members in your Family so that your Family becomes a Family of one Member, only the amounts that had been applied toward the Plan Deductible for Services that you received during the Accumulation Period will be applied toward the Plan Deductible required for self-only coverage. You must pay Charges for covered Services you receive on or after the date you become a Family of one Member until you reach the Plan Deductible required for self-only coverage, even if the Family had previously met the Plan Deductible for a Family of two or more Members

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. Refer to the "Cost Share Summary" section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the Plan Out-of-Pocket Maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either they reach the maximum for any one Member or your Family reaches the Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for covered Services apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a covered Service will apply to the maximum refer to the "Cost Share Summary" section of this *EOC*.

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, those Services will apply toward the maximum. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org** or call Member Services. We will provide you with accrual balance information for every month that you receive Services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

We will provide accrual balance information by mail unless you have opted to receive notices electronically. You can change your document delivery preferences at any time at **kp.org** or by calling Member Services.

Administered Drugs and Products

Administered drugs and products are medications and products that require administration or observation by medical personnel, such as:

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood
- Other administered drugs and products

We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

Certain administered drugs are Preventive Services. Refer to "Reproductive Health Services" for information about administered contraceptives and refer to "Preventive Services" for information on immunizations.

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient Services related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

For covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Share you would pay if the Services were not related to a bariatric surgical procedure. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

For the following Services, refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services under this *EOC*, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

For covered dental and orthodontic procedures that you may receive, you will pay the Cost Share you would pay if the Services were not related to dental and orthodontic Services. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services.

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits" section

("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)

- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

For the following Services, refer to these sections

- Accidental injury to teeth (refer to "Injury to Teeth")
- Office visits not described in the "Dental and Orthodontic Services" section (refer to "Office Visits")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- The Services are provided inside our Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient Services (refer to "Hospital Inpatient Services")
- Office visits not described in the "Dialysis Care" section (refer to "Office Visits")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section

- The Services are provided inside our Service Area

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

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

We cover DME that is not described under "Base DME Items" or "Lactation supplies," including repair and replacement of covered equipment, if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met.

Lactation supplies

We cover one retail-grade milk pump (also known as a breast pump) per pregnancy and associated supplies, as listed on our website at **kp.org/prevention**. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

If you or your baby has a medical condition that requires the use of a milk pump, we cover a hospital-grade milk pump and the necessary supplies to operate it, in accord with the coverage rules described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to an Emergency Medical Condition or Urgent Care episode (refer to "Post-Stabilization Care" and "Out-of-Area Urgent Care")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusions

- Comfort, convenience, or luxury equipment or features except for retail-grade milk pumps as

described under "Lactation supplies" in this "Durable Medical Equipment ("DME") for Home Use" section

- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse

Emergency Services and Urgent Care

We cover the following Services:

- Emergency department visits
- Urgent Care consultations, evaluations, and treatment

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Diagnosis and treatment of Infertility

We cover the following Services for the diagnosis and treatment of Infertility:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stay directly related to diagnosis and treatment of Infertility

Artificial insemination

We cover the following Services for artificial insemination:

- Office visits
- Outpatient surgery and outpatient procedures
- Outpatient imaging and laboratory Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Hospital inpatient stays directly related to diagnosis and treatment of Infertility

Assisted reproductive technology ("ART") Services

We cover the following ART Services:

- Gamete intrafallopian transfer ("GIFT")
- In vitro fertilization ("IVF")
- Zygote intrafallopian transfer ("ZIFT")
- Transfer of cryopreserved embryos

Covered ART Services are limited to one treatment cycle per lifetime under any Health Plan evidence of coverage offered by your Group. If you reach the treatment cycle limit, we will not cover any more treatment cycles for as long as you are covered under this or any other Health Plan evidence of coverage offered by your Group.

A covered treatment cycle includes cryopreservation and storage of embryos for up to 6 months.

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to

"Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Fertility Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Services related to the procurement and storage of semen and eggs, except if the retrieval is part of your covered ART treatment cycle
- Services related to the procurement and storage of embryos, except for storage of embryos that is part of your covered ART treatment cycle

Fertility Preservation Services for Iatrogenic Infertility

Standard fertility preservation Services are covered for Members undergoing treatment or receiving covered Services that may directly or indirectly cause iatrogenic Infertility. Fertility preservation Services do not include diagnosis or treatment of Infertility.

For covered fertility preservation Services that you receive, you will pay the Cost Share you would pay if the Services were not related to fertility preservation. For example, see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for outpatient procedures.

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or Member Services or go to our website at **kp.org**.

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction
- Physician Specialist Visits to diagnose and treat hearing problems

Hearing aids

Hearing aids and related Services are not covered under this *EOC*. For internally implanted devices, see "Prosthetic and Orthotic Devices" in this "Benefits" section.

For the following Services, refer to these sections

- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to "Preventive Services")
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover home health care only if all of the following are true:

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

- The Services are provided inside our Service Area

We cover only part-time or intermittent home health care, as follows:

- 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)
- Up to 120 visits per Accumulation Period (counting all home health visits)

Note: 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.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility
- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice Services listed below only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services

- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient Services required at a level that cannot be provided at home

Hospital Inpatient Services

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Benefits" section)
- Behavioral Health Treatment for Autism Spectrum Disorder
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental and orthodontic procedures (refer to "Dental and Orthodontic Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services related to diagnosis and treatment of Infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Injury to Teeth

Services for accidental injury to teeth are not covered under this *EOC*.

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the prevention, diagnosis, or treatment of Mental Health Conditions. A "Mental Health Condition" is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment, including treatment of first episode psychosis
- Psychological testing when necessary to evaluate a Mental Health Condition
- Outpatient Services for the purpose of monitoring drug therapy
- Behavioral Health Treatment for Autism Spectrum Disorder
- Electroconvulsive therapy
- Transcranial magnetic stimulation

Intensive psychiatric treatment programs

We cover intensive psychiatric treatment programs at a Plan Facility, such as:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient or day-treatment program
- Psychiatric observation for an acute psychiatric crisis

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Gender-affirming Services

For covered Services you receive for treatment of gender dysphoria, you will pay the Cost Share you would pay if the Services were not related to gender dysphoria. For example:

- See "Administered Drugs" for administered drugs
- See "Office Visits" for consultations for gender dysphoria treatment, such as hormone therapy, and hair removal procedures
- See "Outpatient Laboratory, Imaging, and Other Diagnostic and Treatment Services" for laboratory and imaging Services
- See "Outpatient Prescription Drugs, Supplies and Supplements" for drugs, supplies, and supplements
- See "Reconstructive Surgery" for surgical Services
- See "Rehabilitative and Habilitative Services" for speech (voice) therapy

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory and sleep studies (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Telehealth Visits (refer to "Telehealth Visits")

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- 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)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")

Ostomy and Urological Supplies

We cover ostomy and urological supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Ostomy and urological supplies exclusions

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services only when part of care covered under other headings in this "Benefits" section. The Services must be prescribed by a Plan Provider.

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment

has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section and (2) the equipment is provided inside our Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)

We cover laboratory tests to diagnose or screen for COVID-19 from Plan Providers or Non-Plan Providers, including a provider visit for purposes of receiving the laboratory test.

We cover up to a total of eight FDA-authorized over-the-counter COVID-19 tests per calendar month from Plan Providers or Non-Plan Providers. Over-the-counter tests are self-administered tests that deliver results at home and are available without a prescription. For purposes of this section, "Plan Provider" means a Plan Pharmacy, mail order delivery through our website at **kp.org**, or a participating retail pharmacy. For purposes of this section, a "Non-Plan Provider" means a pharmacy or online retailer that isn't a Plan Provider. To find out more about coverage and limitations, including the current list of Plan Providers, visit our website or call Member Services.

For the following Services, refer to these sections

- Abortion and abortion-related Services (refer to "Reproductive Health Services")
- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient Surgery and Outpatient Procedures")
- Services related to diagnosis and treatment of Infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services exclusions

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
  - Non–Plan Providers that are not providers of Emergency Services or Out-of-Area Urgent Care if the prescription is for COVID-19 therapeutics (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Post-Service Claims and Appeals" section)

Note: If you obtain a prescription from a Non-Plan Provider related to dental care or for COVID-19 therapeutics as described above, we do not cover an office visit or any other services from the Non-Plan Provider.

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item from a Non-Plan Provider as part of covered Emergency

Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section or a Non-Plan Provider prescribes COVID-19 therapeutics for you.

For the locations of Plan Pharmacies, refer to our Provider Directory or call Member Services.

Refills

You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, item, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply (or 365-day supply if the item is a hormonal contraceptive) for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary," you will receive the supply prescribed up to the day supply limit specified in this section or in the drug formulary for your plan (see "About the drug formulary" below). The maximum you may receive at one time of a covered item, other than a hormonal contraceptive, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

If your plan includes coverage for hormonal contraceptives, the maximum you may receive at one time of contraceptive drugs is a 365-day supply. To obtain a 365-day supply, talk to your prescribing provider. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for hormonal contraceptives.

If your plan includes coverage for sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for sexual dysfunction drugs.

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary" for any drug to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, please refer to the California Commercial HMO formulary on our website at **kp.org/formulary**. The formulary also discloses requirements or limitations that apply to specific drugs, such as whether there is a limit on the amount of the drug that can be dispensed and whether the drug must be obtained at certain specialty pharmacies. If you would like to request a copy of this drug formulary, please call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Formulary exception process

Drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the "Dispute Resolution" section.

Continuity drugs

If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration.

About drug tiers

Drugs for your plan are categorized into tiers as described in the table below (your plan doesn't have a Tier 3). Your Cost Share for covered items may vary based on the tier. Refer to "Outpatient prescription drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC* for Cost Share for items covered under this section. Refer to the drug formulary to find out which tier a particular drug is on and for the definition of "generic drug," "brand-name drug," and "specialty drug."

Tier	Description
Tier 1	Most generic drugs, supplies and supplements (also includes certain brand-name drugs, supplies, and supplements)
Tier 2	Most brand-name drugs, supplies, and supplements (also includes certain generic drugs, supplies, and supplements)
Tier 4	High-cost brand-name or generic drugs, supplies, and supplements (sometimes called "specialty drugs")

These tiers apply to formulary and non-formulary drugs, supplies and supplements. If you need help determining whether a formulary or non-formulary drug, supply, or supplement is categorized as Tier 1, Tier 2, or Tier 4, please call Member Services. Note: Non-formulary drugs are not covered unless Medically Necessary as described under "Formulary exception process" in the "About the drug formulary" section above.

General rules about coverage and your Cost Share

We cover the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Drugs for which a prescription is required by law. We also cover certain over-the-counter drugs and items (drugs and items that do not require a prescription by law) if they are listed on our drug formulary and prescribed by a Plan Physician, except a prescription is not required for over-the-counter contraceptives
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on Tier 4, not the Cost Share for drugs on Tier 2)

Schedule II drugs

You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service

Prescription refills can be mailed within 3 to 5 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail-order service in the following ways:

- To order online, visit **kp.org/rxrefill** (you can register for a secure account at **kp.org/registernow**) or use the KP app from your smartphone or other mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option
- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Restrictions and limitations apply. For example, not all drugs can be mailed and we cannot mail drugs to all states.

Manufacturer coupon program

For outpatient prescription drugs or items that are covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, after reaching your applicable deductible amount and as allowed under Health Plan's coupon program. You will owe any additional amount if the

coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum if applicable. Refer to the "Cost Share Summary" section of this *EOC* to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Base drugs, supplies, and supplements

Cost Share for the following items may be different than other drugs, supplies, and supplements. Refer to "Base drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC*:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis
- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

For the following Services, refer to these sections

- Drugs prescribed for abortion or abortion-related Services (refer to "Reproductive Health Services")
- Administered contraceptives (refer to "Reproductive Health Services")
- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment ("DME") for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment ("DME") for Home Use")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - insulin
  - over-the-counter drugs covered under "Preventive Services" in this "Benefits" section (this includes tobacco cessation drugs and contraceptive drugs)
  - an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- Drugs when prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. We may require Members who are prescribed drugs for morbid obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug

Outpatient Surgery and Outpatient Procedures

We cover the following outpatient care Services:

- Outpatient surgery
- Outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or in any setting where a licensed staff member monitors your vital signs as you regain

sensation after receiving drugs to reduce sensation or to minimize discomfort

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient procedures (including imaging and diagnostic Services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Preventive Services

We cover a variety of Preventive Services from Plan Providers, as listed on our website at **kp.org/prevention**, including the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list of recommended immunizations can be found at **cdc.gov/vaccines/schedules**
- Preventive services recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at **hrsa.gov/womens-guidelines**

Note: We cover immunizations to prevent COVID-19 that are administered in a Plan Medical Office or by a Non-Plan Provider. If you obtain this immunization from a Non-Plan Provider (except for providers of Emergency Services or Out-of-Area Urgent Care), we do not cover an office visit or any other services from the Non-Plan Provider other than administration of the vaccine.

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

If you are enrolled in a grandfathered plan, certain preventive items listed on our website, such as over-the-counter drugs, may not be covered. Refer to the "Certain preventive items" table in the "Cost Share Summary" section of this *EOC* for coverage information. If you have questions about Preventive Services, please call Member Services.

Note: Preventive Services help you stay healthy, before you have symptoms. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services that are not Preventive Services before, during, or after a visit that includes Preventive Services, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

For the following Services, refer to these sections

- Milk pumps and lactation supplies (refer to "Lactation supplies" under "Durable Medical Equipment ("DME") for Home Use")
- Health education programs (refer to "Health Education")
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Family planning counseling, consultations, and sterilization Services (refer to "Reproductive Health Services")

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices

We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

For internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Surgery and Outpatient Procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for Outpatient Surgery.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast:
  - ♦ prostheses, including custom-made prostheses when Medically Necessary
  - ♦ up to three brassieres required to hold a prosthesis in any 12-month period
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses 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

Supplemental prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items:

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services for Adult Members" and "Vision Services for Pediatric Members")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered Drugs and Products")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss, theft, or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection,

tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible

- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

For covered Services related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the Services were not related to reconstructive surgery. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services, and see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Office visits not described in the "Reconstructive Surgery" section (refer to "Office Visits")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Rehabilitative and Habilitative Services

We cover the Services described in this "Rehabilitative and Habilitative Services" section if all of the following requirements are met:

- The Services are to address a health condition
- The Services are to help you keep, learn, or improve skills and functioning for daily living
- You receive the Services at a Plan Facility unless a Plan Physician determines that it is Medically Necessary for you to receive the Services in another location

We cover the following Services:

- Individual outpatient physical, occupational, and speech therapy
- Group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

For the following Services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")

Rehabilitative and habilitative Services exclusions

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Reproductive Health Services

Family planning Services

We cover the following Services when provided for family planning purposes:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") and office visits related to their insertion, removal, and management when provided to prevent pregnancy

- Sterilization procedures for Members assigned female at birth
- Sterilization procedures for Members assigned male at birth

Plan Doula services

If you are pregnant or were pregnant within the last 12 months and want Plan Doula services, talk to your care team. We cover the following Plan Doula services:

- One initial visit
- Up to eight one-hour visits that may be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery

Up to two additional postpartum visits may be available.

Abortion and abortion-related Services

We cover the following Services:

- Surgical abortion
- Prescription drugs, in accord with our drug formulary guidelines
- Abortion-related Services

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services to diagnose or treat Infertility (refer to "Fertility Services")
- Office visits related to injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") when provided for medical reasons other than to prevent pregnancy (refer to "Office Visits")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient surgery and outpatient procedures when provided for medical reasons other than to prevent pregnancy (refer to "Outpatient Surgery and Outpatient Procedures")

Reproductive health Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- Plan Doula services exclusions:
  - Clinical or medical Services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care)
  - Assistance with activities of daily living
  - Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation)
  - Yoga
  - Birthing ceremonies
  - Over-the-counter supplies or drugs
  - Home birth

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - a Plan Provider makes this determination
  - you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the federal Food and Drug Administration

- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - ♦ the National Institutes of Health
  - ♦ the Centers for Disease Control and Prevention
  - ♦ the Agency for Health Care Research and Quality
  - ♦ the Centers for Medicare & Medicaid Services
  - ♦ a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - ♦ a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - ♦ the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services.

Services in connection with a clinical trial exclusions

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral Health Treatment for Autism Spectrum Disorder
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the prevention, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling

- Intensive outpatient programs
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment at a licensed treatment center approved by Medical Group

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Additionally, we cover Services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services" section.

For these referral Services and 988 Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Outpatient laboratory, including drug testing (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits, and you may choose to receive in-person Services from a Plan Provider instead. Some Plan Providers offer Services exclusively through a telehealth technology platform and have no physical location at which you can receive Services. If you receive covered Services from these Plan Providers, you may access your medical record of the Telehealth Visit and, unless you object, such information will be added to your Health Plan electronic medical record and shared with your Primary Care Physician.

We cover the following types of Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits
- Scheduled telephone visits

Transplant Services

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call Member Services for questions about donor Services

For covered transplant Services that you receive, you will pay the Cost Share you would pay if the Services were not related to a transplant. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient Services. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge subject to the Plan Deductible**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Vision Services for Adult Members

For the purpose of this "Vision Services for Adult Members" section, an "Adult Member" is a Member who is age 19 or older and is not a Pediatric Member, as defined under "Vision Services for Pediatric Members" in this "Benefits" section. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Adult Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Adult Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Adult Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Vision Services for Pediatric Members

For the purpose of this "Vision Services for Pediatric Members" section, a "Pediatric Member" is a Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Pediatric Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Pediatric Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Pediatric Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. These exclusions or limitations do not apply to Services that are Medically Necessary to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or

licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, including cosmetic surgery (surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or hospital inpatient Services.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to the following Services:

- Services covered under "Dental and Orthodontic Services" in the "Benefits" section
- Service described under "Injury to Teeth" in the "Benefits" section
- Pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, if any. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the federal Food and Drug Administration ("FDA") and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," "Hospital Inpatient Services," "Rehabilitative and Habilitative Services," or "Skilled Nursing Facility Care" in the "Benefits" section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, and services of massage therapists.

Oral nutrition and weight loss aids

Outpatient oral nutrition, such as dietary supplements, herbal supplements, formulas, food, and weight loss aids.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, or inpatient respite care covered in the "Hospice Care" section.

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration ("FDA") approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits" section
- COVID-19 Services granted emergency use authorization by the FDA (COVID-19 laboratory tests, therapeutics, and immunizations must be prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care)

Refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the

Member's condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to covered Plan Doula services.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Also, Services in connection with assisted reproductive technology ("ART") Services related to a Surrogacy Arrangement. Refer to "Surrogacy Arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling Member Services.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Coordination of Benefits

The Services covered under this *EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *EOC*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *EOC* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, please call Member Services.

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call Member Services to find out which Medicare rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and when we

cover any such Services we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such Services we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by other parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain (1) against another party, and/or (2) from other types of coverage or sources of payment that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, and/or personal injury coverages, any other types of medical payments and all other first party types of coverages or sources of payment. The proceeds of any judgment or settlement that you or we obtain and/or payments that you receive shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

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

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-753-7064

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

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

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive monetary compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Note: This "Surrogacy Arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or

any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

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

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

You must send this information to:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-753-7064

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

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Surrogacy Arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call Member Services.

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

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

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services from a Non–Plan Provider and you want us to pay for the Services
- You have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 testing, therapeutics, or immunization Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our grievance form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for Services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

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 follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call Member Services.

Submitting a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

You may file a claim (request for payment/reimbursement):

- By visiting **kp.org**, completing an electronic form and uploading supporting documentation;
- By mailing a paper form that can be obtained by visiting **kp.org** or calling Member Services; or
- If you are unable access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claim:
  - Member/Patient Name and Medical/Health Record Number
  - The date you received the Services
  - Where you received the Services
  - Who provided the Services
  - Why you think we should pay for the Services
  - A copy of the bill, your medical record(s) for these Services, and your receipt if you paid for the Services

Mailing address to submit your claim to Kaiser Permanente:

Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

Please call Member Services if you need help filing your claim.

Submitting a claim for all other Services

If you have received any other Services from a Non–Plan Provider that we did not authorize, then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Please call Member Services if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- 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 need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call Member Services for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:

  Kaiser Foundation Health Plan, Inc.

Special Services Unit
P.O. Box 23280
Oakland, CA 94623

- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for all other Services from a Non-Plan Provider that we did not authorize

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to any Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- In person at any Member Services office at a Plan Facility or any Plan Provider (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, please include any information that clarifies or supports your position. 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. To make a request, you should call Member Services.

Additional information regarding claims for all other Services from a Non–Plan Provider that we did not authorize

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and 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 the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about the external review process, see "Independent Medical Review ("IMR")" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at most Plan Facilities, or you can call Member Services.

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received from a Non–Plan Provider, please follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received.

Standard Procedure

To file a grievance electronically, use the grievance form on **kp.org**.

To file a grievance orally, call Member Services toll free at **1-800-464-4000** (TTY users call **711**).

To file a grievance in writing, please use our grievance form, which is available on **kp.org** under "Forms & Publications," in person from any Member Services office at a Plan Facility, or from Plan Providers (for addresses, refer to our Provider Directory or call Member Services). You can submit the form in the following ways:

- In person at any Member Services office at a Plan Facility

- By mail to any Member Services office at a Plan Facility

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Please call Member Services if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary prescription drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Urgent procedure

If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance. Note: Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure 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
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary prescription drug and your grievance involves a request to refill a non-formulary prescription drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but no later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non- Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding pre-service requests for Medically Necessary Services
You may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization
You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Additional information about utilization review determination criteria for mental health Services or substance use disorder treatment
Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health Services or substance use disorder treatment are available at **kp.org** at no cost.

Independent Review Organization for Non-Formulary Prescription Drug Requests

If you filed a grievance to obtain a non-formulary prescription drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization ("IRO"). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit

P.O. Box 1809
Pleasanton, CA 94566

- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

For urgent IRO reviews, we will forward to you the independent reviewer's decision within 24 hours. For non-urgent requests, we will forward the independent reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care ("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary Services
  - you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials."

If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's IMR organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or investigational denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within three days after we received your request. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying their recommendation. We do not cover the Services of the Non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, go to **hhs.gov/civil-rights**.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered),

for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted

- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
393 E. Walnut St.
Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the

Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2026, your last minute of coverage was at 11:59 p.m. on December 31, 2025). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any

Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2026, your last minute of coverage was at 11:59 p.m. on December 31, 2025.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy Arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

If you believe that we have terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this

coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act ("Cal-COBRA"), you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Member Services within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA enrollment and Premiums

Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay Full Premiums within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, your Premium payment for the upcoming coverage month is due on the last day of the preceding month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments may be subject to a fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for nonpayment of Cal-COBRA Premiums" section.

Changes to Cal-COBRA coverage and Premiums

Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *EOC* is still in effect and give you a

current one if this *EOC* has expired or been amended. You can also request one from Member Services.

Cal-COBRA open enrollment or termination of another health plan

If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call Member Services. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage

You may terminate your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA Premiums

If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the last day of the preceding month. If we do not receive Full Premium payment by the due date, we will send a notice of nonreceipt of payment to the Subscriber's address of record. You will have a 30-day grace period to pay the required Premiums before we terminate your Cal-COBRA coverage for nonpayment. The notice will state when the grace period begins and when the memberships of the Subscriber and all Dependents will terminate if the required Premiums are not paid. Your coverage will continue during this grace period. If we do not receive Full Premium payment by the end of the grace period, we will mail a termination notice to the Subscriber's address of record. After termination of your membership for nonpayment of Cal-COBRA Premiums, you are still responsible for paying all amounts due, including Premiums for the grace period.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums

If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage

Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under

"Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities

If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

USERRA

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

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC,* including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **buykp.org** or call Member Services. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement,* including this *EOC*.

Advance Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services office at a Plan Facility. For more information about advance directives, refer to our website at **kp.org** or call Member Services.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee

Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

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

Group and Members Not Our Agents

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

No Waiver

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

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy Practices

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

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request

confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call Member Services. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **about.kp.org** or from Member Services. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling Member Services.

Provider Directory

Refer to the Provider Directory for your Home Region for the following information:

- A list of Plan Physicians
- The location of Plan Facilities and the types of covered Services that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at **kp.org**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our Services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

Document Delivery Preferences

Many Health Plan documents are available electronically, such as bills, statements, and notices. If you prefer to get documents in electronic format, go to **kp.org** or call Member Services. You can change delivery preference at any time. To get a copy of a specific Heath Plan document in printed format, call Member Services.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week:

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (closed holidays)

Visit Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Write Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Website **kp.org**

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-390-3507** (TTY users call **711**)

Monday through Friday 6 a.m. to 5 p.m.

Website **kp.org**

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

24 hours a day, seven days a week (closed holidays)

Website **kp.org/travel**

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section under "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (closed holidays)

Website **kp.org**

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, and COVID-19 Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section, under "Ambulance Services" in the "Benefits" section, or COVID-19 Services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Preventive Services" in the "Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

Text telephone access ("TTY")

If you use a text telephone device ("TTY," also known as "TDD") to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call Member Services.

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *EOC*. Payment responsibility is more fully described in other sections of the *EOC* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Cost Share for covered Services (refer to the "Cost Share Summary" section)
- If you receive Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or COVID-19 Services from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance Services, or COVID-19 Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or another party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for noncovered Services

Important Notices

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, or materials translated into your language or alternative formats. You can also request auxiliary aids and devices at our facilities. Call our Member Service Contact Center for help, 24 hours a day, 7 days a week (closed holidays).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. اتصل مع مركز اتصال خدمة الأعضاء لدينا، على مدار 24 ساعة في اليوم و 7 أيام في الأسبوع (العطلات مغلق).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- جميع الآخرين: **1-800-464-4000** (TTY **711**)

Armenian: Ձեզ կարող է անվճար լեզվական աջակցություն տրամադրվել օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման կապի կենտրոն օրը 24 ժամ, շաբաթը 7 օր (տոն օրերին փակ է):

- Medi-Cal՝ **1-855-839-7613** (TTY **711**)
- Այլ՝ **1-800-464-4000** (TTY **711**)

Chinese: 我们每周 7 天，每天 24 小时免费提供语言帮助。您可以要求提供口译员、或将材料翻译为您所用语言或其他格式。您还可以在我们的设施中要求使用辅助工具和设备。请打电话给我们的会员服务联络中心，服务时间为每周 7 天，每天 24 小时（节假日除外）。

- 所有会员：**1-800-757-7585** (TTY **711**)

Farsi: خدمات زبانی در 24 ساعت شبانه‌روز و 7 روز هفته به‌صورت رایگان در اختیار شماست. می‌توانید خدمات مترجم شفاهی، یا ترجمه مدارک به زبان خود یا به فرمت‌های دیگر را درخواست کنید. همچنین می‌توانید دستگاه‌ها و کمک‌های دیگر را در مراکز ما درخواست نمایید. برای دریافت کمک، در 24 ساعت شبانه‌روز و 7 روز هفته (به‌جز تعطیلات) با مرکز تماس خدمات اعضای ما تماس بگیرید.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- سایر: **1-800-464-4000** (TTY **711**)

Hindi: बिना किसी लागत के भाषा सहायता, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप दुभाषिये की सेवाओं के लिए, या बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों का अनुरोध कर सकते हैं। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी अनुरोध कर सकते हैं।सहायता के लिए हमारी सदस्य सेवाओं के सम्पर्क केंद्र को, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- बाकी दूसरे: **1-800-464-4000** (TTY **711**)

Hmong: Muaj kev pab txhais lus pub dawb rau koj, 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. Hu rau peb Qhov Chaw Pab Cov Tswv Cuab 24 teev tuaj ib hnub twg, 7 hnub tuaj ib lim tiam twg (cov hnub caiv kaw).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Dua lwm cov: **1-800-464-4000** (TTY **711**)

Japanese: 多言語による情報支援を無料で 24 時間年中無休でご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは別の形式による資料もご所望いただけます。また、当施設における補助的な支援や機器についてもご所望いただけます。お気軽にご連絡ください（祝祭日を除き 24 時間週 7 日）。

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- その他のご連絡先: **1-800-464-4000** (TTY **711**)

Khmer (Cambodian): ជំនួយភាសា គឺឥតគិតថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ ឬឯកសារដែលបានបកប្រែ ជាភាសាខ្មែរ ឬទម្រង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយ ទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ ទូរស័ព្ទទៅមជ្ឈមណ្ឌល ទំនាក់ទំនងសេវាកម្មសមាជិករបស់យើងសម្រាប់ជំនួយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (ថ្ងៃឈប់សម្រាកបិទ)។

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ផ្សេងទៀតទាំងអស់: **1-800-464-4000** (TTY **711**)

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스 또는 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 저희 가입자 서비스 연락 센터에 주 7 일, 하루 24 시간(공휴일 휴무) 전화하셔서 도움을 받으십시오.

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- 기타 모든 경우: **1-800-464-4000** (TTY **711**)

Laotian: ມີການຊ່ວຍເຫຼືອດ້ານພາສາບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ. ທ່ານຍັງສາມາດຂໍບໍລິການຜູ້ແປພາສາ ຫຼື ເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ໃນຮູບແບບອື່ນໄດ້. ທ່ານຍັງສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ເຄື່ອງມືຢູ່ສະຖານບໍລິການຂອງພວກເຮົາໄດ້. ໂທຫາສູນຕິດຕໍ່ບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ, 24 ຊົ່ວໂມງຕໍ່ວັນ, 7 ວັນຕໍ່ອາທິດ (ບໍ່ດໃນວັນພັກ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ອື່ນໆທັງໝົດ: **1-800-464-4000** (TTY **711**)

Mien: Mbenc nzoih liouh wangv-henh tengx nzie faan waac bun muangx meih maiv cingv, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm leiz baaix mbenc maaih 7 hnoi. Meih se haih tov heuc tengx faan benx meih nyei waac bun muangx, a'fai zoux benx nyungc horngh jaa-sic zoux benx meih nyei waac. Meih corc haih tov tengx nyungc horngh jaa-dorngx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Beiv hnangv qiemx zuqc longc mienh nzie weih nor douc waac lorx taux yie mbuo ziux goux baengc mienh nyei gorn zangc, yietc hnoi tengx duqv 24 norm ziangh hoc, yietc norm leiz baaix tengx duqv 7 hnoi (simv cuotv gingc nyei hnoi se guon oc).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yietc zungv da'nyeic deix: **1-800-464-4000** (TTY **711**)

Navajo: Díí hózhó nízhoní bee hane' dóó jíik'ah jóóní doonílwo'. Ndik'é yádi naaltsoos bee haz'áanii bee hane' dóó yádi nihookaa dóó nádááhágíí yádi nihookaa. Shí éí bee háídínii bibee' haz'áanii dóó bee t'ah kodí bízíkinii wo'da'gi doolyé. Ahéhee' bik'ehgo nohólǫǫn'ígíí, 24 t'áádawołíí, 7 t'áádawołíígo (t'áadoo t'áálwo').

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Yadilzingo biłk'ehgo bee: **1-800-464-4000** (TTY **711**)

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਲਈ, ਜਾਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। ਮਦਦ ਲਈ ਸਾਡੀ ਮੈਂਬਰ ਸੇਵਾਵਾਂ ਦੇ ਸੰਪਰਕ ਕੇਂਦਰ ਨੂੰ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਕਾੱਲ ਕਰੋ।

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ਹੋਰ ਸਾਰੇ: **1-800-464-4000** (TTY **711**)

Russian: Языковая помощь доступна для вас бесплатно круглосуточно, ежедневно. Вы можете запросить услуги переводчика или материалы, переведенные на ваш язык или в альтернативные форматы. Вы также можете заказать вспомогательные средства и приспособления. Для получения помощи позвоните в наш центр обслуживания участников ежедневно, круглосуточно (кроме праздничных дней).

- Medi-Cal: **1-855-839-7613** (линия TTY **711**)
- Все остальные: **1-800-464-4000** (линия TTY **711**)

Spanish: Tenemos disponible asistencia en su idioma sin ningún costo para usted 24 horas al día, 7 días a la semana. Usted puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o formatos alternativos. También puede solicitar recursos para discapacidades en nuestros centros de atención. Llame a nuestra Central de Llamadas de Servicio a los Miembros para recibir ayuda 24 horas al día, 7 días a la semana (excepto los días festivos).

- Para todos los demás: **1-800-788-0616** (TTY **711**)

Tagalog: May magagamit na tulong sa wika nang wala kayong babayaran, 24 na oras sa isang araw, 7 araw sa isang linggo. Maaari kayong humiling ng mga serbisyo ng interpreter, o mga babasahin na isinalin sa inyong wika o sa mga alternatibong format. Maaari rin kayong humiling ng mga pantulong na gamit at device sa aming mga pasilidad. Tawagan ang aming Center sa Pakikipag-ugnayan ng Serbisyo sa Miyembro para sa tulong, 24 na oras sa isang araw, 7 araw sa isang linggo (sarado sa mga pista opisyal).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Lahat ng iba pa: **1-800-464-4000** (TTY **711**)

Thai: มีบริการช่วยเหลือด้านภาษาตลอด 24 ชั่วโมงทุกวันโดยไม่มีค่าใช้จ่าย โดยคุณสามารถขอใช้บริการล่าม บริการแปลเอกสารเป็นภาษาของคุณหรือในรูปแบบอื่นๆ ได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการของเราโดยโทรหาเราที่ศูนย์ติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือตลอด 24 ชั่วโมงทุกวัน (ปิดทำการในช่วงวันหยุด)

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- ที่อื่นๆทั้งหมด: **1-800-464-4000** (TTY **711**)

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача або отримання матеріалів у перекладі мовою, якою володієте, чи в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Телефонуйте в наш контактний центр для обслуговування клієнтів цілодобово, 7 днів на тиждень (крім святкових днів).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Усі інші: **1-800-464-4000** (TTY **711**)

Vietnamese: Dịch vụ hỗ trợ ngôn ngữ được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, hoặc tài liệu được dịch ra ngôn ngữ của quý vị hoặc nhiều hình thức khác. Quý vị cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. Gọi cho Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ).

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**)

Nondiscrimination Notice

Discrimination is against the law. Kaiser Permanente[1] follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center, 24 hours a day, 7 days a week (closed holidays). The call is free:

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Medi-Cal members may call **1-855-839-7613** (TTY **711**). All other members may call **1-800-464-4000** (TTY **711**). Help is available 24 hours a day, 7 days a week (closed holidays)
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.

[1] Kaiser Permanente is inclusive of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Medical Group

- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at:
  https://www.hhs.gov/ocr/complaints/index.html

- **Online:** Visit the Office of Civil Rights Complaint Portal at:
  https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

DELTA DENTAL

Delta Dental of Illinois



Delta Dental PPO[SM]

Dental Benefits Booklet

BMO Financial Corp.

Group #20246

Effective Date: 01/01/22

DENTAL BENEFITS BOOKLET

This is a summary of your Group Dental Plan
prepared for Covered Individuals with:

BMO FINANCIAL CORP.

IMPORTANT: THIS BOOKLET IS NOT A SUMMARY PLAN DESCRIPTION (SPD). IT DOES NOT FULFILL THE REQUIREMENTS OF AN SPD AS REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA). IT IS INTENDED TO PROVIDE A BRIEF DESCRIPTION OF YOUR DENTAL PLAN BASED ON YOUR PLAN DOCUMENTS. IF THERE IS ANY CONFLICT BETWEEN THIS BOOKLET AND THE COMPLETE TEXT OF THE PLAN DOCUMENT, THEN THE PLAN DOCUMENTS GOVERN AND SHALL SUPERSEDE THIS BOOKLET. YOU MAY REVIEW THE COMPLETE PLAN DOCUMENT AT THE COMPANY'S OFFICES DURING REGULAR BUSINESS HOURS AND MAY OBTAIN COPIES OF ALL OR ANY PART OF THE PLAN DOCUMENT.

Dental Benefits Administered by

DELTA DENTAL OF ILLINOIS
111 Shuman Boulevard
Naperville, Illinois 60563

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DELTA DENTAL OF ILLINOIS
GROUP DENTAL PLAN

BMO FINANCIAL CORP
GROUP NO. 20246

ENDORSEMENT NO. 1

This Dental Benefits Booklet is amended, in part, as follows:

ELIGIBILITY REQUIREMENTS:

All present regular, part-time employees of the Group Subscriber who work a minimum of 20 hours per week and all present regular, full-time employees who work a minimum of 40 hours per week are eligible for coverage under this Group Dental Plan.

All future regular, part-time employees who work a minimum of 20 hours per week become eligible on the date of employment.

All future regular, full-time employees who work a minimum of 40 hours per week become eligible on the date of employment.

Domestic partners, as defined herein, and their eligible Dependents are eligible for coverage under this Group Dental Plan.

This Endorsement is effective as of September 1, 2022.

DEFINITIONS

This Group Dental Plan is subject to the following definitions:

"Approved Fee" means the lesser of the Dentist's fee or the Maximum Plan Allowance.

"Benefit Year" means the reference period specified in the Dental Plan Specifications for purposes of determining the application of Deductibles, waiting periods and coverage limits for each Covered Individual.

"Covered Individual" means any employee or any Dependent of that employee who enrolls in this Group Dental Plan and who is entitled to receive Dental Benefits, unless and until coverage terminates as provided herein.

"Covered Individual's Effective Date of Coverage" means the date an individual meets the required conditions of eligibility and becomes enrolled in this Group Dental Plan.

"Delta Dental PPO Dentist" means a Dentist who, by written agreement with DDIL, will provide dental services to Covered Individuals in accordance with DDIL's negotiated fee schedules and has agreed to abide by the bylaws, rules and regulations established by DDIL.

"Dental Benefits" means those dental procedures or services which are listed in this booklet subject to the exclusions, terms and conditions contained in this booklet.

"Dental Benefits Booklet" means this booklet issued to an Enrolled Employee setting forth the terms and conditions of this Group Dental Plan. Employer shall be responsible for distributing this booklet to Enrolled Employees.

"Dental Procedures or Services Received" means the date treatment is COMPLETED for any particular Dental Benefit for the purpose of allocating the particular Dental Benefit to the appropriate Benefit Year and paying claims made under this Group Dental Plan.

"Dentist" means a licensed Dentist legally entitled to practice dentistry at the time and in the place services are provided.

"Dependent" means if you elect coverage for yourself, you may enroll your eligible dependents, who include:

- your legal spouse, unless you are legally separated or divorced (a common-law spouse is eligible if you legally establish the marriage in a state that recognizes common-law marriages);
- your qualifying same-sex or opposite-sex domestic partner if your relationship satisfies certain criteria (see Domestic Partner Eligibility Requirements in this section); and
- your children under age 26.

Note: If you and your spouse or domestic partner are both BMO Harris employees and eligible to enroll in the plan, you may each enroll for individual coverage or one of you may enroll and cover the other. If you each enroll for individual coverage, only one of you may enroll your children as dependents.

Children are defined as:

- your biological children;
- your adopted children or children placed with you for adoption;
- your stepchildren, regardless of where they live;
- foster children living with you;
- a child who is recognized under a qualified medical child support order as having a right to health care coverage, if the child meets the other eligibility requirements of the plan for dependent coverage;
- any other child for whom you are the legal guardian and whom you support in a parent-child relationship; and
- your domestic partner's children if they qualify as your dependents for income tax purposes according to Section 152 of the Internal Revenue Code.

Extended Coverage for Disabled Children
If a dependent child is physically or mentally incapable of self-support after reaching age 26 and was continuously covered under the Plan up to and including the date the child became incapacitated, you may continue coverage for that dependent if the child's physical or mental handicap started before he or she reached age 26. You must provide proof of the disability to Benefits Administration within 31 days of when the child's coverage would normally end under the plan. Your child is considered physically or mentally incapable of self support if the child is not able to earn his or her own living because of mental retardation or physical handicap and if the child is mainly dependent on you for support and maintenance.

If you were just hired or recently became eligible for coverage because of a change in employment status, you must provide this proof within 31 days of your eligibility to cover an adult disabled dependent. You may also need to provide proof of continued disability from time to time to maintain coverage.

Domestic Partner Eligibility Requirements

- Eligibility is available to employees' domestic partners, whether same-sex or opposite-sex. Your domestic partner's children may also qualify as dependents under the Medical Plan if they meet the same requirements that apply to all dependent children and they qualify as your dependents for income tax purposes according to Section 152 of the Internal Revenue Code.

Domestic Partners

For your domestic partner to be eligible under the Medical Plan, the two of you must meet all the following requirements:

- you share a sole, committed relationship with each other that has existed for at least one year and is expected to last indefinitely;
- you are jointly responsible for each other's welfare and financial obligations;
- you share your principal place of residence;
- you are both at least 18 years old and mentally competent to consent to a contract;
- neither of you is married to, legally separated from or in another domestic partner relationship with anyone else; and
- you are not related to each other in a way that would prohibit a legal marriage from being recognized in the state in which you live.

Domestic Partner's Children

If your domestic partner meets the requirements listed above, then his or her children may also be considered eligible dependents under the Medical Plan. Children of domestic partners are subject to the same eligibility requirements that biological and adopted children must meet.

You can enroll your domestic partner's children only if they qualify as your legal tax dependents. As a result, premiums for coverage of all dependent children are made on a pretax basis with no imputed income.

"Domestic Partner" means an individual with whom the Subscriber is in a relationship which meets the following criteria:

(a) The individual must be at least 18 years of age or older;
(b) The individual is not married, by statute or common law, or in a domestic partner relationship with anyone other than the Subscriber;
(c) The individual is not related to the Subscriber to a degree of closeness that would prohibit legal marriage between opposite sex partners in the state in which both parties reside;
(d) The individual lives in the same residence with the Subscriber;
(e) The individual is in an exclusive, committed relationship with the Subscriber that is intended to be permanent and where both parties have agreed to be mutually responsible for each other's common welfare; and
(f) The individual has been in the current relationship for a period of at least 12 months.

"Eligibility Date" means the date an employee or Dependent may become enrolled in this Group Dental Plan.

"Enrolled Employee" means an employee who has satisfied the requirements for eligibility as set forth herein and who enrolls in this Group Dental Plan and makes the required contribution, if any.

"Group Plan Commencement Date" means the date this Group Dental Plan begins pursuant to the date designated in the Dental Plan Specifications.

"Maximum Plan Allowance" means the amount that a Delta Dental Premier Dentist agrees contractually to accept as full payment for covered procedures. The Maximum Plan Allowance is calculated as a percentile of billed fees.

"Non-Delta Dental PPO Dentist" means a Dentist who has not agreed to be a Delta Dental PPO Dentist. There are two categories of Non-Delta Dental PPO Dentists. First, there are those Dentists who are Delta Dental Premier Dentists and second, there are those Dentists who are not Delta Dental Premier Dentists.

(a) Delta Dental Premier Dentists are bound to accept DDIL's Approved Fee as full reimbursement for their services after application of any Deductible and DDIL's benefit payment.

(b) Non-Delta Dental Premier Dentists have not agreed to accept DDIL's Approved Fee as full payment of their services. Non-Delta Dental Premier Dentists may bill the patient the difference between his/her fee and DDIL's benefit payment.

"Proof of Claim" means the required documentation set forth in the section titled *Required Documentation* as well as all the requested information indicated on DDIL's claim form.

"Retiree" means a person retired from the active service of the employer who was covered under this Group Dental Plan immediately prior to retirement

GENERAL INFORMATION
ON HOW THE PLAN WORKS

Under this Group Dental Plan, you are free to go to the Dentist of your choice; however, you will receive greater benefits if you go to a Delta Dental PPO Dentist. A list of Delta Dental PPO Dentists is available on the Delta Dental of Illinois website www.deltadentalil.com.

The level of covered Dental Benefits paid under this Group Dental Plan depends on whether you go to (1) a Delta Dental PPO Dentist, (2) a Non-Delta Dental PPO Dentist who is a Delta Dental Premier Dentist, or (3) a Non-Delta Dental PPO Dentist who is not a Delta Dental Premier Dentist. See the Schedule of Dental Benefits for a description of the payment levels for each of the above categories of Dentists.

This Group Dental Plan will pay Delta Dental PPO Dentists and Non-Delta Dental PPO Dentists who are Delta Dental Premier Dentists directly and the right to receive that payment shall not be assignable. If your Dentist is a Non-Delta Dental PPO Dentist who is not a Delta Dental Premier Dentist, you will be paid directly and the right to receive that payment shall not be assignable.

HOW TO FILE A CLAIM

TO USE YOUR GROUP DENTAL PLAN, FOLLOW THESE STEPS

(1) Please read this Dental Benefits Booklet carefully in order to familiarize yourself with the benefits and provisions of this Group Dental Plan.

(2) If your Dentist does not have a claim form, you may obtain one from your personnel office. Please be sure that the information portion of the claim form includes the following:

(a) the employee's full name and address;

(b) the employee's social security number;

(c) the name and date of birth of the person receiving dental treatment; and

(d) the group name and number.

(3) If your Dentist is not familiar with this Group Dental Plan or has any questions regarding this Group Dental Plan, he/she may contact Delta Dental of Illinois, 111 Shuman Boulevard, Naperville, Illinois 60563; telephone (1-800) 323-1743.

(4) If your Dentist expects that the total fees for your dental treatment will exceed $200, then DDIL recommends that a request for the predetermination of plan benefits be submitted, prior to treatment, to DDIL, P.O. Box 5402, Lisle, Illinois 60532, so that you and your Dentist are aware of the coverage afforded under this Group Dental Plan prior to services being rendered. This request must show your dental needs and a description of the procedures and services which the treating Dentist plans to perform, including the actual fees to be charged for each procedure or service.

(5) DDIL will review the request for predetermination of plan benefits and the required documentation (as set forth in the section titled *Required Documentation*) submitted by the treating Dentist in order to determine the level of payment under this Group Dental Plan. A pre-treatment determination does not take into account other coverage you may have; DDIL coordinates its benefits with another group dental plan after treatment has been completed.

(6) After your treating Dentist has completed the dental services outlined in the Predetermined Benefit Voucher, this voucher is to be resubmitted to DDIL indicating the date each dental procedure or service was rendered. If procedures or services are rendered after 90 days from the date this Group Dental Plan issued its payment determination, as outlined in the Predetermined Benefit Voucher, the claim must be submitted to DDIL with the required documentation set forth in the section titled *Required Documentation*. This Proof of Claim should be furnished within 90 days after you have received the Dental Benefit.

(7) If a request for predetermination of plan benefits is not submitted in advance as requested, this Group Dental Plan reserves the right to make a determination of the level of payment, taking into account the provisions of this Group Dental Plan. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating Dentist and only relates to the level of payment which this Group Dental Plan is required to make.

(8) Submission of a request for predetermination of plan benefits before treatment commences is not requested for:

(a) procedures and services where the total fees are less than $200;

(b) emergency examination and treatment for accidental injuries; emergency treatment for relief of pain when not related to a final procedure; and

(c) oral surgery necessitated as a result of an injury.

ELIGIBILITY REQUIREMENTS

Effective Date of Coverage

(a) Employee's Date of Eligibility: An employee is eligible to enroll in this Group Dental Plan upon satisfaction of the requirements set forth in the Dental Plan Specifications. Coverage commences on the date the employee becomes an Enrolled Employee.

(b) Dependent's Date of Eligibility: An Enrolled Employee may elect to have his/her Dependents covered by this Group Dental Plan provided that each meets the definition of Dependent as provided herein and the contributions, if any, required of the Enrolled Employee for Dependent coverage are made. A Dependent's coverage commences on whichever of the following dates is applicable.

(i) An Enrolled Employee's Dependents shall have coverage under this Group Dental Plan beginning on the same date as the Enrolled Employee's coverage, if written request for coverage for his/her Dependents is made by the Enrolled Employee on the date he or she first enrolls in this Group Dental Plan.

(ii) Dependent coverage shall commence as of the date of the Enrolled Employee's marriage and shall include any stepchildren of the Enrolled Employee who becomes eligible because of such marriage, if written request is made by the Enrolled Employee and the required contribution is paid within 31 days after the date of marriage.

(iii) Dependent coverage shall commence as of the date of the birth of a newborn child of an Enrolled Employee who on such date has Dependent coverage in force or has no other living Dependents or as of the date of adoption of a child by or the date of placement for adoption with an Enrolled Employee who on such date has Dependent coverage in force and has no other living Dependents, if written request for coverage for such child is made and the required contribution is paid within 31 days after such birth or adoption.

(c) Benefit Year: Regardless of a Covered Individual's Effective Date of Coverage, the reference period for determining the application of coverage limits shall be the Benefit Year as specified in the Dental Plan Specifications.

General Eligibility Rules

(a) Enrollment: No individual shall be eligible for Dental Benefits under this Group Dental Plan unless listed by the employer as a Covered Individual in accordance with the provisions of this Group Dental Plan.

(b) Dependents:

(i) A dependent child may continue to be eligible as a Dependent if he/she is incapable of self-support because of physical or mental incapacity (that commenced prior to losing dependent status) and if he/she

is chiefly dependent on the Enrolled Employee for support, provided proof of such incapacity and dependency is submitted within 31 days after a request by DDIL, and subsequently as may be required by DDIL, but not more frequently than annually after the incapacitated and dependent child has reached age 21.

(ii) Each Enrolled Employee must notify employer of any changes in dependent status, if applicable, immediately upon change of status.

(iii) Dependents in military service are not eligible for coverage under this Group Dental Plan.

(c) Continuation of Coverage: A Covered Individual may be eligible to continue coverage under federal law and regulations. See the section titled *Continuation of Coverage Rights (COBRA)* for continuation of coverage rights if the coverage of an employee, an employee's spouse or dependent child is terminated. A Covered Individual may also be eligible for continuation of benefits under the Federal Family and Medical Leave Act if on an unpaid leave.

Termination of Eligibility

(a) Termination of Group Dental Plan: Eligibility for Dental Benefits under this Group Dental Plan will terminate for all Covered Individuals upon termination of this Group Dental Plan.

(b) Termination of Individual Eligibility:

(i) The eligibility of an Enrolled Employee, and the eligibility of the Dependents of that Enrolled Employee, will terminate if that employee ceases to be eligible under this Group Dental Plan.

(ii) In no event will eligibility for any individual covered under this Group Dental Plan continue beyond the date DDIL is advised by employer to terminate that individual's eligibility, or the date on which employer fails to remit the required payment for the individual.

(c) Completed Treatment: If a Covered Individual should lose eligibility under this Group Dental Plan for any reason, no Dental Benefits will be paid or otherwise discharged after that termination date except for treatment completed on or before the date of termination.

DENTAL BENEFITS

This Group Dental Plan will pay for those dental services or procedures listed in the Schedule of Dental Benefits. Benefit payments are subject to any applicable Deductible, waiting periods and coverage limits listed in the Dental Plan Specifications.

The Dental Benefits furnished under this Group Dental Plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for predetermination of plan benefits, accompanied by any required documentation, should be submitted to DDIL for payment determination before services are rendered. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating Dentist and only relates to the level of payment which this Group Dental Plan is required to make.

Not all dental services and procedures are covered under this Group Dental Plan. See the Schedule of Dental Benefits for a list of services and procedures not covered.

LEVEL OF DENTAL BENEFITS

The level of covered Dental Benefits under this Group Dental Plan depends on whether a Covered Individual goes to (1) a Delta Dental PPO Dentist, (2) a Non-Delta Dental PPO Dentist who is a Delta Dental Premier Dentist, or (3) a Non-Delta Dental PPO Dentist who is not a Delta Dental Premier Dentist. See the Schedule of Dental Benefits for a description of the benefit levels for each of the above categories of Dentists.

REQUIRED DOCUMENTATION

The following information must be submitted to DDIL with every request for predetermination of plan benefits or claim for payment for the listed Dental Benefits. In the absence of this information or the requested information indicated on DDIL's claim form, this Group Dental Plan will be unable to render a benefit determination.

Full Mouth Series of Radiographs: This Group Dental Plan requires the submission of full mouth radiographs with every claim for non-surgical periodontics, surgical periodontics and complete dentures.

Full Arch Periapical Radiographs: This Group Dental Plan requires the submission of full arch periapical radiographs with every claim for osseous fractures and fixed partial and removable dentures.

Periapical Radiographs: This Group Dental Plan requires the submission of periapical radiographs with every claim for surgical extractions, endodontics (post-operative radiographs), cast restorations and space maintainers.

Narrative: This Group Dental Plan requires the submission of a narrative with every claim for consultations, emergency examinations, palliative treatment and general anesthesia.

Histopathology/Hospital Report: This Group Dental Plan requires the submission of a histopathology and/or hospital report with every claim for biopsies and the surgical excision of tissue.

GENERAL PROVISIONS

NOTICE AND PROOF OF DENTAL CLAIMS

Written notice and proof of claim is to be furnished to DDIL within 90 days after the Covered Individual has received a Dental Benefit.

Failure to furnish this Proof of Claim within this 90 day time period shall not invalidate or reduce any claim if the Covered Individual provides a reasonable explanation of this failure to file a timely claim. IN NO EVENT WILL EMPLOYER BE LIABLE FOR ANY NOTICE OR PROOF OF CLAIM WHICH IS SUBMITTED TO DDIL MORE THAN ONE YEAR AFTER THE COVERED INDIVIDUAL HAS RECEIVED DENTAL SERVICES FOR THAT CLAIM. No action shall lie against employer unless, as a condition precedent thereto, the Covered Individual shall have fully complied with the notice and Proof of Claim provisions contained in this Dental Benefits Booklet.

COORDINATION OF BENEFITS

The purpose of this Group Dental Plan is to help you meet the cost of needed dental care or treatment. It is not intended that anyone receive benefits greater than actual expenses incurred. In no event will payment under this plan exceed the amount which would have been allowed if dental coverage did not exist.

If a Covered Individual is entitled to coverage under two or more policies or prepaid health care plans, then the covered Dental Benefits of this Group Dental Plan shall be paid as follows:

(a) The benefits of the plan which covers the person directly as the employee and not as a Dependent will be determined before those of the plan which covers the person as a Dependent.

(b) Except as set forth in paragraph (c), when two or more plans cover the same child as a Dependent of different parents:

1. The benefits of the plan of the parent whose birthday, excluding year of birth, falls earlier in a year will be determined before those of the plan of the parent whose birthday, excluding year of birth, falls later in that year; but

2. If both parents have the same birthday, the benefits of the plan which covered the parent for a longer period of time will be determined before those of the plan which covered the parent for a shorter period of time.

However, if a plan subject to the rule based on the birthday of the parents as stated above coordinates with an out-of-state plan which has a rule based upon the gender of the parent, 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.

(c) If two or more plans cover a dependent child of divorced or separated parents, benefits of the child will be determined in this order:

1. First, the plan of the parent with custody of the child;

2. Second, the plan of the spouse of the parent with custody of the child; and

3. Third, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obliged to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before that entity has that actual knowledge.

But if the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules as set forth in paragraph (b).

(d) The benefits of a plan which covers a person as an employee who is neither laid off nor retired, or as that employee's Dependent, will be determined before those of a plan which covers that person as a laid off or retired employee or as that employee's Dependent. If the other plan is not subject to this rule, and if, as a result, the plans do not agree on the order of benefits, this paragraph shall not apply.

(e) If none of the rules in paragraphs (a), (b), (c) or (d) determine the order of benefits, the benefits of the plan which covered an employee for a longer period of time will be determined before those of the plan which covered that person for the shorter period of time.

If this Group Dental Plan provides only secondary coverage, it shall not be obligated to make payment until DDIL receives a copy of the primary carrier's proof of payment and calculation of benefits.

Where an individual has dual coverage, this Group Dental Plan shall not be charged with a greater amount than the amount for which it would be liable if such dual coverage did not exist. In any event, the benefits under both plans shall not total more than the Dentist's billed fees.

DISPUTED CLAIMS PROCEDURE

Prior Approval of Benefits: This group dental plan *does not require* prior approval of dental services. Nonetheless, a Covered Individual and his/her treating Dentist may request a predetermination of benefits to obtain advance information on the plan's possible coverage of services before they are rendered. Payment, however, is limited to the benefits that are covered under this plan and is subject to any applicable deductible, waiting periods, annual and lifetime coverage limits as well as this plan's payment policies.

Notice of Adverse Benefit Determination: If a claim is denied in whole or in part, DDIL shall notify the enrollee of the denial in writing, by issuing an Explanation of Benefits (sometimes referred to as an adverse benefit determination), within 30 days after the claim is filed, unless special circumstances require an extension of time, not exceeding 15 days, for processing. DDIL will notify the treating Dentist as well by issuing an Explanation of Payment. If an extension is necessary, DDIL shall notify the enrollee and the treating Dentist of the extension and the reason it is necessary within the original 30-day period. If an extension is needed because either the enrollee or the treating Dentist did not submit

information necessary to decide the claim, the notice of extension shall specifically describe the required information. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Explanation of Benefits Form: This form includes the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) why the claim was denied, in whole or in part, including specific plan provisions on which the denial is based and a description of any additional information needed in order to perfect the claim as well as the reason why such information is necessary;
- A description of DDIL's appeal process and the time limits applicable to the process, including a statement of the enrollee's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA following an adverse benefit determination;
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse benefit determination;
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Request for Appeal of Adverse Benefit Determination: If the enrollee disagrees with DDIL's adverse benefit determination, he/she may appeal this determination to the Reevaluation Committee of DDIL within 180 days following receipt of the adverse benefit determination. The appeal must be in writing and must state why it is believed that DDIL's benefit decision was incorrect. The denial notice, as well as any other documents or information bearing on the claim, should accompany the appeal request. The Reevaluation Committee's review of the claim upon appeal will take into account all comments, documents, records or other information submitted by the claimant, regardless of whether such information was submitted or considered in the initial benefit determination.

Upon request, DDIL will provide, free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim.

Reevaluation Committee's Review: The review shall be conducted by a person who is neither the individual who made the initial claim denial nor the subordinate of such individual. If the review is of an adverse benefit determination based in whole or in part on a determination related to dental necessity, experimental treatment or a clinical judgment in applying the terms of the contract, the Reevaluation Committee shall consult with a dentist who has appropriate training and experience in the pertinent field of dentistry and who is neither the dental consultant who made the initial claim denial nor the subordinate of such consultant. The Reevaluation Committee shall provide upon request by the claimant the name of any dental consultant whose advice was obtained in connection with the claim denial, whether or not that advice was relied upon in making the initial benefit determination.

Notice of Review Decision: The Reevaluation Committee shall notify the claimant in writing of its decision on the appeal within 60 days of receipt of the request for review.

If the Reevaluation Committee upholds the adverse benefit determination on appeal, the notice to the claimant shall include the following information:

- Through the use of a reference code (numerical code), a statement of the specific reason(s) for the adverse determination, including specific plan provisions upon which the determination is based;
- A statement that reasonable access to and copies of all documents, records and other information relevant to the denied claim are available free of charge upon request;
- A statement of the claimant's right, if this group dental plan is subject to the federal law known as the Employee Retirement Income Security Act ("ERISA"), to bring a civil action under ERISA;
- If applicable, through the use of a reference code (numerical code), a statement of the specific rule, guideline or protocol relied upon in making the adverse determination;
- If applicable, through the use of a reference code (numerical code), a statement of the relevant scientific or clinical judgment, if the adverse benefit determination is related to dental necessity, experimental treatment or other similar exclusion or limitation.

Employer's Review of Claims for Eligibility Reasons: Notwithstanding the above procedures, employer has the right to review and override all claim determinations related to eligibility or loss of eligibility, whether said claims are approved or denied.

CONTINUATION OF COVERAGE RIGHTS (COBRA)

If employer is required to offer continuation of coverage benefits under federal law and regulations, then Enrolled Employees and their Dependents, if covered under this Group Dental Plan, may be eligible to continue coverage at the individual's own expense. The employer is responsible for advising Covered Individuals of their continuation of coverage rights. For more detailed information, see Appendix D.

APPENDIX A

SCHEDULE OF DENTAL BENEFITS

This Group Dental Plan agrees, SUBJECT TO THE EXCLUSIONS, TERMS AND CONDITIONS SET FORTH HEREIN, to pay for those dental services or procedures listed in this Schedule. Benefit payments are subject to any applicable Deductibles, waiting periods and coverage limits listed in the Dental Plan Specifications.

The level of covered benefits paid under this Group Dental Plan depends on whether a Covered Individual goes to a Delta Dental PPO Dentist, a Non-Delta Dental PPO Dentist who is a Delta Dental Premier Dentist, or a Non-Delta Dental PPO Dentist who is not a Delta Dental Premier Dentist. The following outlines the level of Dental Benefits paid.

IF TREATMENT IS RENDERED BY A DELTA DENTAL PPO DENTIST, this Group Dental Plan shall pay the designated co-payment percentage, as set forth in this Schedule, of the fee that the Delta Dental PPO Dentist has agreed to accept as full reimbursement under this Group Dental Plan. Delta Dental PPO Dentists may only bill the Covered Individual the difference between the fee they have agreed to accept as full reimbursement for services rendered and this Group Dental Plan's benefit payment for a covered service.

IF TREATMENT IS RENDERED BY A NON-DELTA DENTAL PPO DENTIST, this Group Dental Plan shall pay the designated co-payment percentage, as set forth in this Schedule, of DDIL's Approved Fee.

(1) If the Non-Delta Dental PPO Dentist is a Delta Dental Premier Dentist, the Dentist is bound to accept DDIL's Approved Fee as full reimbursement for his/her services after this Group Dental Plan's benefit payment.

(2) If the Non-Delta Dental PPO Dentist is not a Delta Dental Premier Dentist, the Dentist may bill the patient the difference, if any, between his/her fee and this Group Dental Plan's benefit payment.

The benefits furnished under this Group Dental Plan are limited and defined as set forth in the Schedule of Dental Benefits. A request for predetermination of contract benefits, accompanied by any required documentation, should be submitted to DDIL for payment determination before services are rendered. A determination made by DDIL imposes no restrictions on the method of diagnosis or treatment by a treating dentist and only relates to the level of payment which this Group Dental Plan is required to make.

APPENDIX A

SCHEDULE OF DENTAL BENEFITS

If the co-payment percentage shown is "N/A", that procedure is not covered under this group dental plan.
See Appendix B for exclusions.

	Co-Payment Percentage			Deductible Applies		
Procedure	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**	**Delta Dental PPO**	**Delta Dental Premier**	**Out-of-network**
DIAGNOSTIC SERVICES						
Oral evaluations (includes limited – problem focused and re-evaluation – limited, problem focused)	100%	100%	100%	N	N	N
Comprehensive oral evaluation – new or established patient: *once per Dentist.*	100%	100%	100%	N	N	N
Detailed and extensive oral evaluation – problem focused, by report: *once per Dentist.*	100%	100%	100%	N	N	N
Comprehensive periodontal evaluation – new or established patient: *once per Dentist.*	100%	100%	100%	N	N	N
Periodic oral evaluations: *twice per calendar year*	100%	100%	100%	N	N	N
Intra-oral – periapical radiographs	100%	100%	100%	N	N	N
Bitewing x-rays (not including vertical bitewings): *once per calendar year*	100%	100%	100%	N	N	N
Complete full mouth x-rays: *once in a 36-month interval.* *A full mouth x-ray includes bitewing x-rays. Panoramic x-ray in conjunction with any other x-ray, or any combination of intraoral x-rays on the same date for which the total approved amount equals or exceeds the approved amount for a full-mouth x-ray, is considered a full mouth x-ray. One full-mouth x-ray, one set of vertical bitewings, or one panoramic x-ray is a covered benefit in a 36-month interval.*	100%	100%	100%	N	N	N
Diagnostic casts: *when rendered more than 30 days prior to definitive treatment*.	100%	100%	100%	N	N	N
Pulp vitality tests: *once per visit*	100%	100%	100%	N	N	N
Screening or assessment of a patient *once in a 12-month interval*	100%	100%	100%	N	N	N

If additional detailed or comprehensive oral evaluations are billed by the same Dentist, the level of benefits will be limited to that of a periodic oral evaluation.

Detailed or comprehensive oral evaluations count toward the calendar year maximum of two oral evaluations.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
PREVENTIVE SERVICES						
Dental prophylaxis (cleaning): *twice per calendar year**	100%	100%	100%	N	N	N
Topical fluoride applications: twice *per calendar year, for Dependent children under age 19*	100%	100%	100%	N	N	N
Space maintainers: *covered when they replace prematurely lost teeth for covered persons under age 19*	100%	100%	100%	N	N	N
Recementation of space maintainers: *once per lifetime for covered persons under age 19*	100%	100%	100%	N	N	N
Sealants: *applied once per tooth to the occlusal surface of molars that are free of decay and restorations; for Dependent children under age 19*	100%	100%	100%	N	N	N

With an indicator of surgical or non-surgical treatment of periodontal disease, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*
**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

RESTORATIVE SERVICES						
Amalgam and resin-based composite fillings *once per surface in a 12-month interval*.	80%	80%	80%	Y	Y	Y
Onlays (permanent teeth only)	50%	50%	50%	Y	Y	Y
Crowns and ceramic restorations (permanent teeth only)	50%	50%	50%	Y	Y	Y
Recementation of inlays, onlays, partial coverage restorations, cast or prefabricated posts and cores and crowns	80%	80%	80%	Y	Y	Y
Prefabricated stainless steel crowns	50%	50%	50%	Y	Y	Y
Crown repair	80%	80%	80%	Y	Y	Y
Sedative filling	50%	50%	50%	Y	Y	Y
Pin retention	50%	50%	50%	Y	Y	Y
Cast or prefabricated post and core; core build-up	50%	50%	50%	Y	Y	Y
Additional procedures to construct new crown under existing partial denture framework	80%	80%	80%	Y	Y	Y

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network

When an inlay is requested or placed, the level of benefits will be limited to that of an amalgam filling.

When multiple pins are requested or placed, the level of benefits will be limited to one pin per tooth.

Sedative fillings are a covered Dental Benefit once per tooth per lifetime.

Crowns are allowed once every 8 years

ENDODONTIC SERVICES						
Pulpal and root canal therapy	80%	80%	80%	Y	Y	Y

When endodontic therapy is performed on primary teeth, the level of benefits will be limited to that of a pulpotomy, except where radiographs indicate there is no permanent successor tooth and the primary tooth demonstrates sufficient intact root structure.

Retreatment of root canal therapy within 24 months of initial treatment is not a covered benefit.

When incomplete endodontic therapy is billed because the patient has been referred to an endodontist for completion of endodontic treatment, the level of benefits will be limited to that of a pulpal debridement.

Pulpal therapy (resorbable filling) is a covered Dental Benefit once per tooth per lifetime.

SURGICAL PERIODONTIC SERVICES						
Gingivectomy or gingivoplasty; gingival flap procedure	80%	80%	80%	Y	Y	Y
Clinical crown lengthening - hard tissue	80%	80%	80%	Y	Y	Y
Osseous surgery (including flap entry and closure)	80%	80%	80%	Y	Y	Y
Guided tissue regeneration, per site: *only when performed in association with natural teeth*	80%	80%	80%	Y	Y	Y
Bone replacement and soft tissue grafts	80%	80%	80%	Y	Y	Y

Surgical periodontics is allowed once every 3-years.

NON-SURGICAL PERIODONTIC SERVICES						
Periodontal scaling and root planing	80%	80%	80%	Y	Y	Y
Full mouth debridement to enable comprehensive evaluation and diagnosis: *once per lifetime*	80%	80%	80%	Y	Y	Y
Periodontal maintenance: *twice per calendar year**	80%	80%	80%	Y	Y	Y

Periodontal therapy includes treatment for diseases of the gums and bone supporting the teeth once per quadrant in any 24-month interval.

With an indicator of surgical or non-surgical treatment of periodontal disease, a participant is eligible for up to two additional dental visits in a benefit year for periodontal maintenance or adult prophylaxis.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network

**With an indicator for diabetes, high risk cardiac conditions, kidney failure or dialysis conditions, or special healthcare needs, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year.*
**With an indicator for periodontal disease, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for suppressed immune system conditions or cancer-related chemotherapy and/or radiation, the enrollee will be eligible for any combination of four cleanings (prophylaxis or periodontal maintenance) per benefit year and for topical application of fluoride at the frequency stated in this Schedule of Dental Benefits.*
**With an indicator for pregnancy, the enrollee will be eligible for one additional cleaning (prophylaxis or periodontal maintenance) during the time of pregnancy.*

REMOVABLE PROSTHODONTIC SERVICES						
Complete and partial dentures	50%	50%	50%	Y	Y	Y
Adjustments to complete and partial dentures *twice every 12-months*	80%	80%	80%	Y	Y	Y
Repairs to complete and partial dentures *once every 24-months*	80%	80%	80%	Y	Y	Y
Replace missing or broken teeth	80%	80%	80%	Y	Y	Y
Add tooth or clasp to existing partial denture *once per lifetime*	80%	80%	80%	Y	Y	Y
Replace all teeth and acrylic on cast metal framework *once per lifetime*	80%	80%	80%	Y	Y	Y
Denture rebase: *once in a 3-year period*	80%	80%	80%	Y	Y	Y
Denture reline: *once in a 3-year period*	80%	80%	80%	Y	Y	Y
Tissue conditioning *once in a 12-month interval*	80%	80%	80%	Y	Y	Y
Stayplate *once in a 5-year interval*	50%	50%	50%	Y	Y	Y

FIXED PROSTHODONTIC SERVICES (BRIDGES)						
Pontics	50%	50%	50%	Y	Y	Y
Fixed partial denture retainers - inlays/onlays (inlays/onlays placed as abutments, i.e., to retain or support fixed partial dentures)	50%	50%	50%	Y	Y	Y
Fixed partial denture retainers – crowns (crowns placed as abutments, i.e., to retain or support fixed partial dentures)	50%	50%	50%	Y	Y	Y
Recement fixed partial denture *once per lifetime*	80%	80%	80%	Y	Y	Y
Fixed partial denture (bridge) repair *once per lifetime*	80%	80%	80%	Y	Y	Y
Cast or prefabricated post and core; core build-up	50%	50%	50%	Y	Y	Y

When a fixed partial denture is requested or placed and three or more teeth are missing in a dental arch, the level of benefits will be limited to that of a removable partial denture. The placement of any additional appliance in the same arch within 96 months following placement of the initial appliance is not a covered benefit.

When the edentulous space between teeth exceeds 100% of the size of the original tooth, the level of benefits will be limited to that of one pontic per missing tooth.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network

When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the level of benefits will be limited to that of a removable partial denture.

If, in the construction of a prosthodontic appliance, personalized or special techniques including, but not limited to, tooth supported dentures, precision attachments or stress breakers, are elected, the level of benefits will be limited to that of a conventional prosthodontic appliance.

When a porcelain/ceramic inlay is requested or placed as an abutment (i.e., to retain or support a fixed partial denture), the level of benefits will be limited to that of a cast metal inlay.

ORAL SURGERY						
Simple extractions	80%	80%	80%	Y	Y	Y
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	80%	80%	80%	Y	Y	Y
Removal of impacted tooth – soft tissue	80%	80%	80%	Y	Y	Y
Removal of impacted tooth – partially bony	80%	80%	80%	Y	Y	Y
Removal of impacted tooth – completely bony	80%	80%	80%	Y	Y	Y
Tooth reimplantation/stabilization of accidentally evulsed or displaced tooth and/or alveolus	80%	80%	80%	Y	Y	Y
Surgical access of an unerupted tooth	80%	80%	80%	Y	Y	Y
Biopsy of oral tissue; brush biopsy	80%	80%	80%	Y	Y	Y
Alveoloplasty - per quadrant	80%	80%	80%	Y	Y	Y
Surgical excision of soft tissue lesions	80%	80%	80%	Y	Y	Y
Surgical excision of intra-osseous lesions	80%	80%	80%	Y	Y	Y
Other covered surgical/repair procedures: removal of exostosis, torus palatinus or torus mandibularis; incision and drainage of abscess - intraoral soft tissue; frenulectomy or frenuloplasty; excision of hyperplastic tissue or pericoronal gingiva; surgical reduction of osseous or fibrous tuberosity; dilation of salivary duct.	80%	80%	80%	Y	Y	Y

Oral Surgery includes extractions and other listed oral surgery procedures (including pre- and post-operative care) only when provided in a dentist's office.

Procedure	Co-Payment Percentage			Deductible Applies		
	Delta Dental PPO	Delta Dental Premier	Out-of-network	Delta Dental PPO	Delta Dental Premier	Out-of-network
ADJUNCTIVE GENERAL SERVICES						
Palliative (emergency) treatment of dental pain - minor procedure	80%	80%	80%	Y	Y	Y
Deep sedation/general anesthesia: *when provided by a dentist in conjunction with Oral Surgery (surgical procedures) other than simple extractions.*	80%	80%	80%	Y	Y	Y
Intravenous conscious sedation/analgesia: *when medically necessary and provided in conjunction with Oral Surgery (surgical procedures) other than simple extractions.*	80%	80%	80%	Y	Y	Y
Consultations	100%	100%	100%	N	N	N
OTHER						
Treatment of fractures of facial bones	80%	80%	80%	Y	Y	Y
Implants *once every 8-years for covered persons age 16 and older*	50%	50%	50%	Y	Y	Y
Non-surgical treatment of the tempormandibular joint (TMJ) dysfunction	50%	50%	50%	Y	Y	Y
ORTHODONTIC SERVICES						
Treatment necessary for the proper alignment of teeth, *for Dependent children under age 19*.	50%	50%	50%	N	N	N

If specialized techniques (for example, clear or "Invisalign" braces) are elected, a Delta Dental PPO dentist is not obligated to accept the scheduled fee as full payment and may charge the patient any difference in cost between the optional method and a conventional appliance in addition to scheduled copayment amounts.

APPENDIX B
EXCLUSIONS

EXCLUSIONS THAT APPLY TO DIAGNOSTIC SERVICES:

- Pulp vitality tests billed in conjunction with any service except for an emergency exam or palliative treatment are not a covered benefit.

EXCLUSIONS THAT APPLY TO PREVENTIVE SERVICES:

- Recementation of a space maintainer within six months of initial placement is not a covered benefit.

EXCLUSIONS THAT APPLY TO RESTORATIVE SERVICES:

- Fillings are not a covered benefit when crowns are allowed for the same teeth.

- Replacement of any existing cast restoration (onlays, ceramic restorations) with any type of cast restoration within 60 months following initial placement of existing restoration is not a covered benefit.

- Replacement of a stainless steel crown with any type of cast restoration is not a covered benefit by the same office within 24 months following initial placement.

- A cast restoration is a covered benefit only in the presence of radiographic evidence of decay or missing tooth structure. Restorations placed for any other purpose, including, but not limited to, cosmetics, abrasion, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformations of teeth, or the anticipation of future fractures, are not a covered benefit.

- When there is radiographic evidence of sufficient vertical height (more than three millimeters above the crestal bone) on a tooth to support a cast restoration, a crown build-up is not a covered benefit.

- The repair of any component of a cast restoration is not a covered benefit.

- Recementation of inlays, onlays, partial coverage restorations, cast and prefabricated posts and cores and crowns by the same office within six months of initial placement is not a covered benefit.

- Additional procedures to construct a new crown under the existing partial denture framework within six months following initial placement is not a covered benefit.

- When a sedative filling is requested or placed on the same date as a permanent filling, the sedative filling is not a covered benefit.

EXCLUSIONS THAT APPLY TO ENDODONTIC SERVICES:

- When a benefit has been issued for endodontic services, retreatment of the same tooth within two years is not a covered benefit.

- Endodontic procedures performed in conjunction with complete removable prosthodontic appliances are not a covered benefit.

EXCLUSIONS THAT APPLY TO PERIODONTIC SERVICES:

- Guided tissue regeneration billed in conjunction with implantology, ridge augmentation/sinus lift, extractions or periradicular surgery/apicoectomy is not a covered benefit.

- Crown lengthening or gingivoplasty, if not performed at least four weeks prior to crown preparation, is not a covered benefit.

- Bone replacement grafts performed in conjunction with extractions or implants are not a covered benefit.

- Periodontal splinting to restore occlusion is not a covered benefit.

EXCLUSIONS THAT APPLY TO PROSTHODONTIC SERVICES:

- Replacement of any existing prosthodontic appliance (cast restorations, fixed partial dentures, removable partial dentures, complete denture) with any prosthodontic appliance within 96 months following initial placement of existing appliance is not a covered benefit.

- When a fixed partial denture and a removable partial denture are requested or placed in the same arch, the fixed partial denture is not a covered benefit.

- Reline or rebase of an existing appliance within six months following initial placement is not a covered benefit.

- Fixed or removable prosthodontics for a patient under age 16 is not a covered benefit.

- When the edentulous (toothless) space between teeth is less than 50% of the size of the missing tooth, a pontic is not a covered benefit.

EXCLUSIONS THAT APPLY TO ORAL SURGERY:

- Mobilization of an erupted or malpositioned tooth to aid eruption or placement of a device to facilitate eruption of an impacted tooth performed in conjunction with other oral surgery is not a covered benefit.

GENERAL EXCLUSIONS THAT APPLY TO ALL PROCEDURES:

Coverage is NOT provided for:

- Services compensable under Worker's Compensation or Employer's Liability laws.

- Services provided or paid for by any governmental agency or under any governmental program or law, except as to charges which the person is legally obligated to pay. This exception extends to any benefits provided under the U.S. Social Security Act and its Amendments.

- Services performed to correct developmental malformation including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis and congenitally missing teeth. This exclusion does not apply to *newborn infants.*

- Services performed for purely cosmetic purposes, including, but not limited to, tooth-colored veneers, bonding, porcelain restorations and microabrasion. Orthodontic care benefits shall fall within this exclusion unless such benefits are provided by endorsement and a Subscriber elects Family Unit coverage. In no event will a Covered Individual age 19 or over be able to receive orthodontic care benefits.

- Charges for services completed prior to the date the person became covered under this program.

- Services for anesthetists or anesthesiologists.

- Temporary procedures.

- Any procedure requested or performed on a tooth when radiographs indicate that less than 40% of the root is supported by bone.

- Services performed on non-functional teeth (second or third molar without an opposing tooth).

- Services performed on deciduous (primary) teeth near exfoliation.

- Drugs or the administration of drugs, except for general anesthesia and intravenous sedation.

- Procedures deemed experimental or investigational by the American Dental Association, for which there is no procedure code, or which are inconsistent with Current Dental Terminology coding and nomenclature.

- Surgical services with respect to any disturbance of the temporomandibular joint (jaw joint).

- Procedures that Delta Dental considers to be included in the fees for other procedures. For such procedures, a separate payment will not be made by this group dental plan. A Dentist in the Delta Dental PPO or Delta Dental Premier network may not bill the patient for such procedures.

- The completion of claim forms and submission of required information, not otherwise covered, for determination of benefits.

- Infection control procedures and fees associated with compliance with Occupational Safety and Health Administration (OSHA) requirements.

- Broken appointments.

- Services and supplies for any illness or injury occurring on or after the *covered individual's effective date of coverage* as a result of war or an act of war.

- Services for, or in connection with, an intentional self-inflicted injury or illness while sane or insane, except when due to domestic violence or a medical (including both physical and mental) health condition.

- Services and supplies received from either a *covered individual's* or *covered individual's* spouse's relative, any individual who ordinarily resides in the *covered individual's* home or any such similar person.

- Services for, or in connection with, an injury or illness arising out of the participation in, or in consequence of having participated in, a riot, insurrection or civil disturbance or the commission of a felony.

- Charges for services for inpatient/outpatient hospitalization.

- Services or supplies for oral hygiene or plaque control programs.

- Services or supplies to correct harmful habits.

APPENDIX C
DENTAL PLAN SPECIFICATIONS

CONTRACT NUMBER: 20246

BENEFIT YEAR: January 1st through December 31st.

DENTAL BENEFITS BOOKLET REISSUE DATE: January 1, 2022

ELIGIBILITY REQUIREMENTS:

All present regular, part-time employees of the Group Subscriber who work a minimum of 20 hours per week and all present regular, full-time employees who work a minimum of 40 hours per week are eligible for coverage under this Group Dental Plan.

All future regular, part-time employees who work a minimum of 20 hours per week become eligible on the first of the month following 30 days of employment.

All future regular, full-time employees who work a minimum of 40 hours per week become eligible on the first of the month following 30 days of employment.

Domestic partners, as defined herein, and their eligible Dependents are eligible for coverage under this Group Dental Plan.

ELIGIBLE DEPENDENTS:

If you elect coverage for yourself, you may enroll your eligible Dependents, who include:

- your legal spouse, unless you are legally separated or divorced (a common-law spouse is eligible if you legally establish the marriage in a state that recognizes common-law marriages);
- your qualifying same-sex or opposite-sex domestic partner if your relationship satisfies certain criteria (see Domestic Partner Eligibility Requirements in this section); and
- your children under age 26.

Note: If you and your spouse or domestic partner are both BMO Harris employees and eligible to enroll in the plan, you may each enroll for individual coverage or one of you may enroll and cover the other. If you each enroll for individual coverage, only one of you may enroll your children as Dependents.

Children are defined as:

- your biological children;
- your adopted children or children placed with you for adoption;
- your stepchildren, regardless of where they live;
- foster children living with you;
- a child who is recognized under a qualified medical child support order as having a right to health care coverage, if the child meets the other eligibility requirements of the plan for Dependent coverage;
- any other child for whom you are the legal guardian and whom you support in a parent-child relationship; and
- your domestic partner's children if they qualify as your Dependents for income tax purposes according to Section 152 of the Internal Revenue Code.

Extended Coverage for Disabled Children

If a Dependent child is physically or mentally incapable of self-support after reaching age 26 and was continuously covered under the Plan up to and including the date the child became incapacitated, you

may continue coverage for that Dependent if the child's physical or mental handicap started before he or she reached age 26. You must provide proof of the disability to Benefits Administration within 31 days of when the child's coverage would normally end under the plan. Your child is considered physically or mentally incapable of self support if the child is not able to earn his or her own living because of mental retardation or physical handicap and if the child is mainly Dependent on you for support and maintenance.

If you were just hired or recently became eligible for coverage because of a change in employment status, you must provide this proof within 31 days of your eligibility to cover an adult disabled Dependent. You may also need to provide proof of continued disability from time to time to maintain coverage.

Domestic Partner Eligibility Requirements

- Eligibility is available to employees' domestic partners, whether same-sex or opposite-sex. Your domestic partner's children may also qualify as Dependents under the Medical Plan if they meet the same requirements that apply to all Dependent children and they qualify as your Dependents for income tax purposes according to Section 152 of the Internal Revenue Code.

Domestic Partners

For your domestic partner to be eligible under the Medical Plan, the two of you must meet all the following requirements:

- you share a sole, committed relationship with each other that has existed for at least one year and is expected to last indefinitely;
- you are jointly responsible for each other's welfare and financial obligations;
- you share your principal place of residence;
- you are both at least 18 years old and mentally competent to consent to a contract;
- neither of you is married to, legally separated from or in another domestic partner relationship with anyone else; and
- you are not related to each other in a way that would prohibit a legal marriage from being recognized in the state in which you live.

Domestic Partner's Children

If your domestic partner meets the requirements listed above, then his or her children may also be considered eligible Dependents under the Medical Plan. Children of domestic partners are subject to the same eligibility requirements that biological and adopted children must meet.

You can enroll your domestic partner's children only if they qualify as your legal tax Dependents. As a result, premiums for coverage of all Dependent children are made on a pretax basis with no imputed income.

DEDUCTIBLE:

Procedures listed in the Schedule of Dental Benefits for which a Deductible applies are subject to a $50.00 Deductible per Covered Individual per Benefit Period, not to exceed $150.00 per family unit per Benefit Period.

COVERAGE LIMITS:

The maximum coverage limit (excluding orthodontic benefits) per Covered Individual per Benefit Period is $2,000.00.

COVERAGE LIMITS - TMJ:

Benefits for treatment of temporomandibular joint (TMJ) dysfunction are subject to a separate lifetime maximum of $1,000.00 per Covered Individual.

COVERAGE LIMITS - ORTHODONTIA:

Lifetime orthodontic benefits payable by Delta Dental per Dependent child under age 19 shall not exceed $1,500.00. Delta Dental will pay 50 percent of the submitted fee, not to exceed the $1,500.00 lifetime maximum per Dependent child under age 19.

ENHANCED BENEFITS PROGRAM:

Procedures listed in the Schedule of Dental Benefits with a single asterisk (*) are part of Smile Smart. Coverage will be at the group-contracted benefit level, with the additional frequency allowance being the only change. There is no age requirement and the patient may be the Subscriber, or other covered Dependents.

Those eligible for the Enhanced Benefits Program include the following:

- People with periodontal (gum) disease
- People with diabetes
- Pregnant women
- People with high-risk cardiac conditions
- People with kidney failure or who are undergoing dialysis
- People undergoing cancer-related chemotherapy and/or radiation
- People with suppressed immune systems due to HIV positive status, organ transplant, and/or stem cell (bone marrow) transplant
- People with special healthcare needs

If one of these conditions applies to you, sign up for enhanced benefits today by visiting the Subscriber section of www.deltadentalil.com or calling 800-323-1743.

APPENDIX D
CONTINUATION OF COVERAGE

This Appendix contains important information about continuation coverage which may be available to Covered Individuals under federal law. Part A describes continuation coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") for temporarily continuing coverage at group rates in certain instances when coverage would otherwise end. It applies to employers with 20 or more employees. Part B describes continuation coverage available during a leave under the Family and Medical Leave Act of 1993 ("FMLA") applicable to employers with 50 or more employees. Part C describes continuation coverage available to Subscribers who take a military leave and their eligible Dependents under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). It is applicable to group health plans.

Part A

Continuation Coverage Rights Under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (for employees and Dependents)

The right to COBRA continuation coverage, which is a temporary extension of coverage, was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under this group dental plan when you would otherwise lose your group dental coverage. ***The purpose of this Part A is to explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.***

The Plan Administrator is responsible for administering COBRA continuation coverage. The Plan Administrator may in the future arrange with a contract administrator to fulfill certain of the Plan Administrator's responsibilities pertaining to COBRA continuation coverage. In that event, the contract administrator will carry out many of the functions described in this section as being carried out by the Plan Administrator, such as sending notifications or receiving elections and Premiums. You will be advised by the Plan Administrator of the name, address and telephone number of the party responsible for administering COBRA continuation coverage if it is someone other than the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a temporary extension of coverage that would otherwise end because of a life event known as a "qualifying event" occurs and any required notice of that event is properly provided to the Plan Administrator. Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under this group dental plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, Dependent children of employees, and a child who is born to or placed for adoption with an employee during a period of continuation coverage may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

In general, an individual (other than a child who is born to or placed for adoption with an employee during a period of continuation coverage) who is not covered under this group dental plan on the day before the qualifying event cannot be a qualified beneficiary with respect to that qualifying event. The reason for the individual's lack of actual coverage (such as the individual's having declined participation in the group dental plan or failed to satisfy conditions for participation in this group dental plan) is not relevant for this purpose. However, if the individual is denied or not offered group dental coverage under circumstances in which the denial of or failure to offer coverage constitutes a violation of applicable law, then the individual will be considered to have had the coverage that was wrongfully denied or not offered.

Continuation coverage is the same coverage that this group dental plan gives to other participants who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights and obligations under this group dental plan as other participants covered under this group dental plan, including, without limitation, the provisions governing open enrollment, coverage limits, payment policies and any managed care limitations or requirements.

What Qualifying Events Might Trigger COBRA Coverage?

If you are an employee, you will become a qualified beneficiary if you lose your coverage under this group dental plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under this group dental plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under this group dental plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee and other parent become divorced or legally separated; or
- Your child stops being eligible for coverage under your group dental plan as a Dependent.

How Close in Time Must the Qualifying Event Be to the Loss of Coverage?

For purposes of determining whether a qualifying event has occurred, a loss of coverage need not occur immediately after the event, so long as it occurs before the end of the maximum COBRA coverage period associated with that event. However, if neither the employee nor another qualified beneficiary loses coverage before what would be the end of such maximum coverage period, then the event is not a qualifying event.

If a potential qualified beneficiary's coverage is reduced or eliminated in anticipation of an event, the reduction or elimination is disregarded in determining whether the event causes a loss of coverage. For example, if you drop coverage for your spouse several months early in anticipation of a divorce or legal separation, then, upon receiving notice of the divorce or legal separation in a timely manner, continuation coverage will be made available to such person, effective on the date of the divorce or legal separation (but not for any period before the date of divorce or legal separation).

When Will Notice of a Qualifying Event Be Given Automatically to the Plan Administrator?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan Administrator will be deemed to have been notified automatically.

When Must You Give Notice of a Qualifying Event or Other Event that May Affect COBRA Coverage?

For other qualifying events that may trigger, extend, or otherwise affect the COBRA continuation coverage of you, your spouse, or your children, you are under an obligation to give written notice to the Plan Administrator of the event. ***Failure to do so may trigger a loss of COBRA continuation coverage for you, your spouse, or your child or children.***

Either you, your spouse, your child, or a representative acting on behalf of you, your spouse, or your child may provide the notice. The events which trigger a responsibility on your part to notify the Plan Administrator in writing are as follows:

Divorce or Legal Separation. You must notify the Plan Administrator in writing if you become divorced or legally separated from your spouse. You must include with your written notice your name, address, contact telephone number, and a copy of the divorce decree or court order of separation. You must provide the written notice within 60 days of the date on which the divorce or legal separation occurs or the date on which your spouse loses (or would lose) coverage under this group dental plan as a result of the divorce or legal separation, whichever is later. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, you must notify the Plan Administrator within 60 days after the divorce or legal separation that your coverage was reduced or eliminated in anticipation of the divorce or legal separation. You must provide evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

***Child Ceasing to Qualify for Coverage*.** You must notify the Plan Administrator in writing if one or more of your children stops being eligible under this group dental plan as a Dependent child. You must include with your written notice your name, address, contact telephone number, the name of your child, and an explanation of how your child ceased to be an eligible Dependent. You must provide the written notice within 60 days of the date on which your child ceases to qualify for coverage under this group dental plan or the date on which your child loses (or would lose) coverage under this group dental plan, whichever is later.

Second Qualifying Event. You must notify the Plan Administrator in writing if your family experiences a second qualifying event, while receiving 18 months of COBRA continuation coverage, that would extend the maximum period of continuation coverage from 18 (or 29) months to 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a Dependent child's losing eligibility as a Dependent child under the group dental program. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the group dental program if the first qualifying event had not occurred. You must include with your written notice your name, address, contact telephone number, and a description of the second qualifying event and precisely when it occurred. You must provide the written notice within 60 days of the date on which the second qualifying event occurs or the date on which you or another qualified beneficiary loses (or would lose) coverage at the end of the initial maximum period of COBRA coverage, whichever is later.

Determination of Disability by Social Security Administration. You must notify the Plan Administrator in writing if the Social Security Administration determines that a qualified beneficiary is disabled. This disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must include with your written notice your name, address, contact telephone number, the name of the disabled qualified beneficiary, and a copy of the determination by the Social Security Administration. You must provide the written notice within 60 days of (i) the date of the disability determination by the Social Security Administration, (ii) the date on which the qualifying event occurred, (iii) the date on which the qualified beneficiary loses (or would lose) coverage as a result of the qualifying event, or (iv) the date on which the qualified beneficiary is informed of the obligation to provide the disability notice, whichever is later.

Determination of End of Disability by Social Security Administration. You must notify the Plan Administrator in writing if the Social Security Administration determines that a qualified beneficiary is no longer disabled. You are required to notify the Plan Administrator only if notice of disability within the first 60 days of continuation coverage was given to the Plan Administrator in order to obtain the extension of COBRA coverage by reason of disability. You must include with your written notice your name, address, contact telephone number, the name of the formerly disabled qualified beneficiary, and a copy of the determination by the Social Security Administration. You must provide the written notice within 30 days of the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled.

When Does COBRA Coverage Start?

Once the Plan Administrator receives written notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will generally begin on the date of the qualifying event.

When Does COBRA Coverage Normally Last Up to 18 Months? When Does COBRA Coverage Normally Last Up to 36 Months?

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended: (i) a qualified beneficiary becomes disabled; or (ii) a second qualifying event occurs. These two methods for extending continuation coverage are discussed below.

When the qualifying event is the death of the employee, your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months.

When Does a Disability Extend COBRA Coverage Up to a Maximum of 29 Months?

If you or anyone in your family covered under this group dental plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of the COBRA continuation coverage period, the COBRA continuation coverage period may be extended by 11 months to a total maximum of 29 months if certain conditions are satisfied. The conditions that must be satisfied are as follows:

- The qualifying event must be your termination of employment or reduction in hours;
- The qualified beneficiary (who may be you or your spouse or your Dependent child) must be determined under the Social Security Act to have been disabled at any time during the first 60 days of the COBRA continuation coverage period; and
- The qualified beneficiary must notify the Plan Administrator of the disability determination as set forth above under "When Must You Give Notice of a Qualifying Event or Other Event that May Affect COBRA Coverage?" ***This notice should be sent to the Plan Administrator at the address shown in this booklet.***

If the foregoing conditions are satisfied, the disability extension applies to all qualified beneficiaries (all family members who had coverage) with respect to the qualifying event, not only to the disabled qualified beneficiary.

If the qualified beneficiary (who may be you or your spouse or your Dependent child) is determined by the Social Security Administration to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days of the Social Security Administration's determination.

When Does a Second Qualifying Event Extend the 18-Month Period of COBRA Coverage Up to a Maximum of 36 Months?

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and Dependent children in your family can get additional months of COBRA continuation coverage, up to a total maximum of 36 months. This extension is available to your spouse and Dependent children if you die, or get divorced or legally separated. The extension is also available to a Dependent child when that child stops being eligible under this group dental plan as a Dependent child.

When May COBRA Coverage Be Cut Off Early?

The right to continue group health plan coverage that has been elected for a qualified beneficiary will end before the last day of the maximum continuation coverage period upon the earliest of the following dates:

- The first day for which timely payment for continuation coverage is not made with respect to the qualified beneficiary.
- The date on which the employer ceases to provide any group dental plan coverage to any employee.

- The date, after the date of election of continuation coverage, upon which the qualified beneficiary first becomes actually covered under any other group dental plan (as an employee or otherwise) which does not contain any exclusion or limitation for any preexisting condition of that qualified beneficiary (other than an exclusion or limitation which does not apply to or is satisfied by the qualified beneficiary).

- The date your Plan Administrator terminates for cause the coverage of a qualified beneficiary on the same basis that your Plan Administrator terminates for cause the coverage of similarly situated enrollees who have not elected continuation coverage (such as filing fraudulent claims).

How Do You (or Another Qualified Beneficiary) Elect Continuation Coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both you and your spouse may elect continuation coverage, or you may elect COBRA continuation coverage on behalf of your spouse. Parents may elect to continue coverage on behalf of their Dependent children only. A qualified beneficiary must elect coverage by the date specified on the election form provided by the Plan Administrator. Failure to do so will result in loss of the right to elect continuation coverage under this group dental plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you submit the revised election.

How Much Does Continuation Coverage Cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost (including both the employer and employee contributions) for coverage of a similarly situated enrollee who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent), plus any additional amounts that are permitted by COBRA. Required contributions for qualified beneficiaries electing continuation coverage may be increased by the employer from one year to the next.

When and How Must Your First Payment for Continuation Coverage Be Made?

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the election form provided by the Plan Administrator. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the election notice is marked with a U.S. postmark, if mailed.) ***If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under this group dental plan.***

Your first payment must cover the cost of continuation coverage from the time your coverage under this group dental plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Plan Administrator to confirm the correct amount of your first payment.

When and How Must Your Subsequent Payments for Continuation Coverage Be Made?

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under this group dental plan, these subsequent periodic payments for continuation coverage are due on the first day of the month for which the contribution is made. If you make a periodic payment on or before its due date, your coverage under this group dental plan will continue for that coverage period without any break. You will not be sent periodic notices of payments due for these coverage periods.

Payment is considered made on the date it is sent to the Plan Administrator as evidenced by the U.S. postmark date.

Is There Any Grace Period for Your Subsequent Payments for Continuation Coverage?

Although subsequent periodic payments are due on the first day of the month for which you are requesting coverage, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

Should you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under this group dental plan. As a precondition for dropping coverage, the Plan Administrator must provide written notice to you that the payment has not been received. This notice shall be mailed to you at least 15 days before coverage is to cease, advising that coverage will be dropped on a specified date at least 15 days after the date of the notice unless payment has been received by that date. Coverage for you will cease at the end of the 30-day grace period where the required 15-day notice has been provided.

To Whom Should You Direct Questions?

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

Keep the Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Part B

Continuation Coverage Rights Under the Family and Medical Leave Act of 1993 ("FMLA")
(for employees)

What Happens to Your Coverage If You Take a Leave of Absence?

Normally, you have no right to continue any coverage under this group dental plan while you are on a leave of absence unless you have exercised your rights described in Part A of this Appendix. The only exceptions are for leave under the Family and Medical Leave Act of 1993 ("FMLA") and military leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), as described in this section.

Leave Under the Family and Medical Leave Act

Continuation of group dental plan coverage and reinstatement of coverage under this group dental plan is available to employees and their covered eligible Dependents under certain specified conditions.

An employee who takes a leave of absence under the FMLA is entitled to continue coverage under this group dental plan for himself/herself and his/her covered eligible Dependents to the same extent as if the employee had been actively at work during the entire leave period permitted by FMLA, subject to the terms and conditions set forth below.

What Happens If Payments Are Not Made During FMLA Leave?

If you do not make the required payments for coverage for yourself (and any covered eligible Dependents), coverage will cease. Your payment must be received within 30 days of the date the payment is due. The obligation to maintain coverage under this group dental plan during FMLA leave ceases if the employee's contribution is more than 30 days late.

As a precondition to dropping coverage during FMLA leave, the Plan Administrator must provide written notice to the employee that the payment has not been received. The notice shall be mailed to the employee at least 15 days before coverage is to cease, advising that coverage will be dropped on a specified date at least 15 days after the date of the notice unless payment of the contribution has been received by that date. Coverage for the employee and his/her eligible Dependents shall cease at the end of the 30-day grace period, where the required 15-day notice has been provided. The employer may recover the employee's required contribution payments missed by the employee for any FMLA leave period during which the employer maintains coverage under this group dental plan by paying the employee's contribution after the payment is missed.

The employer reserves all rights, as permitted and as limited by the FMLA and its regulations, to recover its share of the applicable cost of coverage during a period of an unpaid FMLA leave for an employee if the employee fails to return to work after the employee's FMLA leave entitlement has been exhausted or expired.

Will Your Coverage Be Reinstated Upon Return from FMLA Leave?

If you decline coverage during your leave or if your coverage is terminated as a result of your failure to pay any required contributions, you shall, upon return from the leave permitted by the FMLA, be entitled to be reinstated to coverage under the group dental plan on the same terms as prior to taking leave, without any waiting period, physical examination, or exclusion as to preexisting conditions, but subject to the group dental plan's eligibility rules.

When Does COBRA Start If You Do Not Return from FMLA Leave?

If you take FMLA leave and do not return to work at the end of your leave, you and your covered eligible Dependents will be entitled to elect COBRA coverage if (i) they were covered under the group dental plan on the day before FMLA leave began (or became covered during FMLA leave); and (ii) they will lose group dental coverage within 18 months because of your failure to return to work at the end of FMLA leave. COBRA coverage elected in these circumstances will begin on the last day of FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours.

Part C

Continuation Coverage Rights under the Uniformed Services Employment and Reemployment Rights Act ("USERRA")(for employees)

Military Leave Under the Uniformed Services Employment and Reemployment Rights Act

In accordance with USERRA, continuation coverage under this group dental plan is available to employees/members (collectively referred to as "employees") who take military leave and their covered eligible Dependents under certain specified conditions. You must give the Plan Administrator written notice within 60 days of your absence from employment for military service of your desire to elect continuation coverage under USERRA.

The requirement of written notice within 60 days, however, does not apply if that type of notice is precluded by military necessity or if the giving of that type of notice is impossible or unreasonable under the circumstances. In that event, the notice may be as late as is reasonable under the circumstances. Similarly, the notice may be oral if written notice would be unreasonable under the circumstances.

Any extension of benefits period provided pursuant to this section will not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the COBRA continuation coverage provisions set forth in Part A of this Appendix. In other words, COBRA coverage and USERRA coverage will run concurrently because the events giving rise to the respective rights occur at the same time.

What Group Health Plan Coverage Will Be Provided?

You may elect to continue group dental coverage for yourself and your covered eligible Dependents if coverage would otherwise cease under this group dental plan due to your absence from employment by reason of your service in the uniformed services. To elect to continue group dental coverage under USERRA, you should complete the appropriate

election and pay the applicable Premium, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Benefits under this group dental plan for employees under an election for military leave continuation coverage shall be the same coverage as provided to all other enrollees. If benefits under this group dental plan are increased, decreased, or otherwise amended or changed either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other enrollees. You may not, however, initiate new coverage at the beginning of a period of service if you did not previously have such coverage.

How Much Do You Have to Pay to Continue Your Health Plan Coverage?

If you elect to continue group dental coverage under USERRA, you may be required to pay up to 102 percent of the full Premium under this group dental plan (the same rate as with COBRA coverage). Notwithstanding the foregoing, in the event you perform services in the uniformed services for less than 31 days, you will not be required to pay more than your share, if any, for such coverage.

How Long Does USERRA Coverage Last?

The maximum period of coverage available to all enrollees under the provisions of this section shall be the lesser of:

(1) the 24-month period beginning on the date on which your absence for the purpose of performing service begins; or

(2) the period beginning on the date on which your absence for the purpose of performing service begins, and ending on the date on which you fail to return from service or apply for a position of employment as provided under section 4312(e) of USERRA.

In the event you fail to pay the required Premiums, coverage will be cancelled. In addition, coverage will be terminated if you lose your rights under USERRA as a result of certain types of undesirable conduct, such as court-martial and dishonorable discharge.

If Coverage Was Terminated During Military Service, Must Coverage Be Reinstated Upon Reemployment?

If group dental coverage or your Dependent's coverage was terminated by reason of your service in the uniformed services, that coverage must be reinstated upon reemployment. An exclusion or waiting period may not be imposed in connection with the reinstatement of your coverage upon reemployment if an exclusion or waiting period would not have been imposed had your coverage not been terminated by reason of such service.

The group dental plan may impose an exclusion or waiting period as to illnesses or injuries determined by the Secretary of Veterans Affairs or his or her representative to have been incurred in, or aggravated during, performance of service in the uniformed services. Other coverage, for injuries or illnesses that are not service-related (or for an employee's eligible Dependents, if the employee has Dependent coverage) must be reinstated. The employer will reinstate your group dental coverage upon request at reemployment. You may not delay reinstatement of group dental coverage until a date that is later than the date of your reemployment.



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Delta Dental of Illinois
111 Shuman Boulevard
Naperville, IL 60563
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Client Vision Care Plan



Client Name: **BMO Financial Corporation**
Client Number: **30028445**
Effective Date: **JANUARY 1, 2024**

EVIDENCE OF COVERAGE

Provided by:

VISION SERVICE PLAN OF ILLINOIS, NFP
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided.

HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within [365] calendar days from the date services are rendered and/or materials provided. Claims received by VSP after [365] days will be denied unless prohibited by applicable state or federal law.

TO OBTAIN FURTHER INFORMATION

Contact VSP at 800-877-7195 or www.vsp.com.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits and/or Additional Benefit Rider (when purchased by Client) for details.

COORDINATION OF BENEFITS

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

URGENT VISION CARE

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP PREFERRED Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP PREFERRED Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP PREFERRED Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

CLAIM PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Covered Person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

In the event this Plan is terminated, VSP coverage may be available for individuals to purchase online www.vsp.com.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER	The document, attached as Exhibit C to the Policy (when purchased by Client), which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.
ASSIGNMENT OF BENEFITS	A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.
CLIENT	An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.
COORDINATION OF BENEFITS	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
COPAYMENTS	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
PLAN OR PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).
OPEN ACCESS PROVIDER	Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN ADMINISTRATOR	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
POLICY	The contract between VSP and Client upon which this Plan is based.
SCHEDULE OF BENEFITS	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
VSP PREFERRED PROVIDER	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.
URGENT CARE	Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

EXHIBIT A

VISION SERVICE PLAN OF ILLINOIS, NFP
SCHEDULE OF BENEFITS
VSP Choice Plan®
Premier Plan

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PLAN BENEFITS
VSP NETWORK DOCTORS

COPAYMENT

There shall be no Copayment payable by the Covered Person at the time services are rendered.

A Copayment amount of $20.00 shall be payable by the Covered Person to the VSP Preferred Provider at the time retinal screening is rendered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Including Retinal Screening – Covered in full*
Coverage for retinal imaging as an enhancement to eye examination.
*Less any applicable Copayment

LENSES - Covered in full* once every 12 months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full.

LENS OPTIONS
Color coating covered in full once every 12 months.**
Mirror coating covered in full once every 12 months.**
Scratch coating covered in full once every 12 months.**
UV (ultraviolet) protected covered in full once every 12 months.**

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to choose one of the following EasyOptions upgrades:

FRAMES: An Additional Allowance of $75 once every 12 months**

OR

LENS ENHANCEMENT

Premium and Custom Progressive lenses: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT

Photochromic: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT

Anti-reflective coating: Covered in full once every 12 months**.

OR

CONTACT LENSES

ELECTIVE: An Additional Allowance of $75 once every 12 months**

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

FRAMES - Covered up to the Plan allowance* once every 12 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Each benefit period, the Enrollee and each of the Enrollee's covered dependents are entitled to an additional allowance (on any Marchon or Altair frame) of $50.00 once every 12 months**.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $175.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a $40.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.
*Less any applicable Copayment.
** Beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

PATIENT OPTIONS

When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses or frames, and the Covered Person will pay the additional costs for the options unless such option is covered as an EasyOptions upgrade.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

There shall be no Copayment payable by the Covered Person at the time services are rendered.

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $ 30.00* once every 12 months**

Bifocal Up to $ 60.00* once every 12 months**

Trifocal Up to $ 80.00* once every 12 months**

Lenticular Up to $100.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 12 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Open Access Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT A

VISION SERVICE PLAN OF ILLINOIS, NFP
SCHEDULE OF BENEFITS
VSP Choice Plan®
Base Plan

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP ("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

PLAN BENEFITS
VSP NETWORK DOCTORS

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $20.00 Copayment payable at the time materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

A Copayment amount of $20.00 shall be payable by the Covered Person to the VSP Preferred Provider at the time retinal screening is rendered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

Including Retinal Screening – Covered in full*
Coverage for retinal imaging as an enhancement to eye examination.
*Less any applicable Copayment

LENSES - Covered in full* once every 12 months**
Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full.

LENS OPTIONS
Color coating covered in full once every 12 months.**
Mirror coating covered in full once every 12 months.**
Scratch coating covered in full once every 12 months.**
Premium and Custom Progressive lenses covered in full[1] once every 12 months.**
UV (ultraviolet) protected covered in full once every 12 months.**

[1]Less a $50.00 Copay

FRAMES - Covered up to the Plan allowance* once every 24 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

Each benefit period, the Enrollee and each of the Enrollee's covered dependents are entitled to an additional allowance (on any Marchon or Altair frame) of $50.00 once every 24 months**.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a $40.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.
*Less any applicable Copayment.
** Beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames and/or lenses may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame and lens brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed in the Frames benefit section, above.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Replacement of lost or damaged contact lenses, except at the normal intervals when services are otherwise available.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

There shall be a Copayment of $10.00 for the examination payable by the Covered Person at the time services are rendered. If materials (lenses, frames or Necessary Contact Lenses) are provided, there shall be an additional $20.00 Copayment payable at the time the materials are ordered. The Copayment shall not apply to Elective Contact Lenses.

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision Up to $ 30.00* once every 12 months**

Bifocal Up to $ 60.00* once every 12 months**

Trifocal Up to $ 80.00* once every 12 months**

Lenticular Up to $100.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 24 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**Beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of Open Access Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT C

VISION SERVICE PLAN OF ILLINOIS, NFP
ADDITIONAL BENEFIT RIDER
SUPPLEMENTAL PRIMARY EYECARE PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VISION SERVICE PLAN OF ILLINOIS, NFP ("VSP") are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Supplemental Primary EyeCare Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. Primary eyecare also involves management of conditions which require monitoring to prevent future vision loss. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse or civil union partner of Enrollee
- Any child of Enrollee, including a natural child from the date of birth, child of a civil union, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Plan Benefits under the Supplemental Primary EyeCare Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS below) will be covered for certain primary eyecare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

SYMPTOMS

Examples of symptoms which may result in a Covered Person seeking services on an urgent basis under the PEC Plan may include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS

Examples of conditions which may require management under the PEC Plan may include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- pink eye
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis
- sty

PROCEDURES FOR OBTAINING SUPPLEMENTAL PRIMARY EYECARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The Supplemental Primary EyeCare Plan provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the Supplemental Primary EyeCare Plan provides Plan Benefits as follows:

1. Covered Person contacts VSP Preferred Provider and makes an appointment.

2. Covered Person pays the applicable Copayment at the time of each Supplemental Primary EyeCare visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Services cannot be provided by Covered Person's VSP Preferred Provider, the doctor will refer the Covered Person to another VSP Preferred Provider or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the PEC Plan, the VSP Preferred Provider will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. Covered Persons do not require a referral from a VSP Preferred Provider in order to obtain Plan Benefits.

PLAN BENEFITS
VSP Preferred PROVIDERS

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered in Full after a Copayment of $20.00.
Special Ophthalmological Services: Covered in Full
Eye and Ocular Adnexa Services: Covered in Full

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Supplemental Primary EyeCare Plan provides coverage for limited vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to Covered Persons upon request.

NOT COVERED

- Services and/or materials not specifically included in this Rider as covered Plan Benefits.
- Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
- Orthoptics or vision training and any associated supplemental testing.
- Surgery, and any pre- or post-operative services, except as an adnexal service included herein.
- Treatment for any pathological conditions.
- An eye exam required as a condition of employment.
- Insulin or any medications or supplies of any type.
- Local, state and/or federal taxes, except where VSP is required by law to pay.

SUPPLEMENTAL PRIMARY EYECARE PLAN DEFINITIONS

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Conjunctivitis	See Pink Eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object.
Eyecare Professional	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.
Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink Eye	An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
Systemic Condition	Any condition of problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

An Eyecare Professional that is an Open Access Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered up to $100.00 less a Copayment amount of $20.00.

Special Ophthalmological Services: Covered up to $120.00 per individual service.

Eye and Ocular Adnexa Services: Covered up to $120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

Summary of Benefits and Coverage
VSP Choice Plan
Base Plan

Prepared for: **BMO FINANCIAL CORPORATION**
Group ID: **30028445**
Effective Date: **JANUARY 1, 2024**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	$10.00 Copay	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Glasses: $20.00 Copay (lenses and/or frames only); Up to $40.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 60.00 Tri-Focal Lenses reimbursed up to $ 80.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 24 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first day of the Benefit Period.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

Summary of Benefits and Coverage
VSP Choice Plan
Premier Plan

Prepared for: **BMO FINANCIAL CORPORATION**
Group ID: **30028445**
Effective Date: **JANUARY 1, 2024**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam		Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	Up to $40.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 60.00 Tri-Focal Lenses reimbursed up to $ 80.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 12 months** Lenses covered every 12 months**
	Fees			

** Beginning with the first day of the Benefit Period.

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If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.

BMO

Employee Assistance Program (EAP)

Plan Details



TELUS Health

Quick Facts

Vendor	TELUS Health
Support	**By Phone:** 1-800-757-0327 **Online:** TELUS Health One portal (https://app.one.telushealth.com) **Mobile App:** TELUS Health One app can be downloaded from your device's app store To access the portal or app, use BMO's U.S. credentials: **User ID:** BMO_US **Password:** Wellness@BMO

Overview

BMO offers an Employee Assistance Program (EAP) to help you navigate personal challenges that might impact your health, well-being, or work performance. The EAP is administered by TELUS Health.

How the EAP Works

The EAP is available 24/7 to you and your immediate family - even if you're not enrolled in a BMO medical plan. It's free and completely confidential.

The EAP provides short-term, solution-focused support for personal and professional challenges. It includes up to **five free counseling sessions** per issue, which are designed to help you address immediate concerns, develop coping strategies, and identify next steps. These sessions are available online, in-person, or by phone.

Common areas of support include:

- Stress management
- Relationship and parenting challenges
- Financial concerns
- Addiction
- Depression and anxiety
- Child and elder care issues
- Workplace conflicts
- Coping with change
- Manager coaching and support

If longer-term care is needed, the EAP can help connect you with appropriate resources, including providers covered under your medical plan. The goal is to offer timely, confidential assistance that helps you move forward - whether you're facing a life transition, a stressful situation, or a workplace issue.

Other Offerings Available Through TELUS Health

- **Work and Life Resources**: Free consultations with professionals on legal, career, or financial matters.
- **Digital CBT**: Therapist-guided internet-based cognitive behavioral therapy to help shift negative thought patterns and behaviors.
- **Exclusive Offers**: Discounts on wellness brands like HelloFresh, Noom, Fitbit, hotels, and mobile plans.
- **Virtual Tutoring**: Up to 6 BMO-paid sessions per child (K–12) per calendar year. Continued services available at preferred rates. *Note: This is a taxable benefit when used.* Access code: BMOLWVT
- **LIFT Virtual Fitness**: Unlimited personalized fitness journeys tailored to your goals and fitness level.
- **Back-up Child Care**: Up to **10 days per child per year**, paid by BMO (max 5 consecutive days). *Note: This is a taxable benefit when used.*
- **Back-up Adult/Elder Care**: Up to **6 visits per year** (3 hours max per visit), paid by BMO. *Note: This is a taxable benefit when used.*
- **Critical Incident and Crisis Support**: Immediate support for workplace incidents such as:
    - Bank hold-ups or robberies
    - Workplace accidents or violence
    - Death of a co-worker
    - Natural disasters
    - Bomb threats
    - Employee termination

  To initiate support for a critical incident, call the TELUS Health EAP toll-free number and request to connect with a **Critical Incident and Stress Management** specialist.

BMO

Health Care and Limited Purpose Flexible Spending Accounts

Plan Details



alight

Smart-Choice Accounts®

Quick Facts

Vendor	Alight Smart-Choice Accounts PO Box 64009 The Woodlands, TX 77387-4009
Support	Human Resources Center (HRC) at 1-888-927-7700
Governance	The Health Care Flexible Spending Account and Limited Purpose Spending Account plans are governed by Internal Revenue Code (IRC) Section 125 which allows employees to pay for qualified medical, dental and vision expenses with pre-tax dollars. The official IRS publications that provide information on these plans are: Publication 502: Medical and Dental Expenses and Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans

Overview

BMO offers two types of Flexible Spending Accounts (FSAs) to help you save on eligible health care expenses by using pre-tax dollars.

- **Health Care Flexible Spending Account (HCFSA) -** The HCFSA helps pay for out-of-pocket medical, prescription, dental, and vision expenses for you and your eligible dependents.
- **Limited Purpose Flexible Spending Account (LPFSA) -** The LPFSA is designed for individuals enrolled in a High Deductible Health Plan (HDHP) and participating in a Health Savings Account (HSA).

  Initially, the LPFSA can only be used for dental and vision expenses, such as:

  - Fillings, X-rays, braces, and caps
  - Eyeglasses, contact lenses, solutions, and LASIK eye surgery

  Once you satisfy your HDHP deductible, you may contact Smart-Choice to convert your LPFSA into a Full Purpose Health Care FSA, allowing you to use your contributions for medical expenses as well.

Important note about HSA participation

If you are contributing to an HSA (whether through BMO or elsewhere) and wish to also contribute to an FSA, you must enroll in the LPFSA.

Until your HDHP deductible is met, only dental and vision expenses are eligible for reimbursement. After meeting the deductible, you can expand your LPFSA coverage to include medical expenses by contacting Smart-Choice.

What's Covered

You can use your Health Care Flexible Spending Account (HCFSA) to pay for eligible health care expenses for yourself and your eligible dependents that may not be fully covered by your medical, dental, or vision plans. This includes costs like deductibles, copayments, coinsurance, and other out-of-pocket expenses.

Important: Expenses reimbursed through your HCFSA cannot also be claimed as deductions on your federal income taxes or be reimbursed by another plan, HSA or FSA.

Examples of Eligible Expenses

Provided they are not reimbursed by any other plan, eligible expenses include:

- Acupuncture
- Allergy shots
- Chiropractor services
- Contact lenses, exams, and related materials (e.g., saline solution)
- Copayments, deductibles, and coinsurance
- Dental expenses not covered by your dental plan
- Medically necessary dietary supplements (with a physician's prescription)
- Eyeglasses and vision exams
- Equipment for individuals with disabilities (e.g., car controls, special phones)
- Hearing exams, hearing aids, and batteries
- Immunizations and vaccinations
- Insulin
- LASIK eye surgery
- Medical/dental expenses exceeding reasonable and customary limits
- Nursing home confinement for illness treatment
- Over-the-counter (OTC) medicines (no prescription required) and menstrual care products
- Physical therapy
- Prescription drugs for illness or injury
- Routine medical exams, including school physicals
- Smoking cessation and weight loss programs (if prescribed)
- Syringes, needles, and injections
- Transportation for necessary medical care (e.g., taxis, buses, airfare, parking)
- Well-baby care
- Wheelchairs
- X-rays

For a complete list of eligible expenses, see IRS Publication 502: Medical and Dental Expenses. For specific questions, contact the claims administrator.

Ineligible FSA expenses

Expenses that do not qualify as tax-deductible under federal income tax laws are not eligible for reimbursement through the HCFSA.

Below are examples of ineligible expenses:

- Cosmetic products
- Cosmetic surgery (unless required due to an accident or injury)
- Custodial care in institutions (e.g., nursing homes)
- Expenses incurred before your HCFSA participation begins
- Expenses paid by another group health or dental plan
- Teeth whitening or external bleaching
- Health club or gym membership dues
- Health care expenses reimbursed by another plan or insurance
- Health insurance premiums
- Household or domestic help
- Maternity clothing
- Uniforms
- Vitamins taken for general health (not prescribed)
- Weight loss or smoking cessation programs not prescribed by a physician

Contributions

The IRS sets annual pre-tax contribution limits for FSAs. BMO uses the maximum determined by the IRS each year.

The amount you elect to contribute to your FSA will be automatically deducted from your pay during the first two pay periods of each month. If there is a third pay period in the month, no deductions will be taken - unless an exception applies (e.g., to recover missed deductions).

For the FSAs, the entire annual elected amount is available to you on the first day of the Plan year, or on the effective date of coverage if you enroll mid-year. This allows you to access your full contribution amount early in the year, even though payroll deductions continue throughout the year.

IRS Non-Discrimination Rules for FSAs

To maintain their tax-advantaged status, FSAs must comply with IRS non-discrimination testing rules. These rules are designed to ensure that FSAs do not disproportionately benefit highly compensated employees (HCEs) or key employees over other participants.

The Plan Administrator may take corrective action at its discretion to ensure compliance with these rules. Corrective actions may include:

- Capping annual contribution limits for highly compensated employees
- Reducing FSA elections for highly compensated employees
- Imputing income on any excess benefit amount received by highly compensated employees

These measures help preserve the integrity and tax-favored status of the plan for all participants.

Other Special IRS rules

The special tax advantages of the FSAs are offered based on current Code rules. The same federal tax laws that allow pre-tax savings on your reimbursements also place certain restrictions on your accounts as follows:

- Your deductions for one kind of FSA cannot be transferred to the other. For example, you cannot transfer remaining Health FSA funds into your DCFSA to pay for eligible dependent care expenses.
- The money you set aside each calendar year must be used for that calendar year's expenses while you were actively participating. Any money that is not used will be forfeited except for the allowed Health FSA carry-over amount (see Carryover amounts for more information).
- Once you make your Health FSA election, your contributions will continue the first two pay periods for the rest of the calendar year. You may, however, change your elections if you experience a qualifying life event or status change that necessitates a mid-year election change.

Claims for reimbursement

As you incur eligible expenses during the Plan year, you can submit claims to your Smart-Choice flexible spending account for reimbursement. Each expense you submit will be reviewed by Smart-Choice to determine whether it qualifies for reimbursement under IRS rules. The service must be incurred during the Plan year and while you were actively participating to qualify for reimbursement. Pre-paid services that were charged or billed but not provided during the Plan year are not eligible for reimbursement.

Smart-Choice debit card

If you contribute $150 or more to your HCFSA, you can use the prepaid card to pay for eligible health care expenses. As you use your Smart-Choice card, eligible health care expenses will be deducted automatically from your account. You will receive a letter with

one Smart-Choice card issued in your name, activation instructions, and benefit cardholder agreement.

You may request additional cards for your spouse and/or eligible dependent(s) through the Smart-Choice website.

The Smart-Choice card remains active as long as your account is in good standing, you continue to participate in a Health FSA, and you remain actively employed. Your card will be canceled upon termination of employment—inactive participants may not use the Smart-Choice card. By signing and using the card, you certify that:

- You'll only use the card for your own eligible health care expenses and those of your eligible Dependents under the Plan.
- The expenses incurred were for health care services or supplies purchased on or after the date your Health FSAs took effect.
- Your expenses don't include any amounts that are otherwise payable by plans for which you or your Dependents are eligible.
- Any expenses paid for with the card have not been, or will not be, reimbursed by another source.

The Smart-Choice card has been designed for use at merchants and providers that primarily sell health care products and services (for example, pharmacies, physician's offices, hospitals, and dentist's offices). Each time you use the card at an approved merchant location for an eligible health care expense, you'll be prompted to use it as either "credit" or "debit." If you choose the credit option, you must provide your signature.

The Smart-Choice card has a pre-assigned PIN that cannot be changed. Once coverage is active, you will be able to obtain your PIN on the Smart-Choice portal. To view this log into the Smart-Choice portal, navigate to the debit cards page, and select the Smart-Choice card for which you need to locate the PIN. Once selected, the card information will expand, and employees will see the four-digit PIN listed on the right side of the information card. Note, the PIN will be displayed once the card is in an active status. You can activate the card directly on the Smart-Choice portal, through the mobile app, or upon the first use with an eligible expense.

Deadline to file claims

You have until April 30 of the following year to submit any health care claims incurred in the previous calendar year while you were actively participating. However, certain carryover provisions apply which are outlined below.

Important: save your itemized receipts. All Smart-Choice card transactions must be verified as eligible health care expenses, and you may be required to provide Smart-Choice with supporting documentation to validate your expenses. The card provides the

convenience of immediate access to your funds. In some situations, your expenses will be automatically validated when you use your Smart-Choice card to purchase eligible items with select merchants that accept health care debit cards. The Smart-Choice card does not eliminate the requirement to keep documentation for your expenses. In many cases, you may need to provide documentation to Smart-Choice for expenses you paid for with your Smart-Choice card. Even if you are not required to submit the itemized receipts, documentation should be retained in the event you are subject to an IRS audit.

Carryover amounts

The Health FSAs and LPFSA allow for up to 20% of the IRS annual limit of unused funds to be carried over into the next Plan year. The carryover funds can then be used for eligible expenses incurred in the current Plan year.

You will not be eligible for any carryover amount if you incur a break in eligibility greater than 31 days at any point within the Plan year, if you are not eligible for the Plan as of December 31, or if you are continuing your coverage through COBRA and have not paid your premiums to extend your coverage through December 31.

How carryover works:

- Carryover only applies to health FSAs. Unused DCFSA funds will not carry over and will be forfeited if not used by the deadline.
- Carryover amounts are available as of the first day of the following Plan year.
- Money will carry over from one year to the next only if you are an eligible HCFSA participant on December 31 of any year. You are also eligible for the carryover balance if your employment with the company has ended, and you have elected COBRA coverage and pay for your premium through December 31. If you have a balance, your carryover will be available through your full COBRA eligibility period.
- If money from your Health FSA is carried over from one year to the next, you may still contribute up to the maximum Health FSA contribution for the new Plan year.
- Up to 20% of the IRS annual limit may be carried over to the new Plan year, even if you do not elect to contribute to the health FSA for the new Plan year.
- If you have more than the IRS carryover limit of unused money in your Health FSA as of December 31, of any year, the unused amount exceeding the limit may not be carried over and this unused excess amount will be forfeited.
- If you have unused HCFSA amounts at the end of a Plan year and elect to contribute to an HSA in the following Plan year, any amount (up to the applicable limit) that you carry over into the subsequent Plan year will be carried over to the LPFSA.
- The carryover rule will continue to apply until you are no longer employed by the Company, or you become ineligible for benefits with the Company.

Keep in mind that you still may file claims for reimbursement of eligible expenses incurred in the current calendar year until April 30 of the following Plan year, whether or not unused money is carried over from one year to the next.

Debit cards

The carryover balance will be available on the first day of the new Plan year (January 1). In accordance, the full balance (including any carryover funds) will also be available on the Smart-Choice card – even if you do not re-enroll. The carryover amount does not affect the ability to elect the maximum annual contribution amount available under the Plan.

Reimbursement for health care expenses

You can file Health FSA claims as often as you like. You will receive reimbursement from your account up to the total amount you elected for the Plan year and any carryover amount if applicable, even if you have not yet contributed the full amount at the time of your request. Refer to the carryover amounts section for additional information on how claims are paid from carryover funds.

Submit your FSA claim form to Smart-Choice along with your receipts for expenses. If you have other group coverage, you will also need to include the Explanation of Benefits (EOB) form provided by the insurance company, if it is an expense that was partially paid by the other group coverage.

All receipts submitted for reimbursement from a Health FSAs must clearly state that the expense is for a qualifying expense as determined by the benefits plan. If a receipt does not clearly identify the expense, you will receive a request for additional information needed to process the claim.

How to file a claim for reimbursement

To submit claims for reimbursement online, go to **Workday**, click on the **My Benefits & Retirement** app, select your network status (on or off the BMO network); click on Reimbursement Accounts. You also have the option to submit your claims through the paper form available on the website, or by submitting your claims through the Smart-Choice app.

You or your authorized representative may file claims for Plan benefits. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

Overpayment process

An overpayment on your account may occur if you have used your Smart-Choice debit card to pay for non-qualified products or services, you have not provided the required documentation to substantiate a qualified expense paid for with your Smart-Choice debit card, or you have been reimbursed for a claim that was subsequently determined to be invalid. Once an overpayment has been identified, you will need to resolve an overpayment on your account to avoid suspension on your Smart-Choice card. If you have received notification of an overpayment, it can be satisfied in the following ways:

1. Resubmit the claim that resulted in an overpayment with additional receipts or other documentation. If the entire claim is approved, the overpayment will be satisfied.
2. Submit new claims for eligible expenses. If your future claims are approved, the overpayment will automatically be paid back by these claims until the full overpayment amount is paid back.
3. Repay the overpayment amount back to be credited to your account by accessing the Smart-Choice website and repaying online, or by mailing a check payable to Smart-Choice Accounts, PO Box 64009, The Woodlands, TX 77387-4009.

Impact of an Overpayment

If your account has an overpayment amount over $100, your Smart-Choice Card will be suspended until the overpayment is repaid. While you're unable to use your card, you may submit claims on the site, via fax, through postal mail, or using the mobile app. **IRS rules state that failure to resolve your overpayment before the end of the plan year can result in tax implications.**

Tips to Avoid an Overpayment

Here are some suggestions to keep in mind when using your Smart-Choice Card:

- Always save your itemized receipts! You may need them if Smart-Choice notifies you to provide documentation for your transaction.
- Send receipts or other documentation for your transaction by the due date.
- Review eligible health care expenses on this site to become familiar with items and services for which you can use your card.
- Don't use your Smart-Choice Card to pay for ineligible health care items.
- Consider shopping at IIAS-certified merchants, where items are automatically identified as eligible or ineligible at checkout.

Notice of a denied claim

If you are denied a full or partial claim for benefits, you will receive written or electronic notice (if valid email on file) of the denial and the notice will:

- explain the reason for the denial;
- refer to the pertinent provision of the Plan on which the denial is based;

- describe any additional material or information necessary for properly completing the claim
- explain why such material or information is necessary
- explain the claim review procedures and
- for HCFSA and LPFSA claims:
  - disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request); or
  - if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request).

Appealing denied claims

If you are not satisfied with the determination of a claim denial, please contact the Human Resources Centre at 1-888-927-7700 and speak with a Smart-Choice representative. If after investigation, you are still not satisfied with the determination, you may file an appeal within 180 days of receiving a claim denial. To make an official appeal of the denial of your reimbursement, you must complete and return the Claims Review Form by requesting from the Smart-Choice representative. If you do not submit a Claim Review Form during this period, no further action will be taken, and you will not be able to file an appeal for the claim later.

When completing the Claim Review Form, state the reason you think you are entitled to reimbursement, including any documentation or information you feel supports your appeal.

The review will be by a person who was not involved in the initial determination, and will consider all comments, documents, and other information submitted by you, without regard to whether that information was submitted or considered in the initial determination. You are entitled to receive, free of charge upon request, any document relevant to your claim for benefits. Your appeal will be reviewed within 30 days from the date of receipt for health care, or within 60 days from the date of receipt for dependent care and provide you with a written explanation of the benefit determination.

Statements

A statement reflecting the activity in your FSA is distributed at the beginning of the fourth quarter each year. Each statement will show your contributions to date, claims paid and available account balances. This information is also available by navigating to Workday, click on the My Benefits & Retirement app, depending on where you are connecting to Workday from, select your network status (on or off the BMO network), click on Reimbursement Accounts.

Please note any amounts that remain in an overpayment status after the Plan year-end deadline (April 30), will appear on your current year W2 as taxable income.

Forfeitures

Before you elect your annual FSA contribution, carefully review, and consider your health needs and previous expenses. IRS regulations require that any amount over the allowed carryover amount for your HCFSA that is not used for reimbursement of eligible expenses incurred by December 31 and submitted for reimbursement by April 30 be forfeited.

You must submit claims for eligible expenses by April 30 of the **following** calendar year. Your claims must be received by the claim's administrator on or before April 30 to be eligible for reimbursement. Any unclaimed balance remaining in your account above the allowed carryover amount after April 30 will be forfeited.

Any amounts remaining in your account, including carryover amounts, upon termination of employment will be forfeited unless you are eligible for and elect COBRA continuation coverage (Health FSA only).

When coverage ends

Your contributions to the FSAs end if any of the following events occur:

- your employment with the Company ends for any reason,
- you become ineligible to participate (see Eligibility), or
- you go on Long Term Disability leave.

If you have a balance in your HCFSA when your coverage ends, you may claim qualified expenses incurred while you were a participant in the Plan, up to the amount you elected less any prior reimbursements. Active coverage ends on the last day of the month in which your employment ends.

To be eligible for reimbursement, your claims must be received by the Claims Administrator no later than April 30th of the following calendar year.

You may be able to continue your HCFSA or LPFSA coverage through COBRA. See Continuing health care coverage under COBRA for more information.

It is your responsibility to notify the Company of any change in your status or the status of any of your Dependents that affects eligibility for coverage under the Plan within 31 days of the status change.

Continuing coverage through COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), when coverage under the health FSAs ends, you or your covered dependents may be

eligible to temporarily continue your coverage at your own expense for a limited period. COBRA continuation coverage is available when a qualifying event occurs that causes you or your eligible dependent to lose coverage under the Plan.

To be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary." A Qualified Beneficiary is any of the following persons who were eligible to have their eligible expenses reimbursed under the health FSAs on the day before a qualifying event:

- the Employee
- the Employee's dependent child
- the Employee's Spouse

Special rule for the Health FSAs

If your Health FSA coverage ends because of a COBRA-qualifying event, COBRA continuation coverage for your Health FSA will be available only if the maximum benefit available under the health FSA for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the Plan year. COBRA coverage ends at the end of the Plan year in which the qualifying event occurs.

BMO

Dependent Care Flexible Spending Account

Plan Details



alight Smart-Choice Accounts®

Quick Facts

Vendor	Alight Smart-Choice Accounts PO Box 64009 The Woodlands, TX 77387-4009
Support	Human Resources Center (HRC) at 1-888-927-7700
Governance	The Dependent Care Flexible Spending Account plan is governed by Internal Revenue Code (IRC) Section 125 and Section 129 which allows employees to pay for qualified expenses with pre-tax dollars.

Overview

A Dependent Care Flexible Spending Account (DCFSA) allows you to set aside money on a pre-tax basis to pay for a variety of eligible dependent care expenses. The DCFSA covers expenses for the daily care of your children under age 13 or other qualified individuals who are unable to care for themselves, so that you can work.

What's Covered

The DCFSA covers eligible dependent care expenses so that you (or you and your spouse if you're married) can work (or look for work) or your spouse can attend school full time.

For dependent care expenses to qualify for reimbursement through the DCFSA, the care must be provided for a Dependent (as defined above) so that you can work (if you're married, your spouse also must work, be looking for work, or attend school full time).

The following expenses are eligible for reimbursement under the DCFSA:

- costs for care at facilities away from home, such as family day care or adult day-care centers, as long as your adult Dependent spends at least eight hours a day in your home;
- recreation programs;
- services of a day-care center, nursery school or preschool (but not kindergarten) if the center complies with all state and local laws;
- summer day camps; and
- wages paid to a baby-sitter or companion in or outside your home.

Ineligible Expenses

The following expenses are not eligible for reimbursement under the DCFSA:

- boarding schools;

- care provided by someone you claim as a dependent;
- educational expenses like swimming, dance lessons or art classes, whether individual or group, even if recommended by a doctor to improve general health;
- expenses incurred before your effective date of participation;
- kindergarten;
- nursing homes;
- overnight camps; and
- providers who watch your eligible dependents while you attend social events.

For additional details on eligible expenses, visit the following website:
https://www.fsafeds.gov/explore/dcfsa/expenses

Contributions

The IRS sets annual pre-tax contribution limits for Flexible Spending Accounts. BMO uses the maximum determined by the IRS each year.

Flexible Spending Accounts (FSAs) must comply with IRS non-discrimination testing rules to maintain their tax-advantaged status. These rules are designed to ensure that FSAs do not disproportionately benefit highly compensated or key employees over others. The Plan administrator, in its discretion, may take corrective action to satisfy these rules. Corrective actions could include capping annual maximums for highly compensated employees, reducing elections for highly compensated employees or imputing income on the excess benefit amount for highly compensated employees.

The maximum amount that you can elect may be less because of other limitations. For example, you cannot elect more than the lower of you or your spouse's earned income for the calendar year.

You may elect to contribute up to IRS maximum per calendar year to the DCFSA if:

- You are married and file a joint federal income tax return;
- You are married and file a separate federal income tax return, and meet the following conditions:
  - your household constitutes the primary residence for more than one-half of the year of a dependent for whom you are eligible to receive reimbursements under the DCFSA;
  - you furnish over half the cost of maintaining this household during the taxable year; and
  - during the last six months of the taxable year, your spouse was not a member of this household.
- You are single or head of household for federal tax purposes.

If you are married and reside with your spouse but you file separate federal income tax returns, the maximum amount you can contribute to the DCFSA is limited to the married and filing separately amount per calendar year. The amount you may elect cannot exceed either your or your spouse's earned income for the calendar year.

The amount you elect will automatically be deducted from your pay on the first two pay periods of each month and deposited into your FSAs. If there is a third pay period in the month, deductions will not be taken (exceptions may apply in certain circumstances such as missed deductions). The money remains credited to your DCFSAs until you incur eligible expenses and submit a claim for reimbursement.

Other Special IRS rules

The special tax advantages of the FSAs are offered based on current Code rules. The same federal tax laws that allow pre-tax savings on your reimbursements also place certain restrictions on your accounts as follows:

- Your deductions for one kind of FSA cannot be transferred to the other. For example, you cannot transfer remaining Health FSA funds into your DCFSA to pay for eligible dependent care expenses.
- The money you set aside each calendar year must be used for that calendar year's expenses while you were actively participating. Any money that is not used will be forfeited.
- Your DCFSA elections must also stay in effect for the calendar year. You may, however, change your elections if you experience a qualifying life event or status change that necessitates a mid-year election change.

Dependent Care Flexible Spending Account vs. dependent care tax credit

The IRS lets you claim work-related dependent care expenses for this credit on your income tax return. The tax credit amount is determined by applying a percentage to your total work-related dependent care expenses. You can use the DCFSA and the tax credit, but you cannot claim the same expenses for both. If you decide to use both the DCFSA and the dependent care tax credit, federal regulations require that the amount you have directed into the DCFSA be subtracted from your tax credit. As with any tax matter, it's recommended to consult a tax professional before making your decision since tax laws change often.

Claims for reimbursement

As you incur eligible expenses during the Plan year, you can submit claims to your Smart-Choice flexible spending account for reimbursement. Each expense you submit will be reviewed by Smart-Choice to determine whether it qualifies for reimbursement under IRS rules. The service must be incurred during the Plan year and while you were

actively participating to qualify for reimbursement. Pre-paid services that were charged or billed but not provided during the Plan year are not eligible for reimbursement.

Deadline to file claims

You have until April 30 of the following year to submit any dependent care claims incurred in the previous calendar year while you were actively participating. Unused DCFSA funds will not carry over and will be forfeited if not used by the deadline.

Reimbursement for dependent care expenses

You will need to submit a DCFSA claim form each time you request reimbursement. You can file DCFSA claims as often as you like. You will receive reimbursement from your account up to the balance in your account at the time you submit your request. If you incur expenses that exceed your available funds, future claims will be reimbursed as additional funds accumulate in your account.

Each time you file a claim, you'll need to include: (1) the name, address and Social Security number or tax ID number of the provider, (2) the name of the person receiving services; and (3) a description of the expense.

Under the DCFSA, you generally must be working to receive reimbursement for dependent care expenses.

How to file a claim for reimbursement

To submit claims for reimbursement online, go to **Workday**, click on the **My Benefits & Retirement** app, select your network status (on or off the BMO network); click on Reimbursement Accounts. You also have the option to submit your claims through the paper form available on the website, or by submitting your claims through the Smart-Choice app.

You or your authorized representative may file claims for Plan benefits. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. All communications from the Plan will be directed to your authorized representative unless your written designation provides otherwise.

Notice of a denied claim

If you are denied a full or partial claim for benefits, you will receive written or electronic notice (if valid email on file) of the denial and the notice will:

- explain the reason for the denial;
- refer to the pertinent provision of the Plan on which the denial is based;
- describe any additional material or information necessary for properly completing the claim;
- explain why such material or information is necessary;

- explain the claim review procedures; and

Appealing denied claims

If you are not satisfied with the determination of a claim denial, please contact the Human Resources Centre at 1-888-927-7700 and speak with a Smart-Choice representative. If after investigation, you are still not satisfied with the determination, you may file an appeal within 180 days of receiving a claim denial. To make an official appeal of the denial of your reimbursement, you must complete and return the Claims Review Form by requesting from the Smart-Choice representative. If you do not submit a Claim Review Form during this period, no further action will be taken, and you will not be able to file an appeal for the claim later.

When completing the Claim Review Form, state the reason you think you are entitled to reimbursement, including any documentation or information you feel supports your appeal.

The review will be by a person who was not involved in the initial determination, and will consider all comments, documents, and other information submitted by you, without regard to whether that information was submitted or considered in the initial determination. You are entitled to receive, free of charge upon request, any document relevant to your claim for benefits. Your appeal will be reviewed within 30 days from the date of receipt for health care, or within 60 days from the date of receipt for dependent care and provide you with a written explanation of the benefit determination.

Statements

A statement reflecting the activity in your FSA is distributed at the beginning of the fourth quarter each year. Each statement will show your contributions to date, claims paid and available account balances. This information is also available by navigating to Workday, click on the My Benefits & Retirement app, depending on where you are connecting to Workday from, (on or off the BMO network), click on Reimbursement Accounts.

Please note any amounts that remain in an overpayment status after the Plan year-end deadline (April 30), will appear on your current year W2 as taxable income.

Forfeitures

Before you elect your annual FSA contribution, carefully review, and consider your dependent day care needs and previous expenses. IRS regulations require that any money left in your DCFSA that is not used for reimbursement of eligible expenses incurred by December 31 and submitted for reimbursement by April 30 be forfeited.

You must submit claims for eligible expenses by April 30 of the **following** calendar year. Your claims must be received by the claim's administrator on or before April 30 to be

eligible for reimbursement. Any unclaimed balance remaining in your account after April 30 will be forfeited.

Also, remember that you cannot use money in your DCFSA to reimburse health care expenses and vice versa.

When coverage ends

Your contributions to the DCFSA ends if any of the following events occur:

- your employment with the Company ends for any reason,
- you become ineligible to participate (see), or
- you go on Long Term Disability leave.

If you have a balance in your DCFSA when your coverage ends you may claim qualified expenses incurred for the remainder of the calendar year. Expenses will be reimbursed up to the total amount of unused funds remaining in your account. To be eligible for reimbursement, qualified DCFSA expenses must have been incurred while you are gainfully employed, actively looking for work or a full-time student. Active coverage ends on your last day worked.

To be eligible for reimbursement, your dependent care claims must be received by the Claims Administrator no later than April 30th of the following calendar year. It is your responsibility to notify the Company of any change in your status or the status of any of your Dependents that affects eligibility for coverage under the Plan within 31 days of the status change.

BMO

Health Savings Account (HSA)

Plan Details



alight

Smart-Choice Accounts®

Quick Facts

Vendor	Alight Smart-Choice Accounts PO Box 64009 The Woodlands, TX 77387-4009
Custodian	WealthCare Saver
Support	Human Resources Center (HRC) at 1-888-927-7700
Governance	The Health Savings Account (HSA) plan is governed by Publication 502: Medical and Dental Expenses and Publication 969: Health Savings Accounts and Other Tax-Favored Health Plans of the IRS Tax Code, which allows employees to pay for qualified medical, dental and vision expenses with pre-tax dollars.

Overview

A Health Savings Account (HSA) is a **tax-advantaged savings account** available to individuals enrolled in a **qualified High Deductible Health Plan (HDHP)**. It allows you to use **pre-tax dollars** to pay for eligible out-of-pocket healthcare expenses, including medical, prescription drugs, dental, and vision.

If you enroll in BMO's HDHP, you may be eligible to open an HSA. You own the account, and it's yours to keep when you leave or retire from BMO, and unused funds roll over year to year.

Your HSA offers three key tax benefits:

1. **Tax-Free Contributions -** Contributions made through payroll are deducted pre- tax, reducing your taxable income.
2. **Tax-Free Withdrawals -** Funds used for qualified healthcare expenses are withdrawn tax-free. You can pay directly with your HSA debit card, use online bill-pay, or reimburse yourself.
3. **Tax-Free Growth -** Interest earned on your HSA balance grows tax-free and is not considered taxable income when used for qualified expenses.

What's covered

You can use your tax-free HSA dollars for a wide variety of qualified medical, dental, vision, and prescription drug expenses only after your account was established. Here is a list of commonly eligible items:

- **Medical**: Deductibles, copays, and coinsurance related to exams, x-rays, lab services, hospital stays, prescription expenses, physical therapy, psychiatric care, treatment for alcohol and drug addition, chiropractor, and acupuncture.
- **Dental and vision**: Deductibles, copays, coinsurance, related to dental and vision

exams, x-rays, orthodontia, cleanings, procedures, extractions, surgeries, prescription eye glasses, corrective lenses, corrective eye surgeries.

- **Medical equipment, aids and miscellaneous expenses**: Hearing aids, braces, orthopedic shoes, crutches, wheelchairs, breast pumps and supplies, renovations for handicap accessibility, over-the-counter medicines, menstrual care products, and wigs (for medical purposes).

For a complete list of eligible expenses, see IRS Publication 502: Medical and Dental Expenses.

HSA-specific eligibility

In addition to being eligible for BMO's U.S. Benefits Program, to participate in BMO's Health Savings Account (HSA), you must:

- Be enrolled in BMO's High Deductible Health Plan (HDHP).
- Have no other non-HDHP medical coverage (e.g., TRICARE, traditional Health Care FSA, spouse's non-HDHP plan).
- Not be enrolled in Medicare.
- Not be claimed as a dependent on someone else's tax return.

Please note you can participate in a Limited Purpose Flexible Spending Account (LPFSA) for dental and vision expenses without affecting HSA eligibility.

Medicare and HSA Eligibility

- You cannot contribute to an HSA once you are enrolled in Medicare (Part A and/or Part B).
- You can still use existing HSA funds to pay for qualified medical expenses, including Medicare premiums, deductibles, copayments, and coinsurance.
- If Medicare coverage is retroactive (which can happen if you delay enrollment), you must stop HSA contributions for the months covered retroactively to avoid penalties.
- You may still contribute to an HSA before Medicare coverage begins, even if you're over age 65, as long as you have deferred your enrollment in Social Security and you're not enrolled in any part of Medicare (Part A, B, C or D).
- For additional information on how Medicare and Health Savings Accounts are related, please view our Approaching Medicare & Health Savings Account Guide.
- Medicare and HSA rules are complex so it is best to consult with your Tax Advisor if you become Medicare eligible while you are an active employee.

TRICARE and HSA Eligibility

- Individuals covered by TRICARE are not eligible to contribute to an HSA, because TRICARE is not a high deductible health plan (HDHP).

Contributions to your HSA

BMO Contributions to your HSA

To give you a head start on saving for your healthcare expenses, BMO provides an upfront, lump-sum Core Contribution to your HSA and it's not contingent on whether you choose to contribute to the HSA yourself. The amount is based on your HDHP coverage level, **$500 for Employee only** coverage and **$1,000 for Family** coverage levels.

To receive the BMO Core contribution (if eligible), simply answer "Yes" to the HSA eligibility question during your benefits enrollment in Workday.

Note to employees on Medicare or TRICARE: If you are enrolled in BMO's HDHP and are also covered by Medicare or TRICARE, you are not eligible to make or receive HSA contributions. Instead, BMO will provide your Core contribution in the form of taxable cash, paid once per year through your paycheck. This contribution is intended to help offset your out-of-pocket healthcare expenses.

Action Required to receive your Taxable Cash Core contribution: If you are currently enrolled in, or plan to enroll in, Medicare or TRICARE for the upcoming plan year, please notify the BMO U.S. Benefits team by emailing: USBenefits@bmo.com.

IRS Annual Limits

The IRS sets limits for how much you can contribute to your HSA annually based on your HDHP coverage level. BMO uses the maximum limit determined by the IRS each year. The IRS permits employees that are age 55 or older to contribute an extra $1,000 catch-up contribution.

The following types of contributions count toward the annual IRS limit:

- Your own contributions.
- Employer contributions (e.g., BMO's Core contribution).
- Contributions to any other HSA accounts you or your dependents own (e.g., former employment).

Important considerations

- If you've contributed to another HSA earlier in the year (e.g., through a previous employer), you must **subtract those amounts** from your BMO HSA election to avoid exceeding the IRS limit. Exceeding the limit can result in tax penalties unless corrected.

- You can make **after-tax contributions** directly to your BMO HSA outside of payroll that may qualify for an above-the-line deduction on your tax return. You are still subject to the IRS annual contributions.

  This option is not recommended during the plan year, unless necessary (if there are too few pay periods left in the year to reach your desired annual contributions through pre-tax payroll deductions alone). This option may be helpful if you want to make an additional prior year contribution (and did not reach the IRS Limit in that year) before the tax filing deadline. You should consult with your Tax Advisor prior to making after-tax contributions to your HSA.

- If your spouse/domestic partner or child (in Employee + Children coverage) is ineligible for an HSA and you have no other eligible dependents, you must limit your contribution to the employee-only HSA maximum. If you also receive an employer contribution from BMO, subtract that amount from the employee-only limit. However, if at least one of your covered dependents is HSA-eligible, you don't need to self-limit. You can still use your HSA to pay for eligible expenses for ineligible dependents—contribution limits are the only restriction.

- The IRS Last-Month rule: If you are HSA-eligible on December 1, you are considered eligible for the entire calendar year. This means you can contribute up to the full IRS annual limit for that year, regardless of when your HDHP coverage began. However, you must remain HSA-eligible through the entire following calendar year (i.e., until December 31 of the next year). If you lose eligibility before then (except due to death or disability), the IRS will treat the excess contributions as taxable income and impose a 10% penalty on those contributions.

- Only you, the employee, can make a catch-up contribution to your BMO HSA if you're age 55 or older and eligible. Your spouse/domestic partner cannot contribute to your HSA, even if they are 55 or older and covered under your HDHP.

Rolling over funds from another HSA

You can roll over funds from another qualified HSA into your BMO HSA at any time. This can be a helpful way to consolidate your HSA funds in one place for easier management.

- Rollover contributions do not count toward your annual IRS contribution limit.
- Be sure to follow the proper rollover process with your current HSA provider to avoid tax implications.

Enrolling in the HSA

When you enroll in the HSA, you'll make an Annual Election for the total amount you want to contribute for the year. That amount is then divided evenly across the number of pay periods you'll be contributing for the year.

- If you're contributing for the full year, your election is divided by 24 pay periods (deductions occur only on the 1st and 2nd paychecks of each month).
- If you enroll mid-year, your annual election is divided by the remaining pay periods in the year (again, deductions only occur on the 1st and 2nd paychecks of each month).
- If you miss any paychecks during the year, your remaining deductions will be automatically recalculated to help ensure you still reach your annual election amount.

To enroll as a hire/newly eligible:

If you're a new hire or you've recently become benefits-eligible, you have **31 calendar days** (includes the event date) to make your benefit elections. If you enroll in BMO's HDHP, you may also be eligible to open and contribute to BMO's HSA. Your HSA election will take effect on the first of the month following 30 days from your hire/newly eligible date based on your HDHP coverage effective date.

1. Go to **Workday**, click **My Benefits & Retirement** app
2. Select your network status (on or off BMO network)
3. Click the **Enroll in your benefits** tile
4. Follow the prompts to navigate through the benefits election process

Note: If you are rehired at BMO within 30 days of your termination date, your benefit elections in place at the time of your termination will be automatically reinstated without a break in coverage. Your bi-weekly HSA deduction may be recalculated if you missed any paychecks during your break in service.

To enroll or make changes during a Qualifying Life Event:

If you experience a mid-year life event (like marriage, birth/adoption, or a change in coverage), you have 31 calendar days (including the date of the event) to update your benefit elections. If you enroll in BMO's HDHP as part of that change, you may also be eligible to open and contribute to BMO's HSA.

If you're newly enrolling in the HDHP, your HSA election will take effect based on your HDHP coverage effective date. If you're changing an existing HSA election, the change will take effect as of the date of the life event.

1. Go to **Workday**, click **My Benefits & Retirement** app
2. Select your network status (on or off BMO network)
3. Click the **Change your Coverage** tab
4. Choose the applicable life event, enter the date of the event and follow the prompts to navigate through the benefits election process

As a result of your life event if you change your HDHP coverage level from employee only to family coverage level, you'll receive a one-time adjustment to true-up your employer core contribution; however, if your coverage level changes from a family level to employee only, no adjustment will be made to the employer contributions already provided.

To make mid-year HSA changes:

Unlike most other benefits, you can start, change or end your HSA contributions at any point during the year - as long as you're enrolled in the HDHP.

1. Go to **Workday**, click **My Benefits & Retirement** app
2. Select your network status (on or off BMO network)
3. Click the **Enroll in your benefits** tile
4. Follow the prompts to navigate through the benefits election process

Your changes will typically take effect within 1-2 payroll cycles.

Note: Once deducted from your pay and deposited to your HSA, contributions cannot be refunded. This means you cannot reduce your annual election below the amount you've already contributed for the year. If you need to adjust your election during the year, you can still increase it or stop future contributions.

Establishing your HSA

When you make your first HSA election in Workday, your information is securely sent to Smart-Choice, BMO's HSA administrator, to open your account.

What to Expect:

- In accordance with the USA PATRIOT Act, federal law requires all financial institutions to verify your identity when opening a new account.
- This process typically happens behind the scenes when your enrollment data is sent to Smart-Choice, but if any information is missing, incorrect or outdated, Smart-Choice may contact you to request additional documentation.
- If your account is flagged during the **Customer Identification Program (CIP) process**, Smart-Choice will conduct a further review before completing your enrollment.
- Smart-Choice offers secure options for submitting any required documents. If you have questions or need assistance, please contact the Human Resources Centre at 1-888-927-7700.

Important: If Smart-Choice is unable to verify your identity and you do not provide the requested documentation within 90 days, your HSA application will be closed. Any deducted, undeposited employee contributions will be returned and you will forfeit BMO's Core Contribution. Tax reporting may apply for the period the account was open.

To avoid these issues, please respond promptly to any outreach from Smart-Choice and submit the requested documentation as soon as possible.

After your HSA is opened, you'll receive a Smart-Choice welcome letter with your debit card and key account details.

Managing your account

To access your HSA:

1. Go to **Workday**, click **My Benefits & Retirement** app
2. Select your network status (on or off BMO network)
3. Click **Reimbursement Account** at the top of the page
4. Click **Health Savings Account**

From the HSA dashboard you can:

- Access your account balance and transaction history
- Request reimbursement or pay your provider
- Learn about your investment opportunities
- Manage communications preferences
- Initiate a Rollover
- View form and documents
- Report a card lost/stolen
- Request additional cards for your spouse and/or eligible dependent(s)
- View assigned PIN for yourself or family members

  The Smart-Choice card has a pre-assigned PIN that cannot be changed. To view this log into the Smart-Choice portal, navigate to the debit cards page, and select the Smart-Choice card for which you need to locate the PIN. Once selected, the card information will expand, and employees will see the four-digit PIN listed on the right side of the information card. Note, the PIN will be displayed once the card is in an active status. You can activate the card directly on the Smart-Choice portal, through the mobile app, or upon the first use with an eligible expense.

Options to use your HSA Funds for eligible expenses:

You have several options for using your HSA funds through Smart-Choice:

- **Use your Smart-Choice debit card*** at pharmacies or medical, dental, and vision providers.
- **Pay out of pocket** and request reimbursement from your HSA to your personal bank account.
- **Pay a provider directly** through the Smart-Choice portal.

* When enrolled in both an LPFSA and HSA, the stacked Smart-Choice card automatically uses your LPFSA balance first for dental and vision expenses to preserve your HSA funds; once the LPFSA is exhausted, those expenses shift to your HSA, while medical expenses always draw from the HSA.

To submit a claim:

1. Go to **Workday**, click **My Benefits & Retirement** app
2. Select your network status (on or off BMO network)

3. Click **Reimbursement Account** at the top of the page
4. Click **Health Savings Account**
5. Select **Add Expense** from the menu.
6. Enter the required details to process your payment or reimbursement.

Note: You are not required to submit receipts to substantiate your expenses, but you should keep them for tax purposes. You can only be reimbursed for qualified expenses incurred after your HSA is established.

Details about your HSA

HSA Deposit Account: Your Smart-Choice HSA is an interest-bearing deposit account with an optional investment feature.

- Funds in the deposit account are FDIC-insured up to the legal limit.
- Interest is compounded monthly and credited at the end of each month.
- Interest is calculated using the daily balance method.
- You can view current annual percentage yield (APY) rates by logging into your account.

HSA Investment Account: Once your HSA balance reaches $1,001, you become eligible to invest your funds.

- Similar to a 401(k), you can choose from a variety of mutual funds.
- You must maintain a minimum balance of $1,000 in your HSA deposit account to invest.
- You can view balances, transactions, and portfolio holdings, place trades, and transfer funds between your HSA and investment account directly through the portal.

To explore investment options:

- Visit the Fund Performance Dashboard to view historical performance, fund categories, and expense ratios.
- Access fund prospectuses, fact sheets, and Morningstar® pages via the Resource Links in the dashboard.

Fees: As an active BMO employee, you will not pay ongoing maintenance fees for your HSA. A $2.50 monthly fee applies to accounts with an investment balance, which covers unlimited trades and is deducted from your base HSA balance. If you leave BMO, your HSA becomes a retail account and standard maintenance fees will apply.

Portability: Your HSA is yours to keep, even if you change health plans or leave BMO.

Balance carry forward: Any unused funds roll over year to year and are non-forfeitable. You may also roll over your balance to another qualified HSA provider if you choose. Many

people use HSAs as a long-term savings vehicle by paying current expenses out of pocket (or using a LPFSA, if applicable) and allowing their HSA to grow over time.

Communications and tax forms: You will receive quarterly statements and annual tax forms from Smart-Choice for your HSA.

- Quarterly account statements will be available via the Smart-Choice platform or by mail if you're not enrolled in electronic delivery.
- IRS Form 1099-SA, sent by January 31 each year, reports each type of HSA distribution made during the tax year.
- IRS Form 5498-SA, sent by May 31 each year, summarizes all contributions made to your HSA during the tax year.
- Both forms are used to complete IRS Form 8889.

Important information

- ATM access is not available with your Smart-Choice card.
- You are responsible for:
  - Ensuring funds are only used for qualified medical expenses.
  - Keeping receipts and documentation for tax purposes.
  - Understanding that non-qualified withdrawals are subject to income tax and a 20% penalty.
- If you make a transfer into another HSA account and your balance is zero, your Smart-choice account will automatically close after 180 days in inactivity if your balance remains zero. You will receive notification once the account is closed and per the policy, as account closed due to a zero balance for an extended period (180 days) cannot be reopened.

If you leave BMO: What happens to your HSA

One of the key advantages of a Health Savings Account (HSA) is that it’s yours to keep, even if you leave BMO.

- Your HSA will remain active and continue to be administered by Smart-Choice Accounts and WealthCare Saver.
- You’ll receive a letter with instructions on how to access your account.
- A new Smart-Choice debit card will be issued for continued access to your funds.
- Once you leave BMO, your HSA will be reclassified as a retail account and will no longer be affiliated with BMO.
- As a retail account, it will be subject to standard fees outlined in the fee schedule available at www.wealthcaresaver.com/disclosures/smart-choice
- If you return to BMO in the future, your HSA can be reaffiliated with BMO, and the monthly account maintenance fee will be waived once again.

When HSA Contributions cease

Your HSA employee contributions will automatically stop if:

- you do not complete Customer Identification Program Verification, if required.
- your enrollment BMO's HDHP ends.
- you experience a change in status that make you ineligible for BMO's Benefits Program.
- your employment with the Company ends for any reason.
- you become a participant in BMO Long Term Disability.

You will need to stop your HSA employee contributions if:

- You no longer wish to contribute to your HSA.
- You become ineligible to contribute to an HSA due to enrollment in Medicare.
- You will exceed the IRS Annual Limit due to contributions you made to other HSAs during the plan year.

A final note

Important Information About Your Health Savings Account (HSA)

An HSA is not an employer-sponsored benefit plan. It is an individual trust or custodial account that you open with an HSA trustee or custodian, intended primarily for the reimbursement of eligible healthcare expenses, as defined under Internal Revenue Code Section 223.

BMO's Role: BMO's involvement is limited to enabling you to make pre-tax contributions to your HSA through payroll deductions. BMO does not manage, control, or have access to the funds in your HSA. Your HSA, and the payroll mechanism that allows you to contribute to it, is not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Information Disclaimer: The BMO U.S. Benefits website (www.bmousbenefits.com) provides highlights of the Company's benefit plans. While every effort is made to ensure accuracy, it does not include every detail, limit, or exclusion.

- The official plan documents govern all aspects of the plans and take precedence over any summaries.
- BMO reserves the right to **modify, amend, replace, or discontinue** any benefit or plan at any time, for any reason.

BMO

Commuter Benefits

Plan Details



alight

Smart-Choice Accounts®

Quick Facts

Vendor	Smart-Choice Account powered by Edenred Benefits
Support	Human Resources Center (HRC) at 1-888-927-7700
Governance	The Commuter Benefits Program is governed by Section 132(f) of the IRS Tax Code (26 USC §132 – Certain Fringe Benefits), which allows employees to pay for qualified transportation expenses with pre-tax dollars.

Overview

Commuter Benefits help you pay for your commute to and from work using tax-free dollars, which saves you money on your taxes each year. You can use commuter benefits to save money on eligible transit, vanpool, and parking expenses.

In addition to tax savings, you benefit from the convenience of online ordering and managing your transit and parking orders at your convenience via Workday. As a participant of the commuter benefits program, you can enroll, change your contribution amount, or stop participating any month during the year. You can also opt out of certain benefit months if you know you will not need an order for a particular month.

What's Covered

You can use commuter benefits for:

- **Public Transit**: Train, bus, subway, ferry, trolley, water taxi, and vanpools.
- **Parking**: Near work or near your commute location and discounts through SpotHero (where available).

Ineligible Expenses

Expenses that **do not qualify**:

- Tolls, fuel, mileage, taxi fares
- EZ Pass, airline tickets
- Business travel
- Family member expenses
- Airport/home parking
- Expenses that are incurred before your first contribution or after employment ends

Commuter Benefit Products

To support your daily commute and make transportation more affordable and convenient, Edenred offers a variety of commuter benefit options. Whether you use public transit, vanpools, or need parking near your workplace, there's a solution designed to fit your needs. Below is a summary of the available options and how each one works to help you make the most of your commuting experience.

Option	Description
Prepaid Cards*	Reloadable Commuter Benefits Prepaid Mastercard. Use for public/shared transportation or parking expenses. Accepted at transit agencies, retail centers, and fare machines.
Transit Passes	Monthly passes mailed directly to you. Available for hundreds of transit agencies nationwide.
Smart Cards	Reloadable cards offered by select transit agencies. Can be reloaded monthly.
Transit Vouchers	Redeemable for transit or vanpool services. Only accepted by transportation service providers.
Direct Pay	Your selected parking provider is paid directly each month on your behalf.
Reimburse Me	Submit claims to be reimbursed for eligible out-of-pocket parking expenses.

***Transit and Parking Flex feature -** To provide greater flexibility for employees managing their commuter benefits, Edenred offers the **Transit and Parking Flex** feature for participants using the prepaid card. This allows for more dynamic use of pre-tax funds across transit and parking categories. While transit and parking funds have traditionally been non-transferable and non-refundable under IRS rules, recent guidance now permits the use of accumulated transit funds for parking expenses - and vice versa.

Missing or Lost Products

If you ordered a transit card/product and haven't received it by the first calendar day of the benefit month, there are steps you can take to resolve the issue. You can review your benefit election history and select the **"Lost/Stolen/Damaged Card"** option under the specific benefit you ordered. Alternatively, you can contact the **HRC** at **1-888-927-7700** for further assistance.

Please ensure you report your missing card/product promptly so it can be reissued without delay. **Payments for commuter expenses are not refundable**, so timely reporting is essential to avoid any loss of benefit.

Contributions

The IRS sets monthly pre-tax contribution limits for Commuter Benefits. BMO uses the maximum determined by the IRS each year.

Your Commuter Benefits contributions are deducted once a month, taken from your first paycheck of the month. If your monthly commuting expenses exceed the IRS pre-tax limits, the remaining amount will be deducted after-tax - allowing you to fund the full cost of your transit pass in a single transaction. Pre-tax contributions are taken before taxes are withheld, which can reduce your taxable income and potentially save you up to 40% on commuting costs, depending on your tax bracket. These contributions are exempt from federal, most state, and FICA taxes.

Please note that if you reside in a state that does not recognize the federal pre-tax limit, your contribution will be adjusted accordingly. For state-specific guidance, it's recommended to consult a tax professional.

Enrolling and Managing Your Account

To access the Commuter Program

- Go to **Workday**, click **My Benefits & Retirement** app
- Select your network status (on or off the BMO network)
- Click **Reimbursement Account** at the top of the page
- Click **Commuter Account**

From here you can:

- View your benefit election deadline
- Manage recent orders
- Check your card balance and claims
- Access support, videos, and guides
- Place an order
- Make Changes (Changes must be made **before the monthly deadline)**

Monthly deadlines for enrolling or changes

- **General deadline**: 10th of each month (by midnight ET)
- **Long Island & Metro North Railroad**: 4th of each month

Example ordering timeline

General deadline	Place your order by **December 10**	Receive your pass before **January 1**	Use it in **January**
Long Island & Metro North Railroad Users	Place your order by **December 4**	Receive your pass before **January 1**	Use it in **January**

To make commuting even more convenient, you have the flexibility to **set up recurring orders** for your transit or parking benefits - ensuring you never miss a month. If your commuting needs change, you can also **opt out for specific months** as needed. This allows you to tailor your benefits to match your schedule and avoid unnecessary deductions.

Important Note for Employees on Leave or Terminating from BMO

Since Commuter Benefits elections are made by the 10th (or 4th for Long Island & Metro North Railroad Users) of the month prior to the benefit month, it's important to proactively stop your election if you will be on a leave of absence or leaving BMO the following month and won't need the benefit. If you do not cancel your election in advance, you will still be responsible for the cost of your commuter benefits for that month - as products are not returnable and contributions are non-refundable.

Ending Participation

- You can stop anytime
- Cancel by the **10th (or 4th for Long Island & Metro North Railroad Users)** to avoid next month's charges
- Participation ends automatically on your **termination date** or **when you transition to Long Term Disability (LTD)**
- **Unused funds are forfeited** per IRS rules and cannot be refunded

Terms of use

The Commuter Benefits website is comprised of various web pages operated by Edenred Benefits, LLC. The terms of use define the relationship between the Company and you, the person accessing the site or mobile application and/or registering for services.

By accessing the Edenred site or accessing, registering for, or using the services, you confirm that (1) You are at least 13 years old, and (2) You have read these terms of use, and (3) You accept these terms of use. If you cannot confirm each of (1) through (3) above, then you must not accept these terms of use and may not use the site or services.

AGREEMENT WITH RESPECT TO TERMS OF USE These Terms of Use constitute a legally binding agreement between the Company and you. You are responsible for regularly reviewing these Terms of Use, which can be viewed any time on your Commuter dashboard. You can review the most current version of the Terms of Use at any time at: click here. Additional terms may govern use of certain Web pages within the Site or linked within the Mobile Application. In the event that any provision, term or guideline contained on a particular Web page in the Site and Mobile Application conflicts with these Terms of Use, the terms of such Web page shall control over these Terms of Use.

YOUR GROUP TERM LIFE INSURANCE PLAN

For Employees of
BMO Financial Corp

D12384 (07/25)

GROUP TERM LIFE INSURANCE CERTIFICATE

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 800-955-7736 www.voya.com

POLICYHOLDER:	BMO Financial Corp
GROUP POLICY NUMBER:	29316-4GAT2
POLICY EFFECTIVE DATE:	July 1, 2025
POLICY ANNIVERSARY DATE:	January 1
GOVERNING JURISDICTION:	Illinois

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. Subject to the provisions of this Certificate, we certify that eligible Employees are insured for the benefits described in this Certificate.

This Certificate summarizes and explains the parts of the Policy which apply to you, if you are an eligible Employee as defined. The Certificate is part of the group Policy but by itself is not a policy. This Certificate replaces any other Certificates we may have given you under the Policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments. Your rights and benefits under the Policy will not be less than those stated in your Certificate.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address.

In this Certificate, “you” and “your” refer to an Employee who is eligible for coverage under the Policy; “we”, “us” and “our” refer to ReliaStar Life Insurance Company.

READ THIS CERTIFICATE CAREFULLY! Insurance benefits may be subject to certain requirements, reductions, limitations and exclusions.

GROUP TERM LIFE INSURANCE

Term life insurance provides a benefit to a named beneficiary upon the death of a person insured under a policy, with benefits payable only if a loss occurs within its term. Group insurance covers a group of persons under a single policy issued to a group policyholder.

Premiums for Basic life insurance are Noncontributory by insured Employees. Premiums for Supplemental life insurance are Contributory by insured Employees.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.

Amelia (Amy) J. Vaillancourt
President

Melissa A. O'Donnell
Secretary

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Policyholder's Contact Information:
BMO Financial Corp, 320 South Canal Street Floor 8, Chicago, Illinois 60606

Illinois Insurance Department Phone Number: (217) 782-4515

California residents:
If you are age 65 or older on the effective date of any Contributory coverage under the Policy, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full Premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

Florida Residents:
The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.

North Dakota Residents:
Please read this Certificate carefully. If you are not satisfied with it for any reason and no benefits have been paid, you may return it within 20 days after receipt for a refund of any Premium you paid.

SCHEDULE OF BENEFITS

EMPLOYER(S): BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

ELIGIBLE CLASS(ES)

All Eligible Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.
Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT

Employees: 20 hours per week.

ELIGIBILITY WAITING PERIOD

Persons in an eligible class on or before the Policy effective date: End of the month in which you complete a continuous period of 30 days of Active Employment

Persons entering an eligible class after the Policy effective date: End of the month in which you complete a continuous period of 30 days of Active Employment

REHIRE

If your employment with the Employer ends and you are rehired within 30 days, your previous Active Employment while in an eligible class will apply toward the Eligibility Waiting Period. All other Policy and Certificate provisions apply.

BASIC LIFE INSURANCE

Basic life insurance is Noncontributory by Employees.

Eligible Class(es)	Amount
All Eligible Employees	2 times your Basic Yearly Earnings, with a minimum amount of $50,000

An insurance amount that does not equal an increment of $1,000 is rounded to the next higher $1,000.

MAXIMUM AMOUNT OF BASIC LIFE INSURANCE FOR EMPLOYEES WHO HAVE BASIC LIFE ONLY

$500,000

SUPPLEMENTAL LIFE INSURANCE

Supplemental life insurance is Contributory by Employees.

Eligible Class(es)	Amount
All Eligible Employees	Choice of 1, 2, 3, 4, 5, 6, 7, or 8 times your Basic Yearly Earnings, with a minimum amount of $10,000

An insurance amount that does not equal an increment of $1,000 is rounded to the next higher $1,000.

MAXIMUM AMOUNT OF BASIC PLUS SUPPLEMENTAL LIFE INSURANCE FOR EMPLOYEES WITH BASIC AND SUPPLEMENTAL LIFE

$3,000,000

BENEFIT REDUCTIONS

Your insurance amount will decrease as follows:

- To 60% of the original amount on the Policy anniversary that is on or next follows your 70th birthday.
- To 40% of the original amount on the Policy anniversary that is on or next follows your 75th birthday.
- To 25% of the original amount on the Policy anniversary that is on or next follows your 80th birthday.
- To 17% of the original amount on the Policy anniversary that is on or next follows your 85th birthday.

Reduced insurance amounts are not rounded.

DEFINITIONS

Active Employment or **Active Employee** means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.
Temporary and seasonal workers are excluded from coverage.

Basic Yearly Earnings means Total Compensation Benefits Base Rate (TCBBR) your base salary, overtime, shift differential and any variable pay related to work performance that you receive between October 1 and September 30 of the prior Year. The greater of the Annual Base Salary as of September 30th (or current date for employees hired/rehired/transferred after October 1st), Benefit Base Rate (BBR) as of September 30th (or current date for employees hired/rehired/transferred after October 1st), or YTD (based on Benefit year – October 1 of prior year to September 30 of current year) TCBBR calculated amount based on pay code list is the actual TCBBR locked in for the calendar year.

Beneficiary means the person(s) or entity to whom we will pay the life insurance benefits in accordance with the BENEFICIARY and PAYMENT OF PROCEEDS provisions.

Certificate means this document that describes the benefits and rights of insured Employees under the Policy. It may include riders, endorsements or amendments.

Contributory means insurance for which insured Employees are required to pay any part of the Premium.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Employee means a person who is a citizen or legal resident of the United States, including its territories and possessions, and who is in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Evidence of Insurability means your affirmation, on a form acceptable to us, of various factors that we will use to determine if you are approved for coverage. Those factors may include, but are not limited to, your medical history and treatment, driving record, and/or family medical history. We may also, at our expense, request additional information to determine your eligibility for coverage.

Noncontributory means insurance for which insured Employees are not required to pay any part of the Premium.

Policy means the Written group insurance contract between us and the Policyholder, including the Certificates issued to insured Employees. It may include riders, endorsements or amendments.

Policyholder means the entity to whom the Policy is issued, as shown on the first page of this Certificate.

Premium(s) means the amount the Policyholder and/or you must pay to us for the insurance provided under the Policy.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

Written or **Writing** means a record which is on or transmitted by paper, electronic or telephonic media, and which is consistent with applicable law.

GENERAL PROVISIONS

ELIGIBILITY

If you are an Employee in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period.

ENROLLMENT

If you are eligible for Contributory coverage, you must enroll for any Contributory coverage before it will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment. You may need to provide Evidence of Insurability, as described below.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and you were covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required for coverage under the conditions described below. Coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of the increase. We must approve any required Evidence of Insurability before coverage becomes effective.

Basic Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Employer's prior Policy…	Any amount exceeding the lesser of the most recent coverage from the Employer's prior Policy or the plan maximum
Initial eligibility under the Employer's plan for basic coverage on or after the Policy effective date…	Evidence is not required for any amount less than or equal to the plan maximum
Increases due to salary, job or class changes…	Evidence is not required for any increase in which the total Basic Life Insurance amount is less than or equal to the plan maximum

Supplemental Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Employer's prior Policy…	Any amount exceeding the lesser of the most recent coverage from the Employer's prior Policy or $1,500,000
Initial eligibility under the Employer's plan for supplemental coverage on or after the Policy effective date…	Any amount exceeding $1,000,000 or 5 times your basic yearly earnings, whichever is less.
Enrollment for supplemental coverage on the Policy effective date, for employees who had supplemental coverage under the Employer's prior Policy…	All increased amounts
Enrollment for supplemental coverage on the Policy effective date, for employees who had no supplemental coverage under the Employer's prior Policy…	All amounts
Enrollment at a scheduled annual enrollment period after the Policy effective date for an increase to existing supplemental coverage…	Any increased amount exceeding $1,000,000 or 1 times your basic yearly earnings, whichever is less. Any total Supplemental Life insurance exceeding $1,000,000 or 5 times your basic yearly earnings, whichever is less.

Enrollment at a scheduled annual enrollment period after the Policy effective date for initial supplemental coverage…	All amounts
Increases due to salary, job or class changes…	Evidence is not required for any increase in which the total Supplemental Life Insurance amount is less than or equal to the plan maximum
Any new or increased supplemental coverage not described above, including enrollments more than 31 days after initial eligibility…	All increased amounts

EFFECTIVE DATE OF COVERAGE

For Noncontributory coverage, you will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for coverage.

For Contributory coverage, you will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you enroll for coverage on or before that date.
- The date you enroll for coverage.
- The date we approve your Evidence of Insurability, if Evidence of Insurability is required.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The Policy anniversary that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The date we approve your Evidence of Insurability, if Evidence of Insurability is required.

Any decrease in coverage will take effect on the next policy anniversary but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The date coverage for all Active Employees under the Policy terminates.
- The date you are no longer in an eligible class.
- The date your eligible class is no longer covered.
- The date you voluntarily cancel your Contributory coverage, as allowed by the Employer.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the Policy grace period.
- The last day you are in Active Employment.

We will pay benefits for a loss that occurs while you are covered under the Policy.

CONVERSION

You may convert your life insurance, without Evidence of Insurability, to an individual life insurance policy if any part of your life insurance under the Policy stops for one of the following reasons:

- Your coverage ends according to the TERMINATION OF COVERAGE provision other than your voluntary cancellation of your Contributory coverage.
- Any continuation of insurance under the Policy ends.
- Your coverage reduces due to your change from one eligible class to another.
- Your coverage reduces due to a Policy change.

Only life insurance is eligible for conversion. The maximum amount of life insurance you are eligible to convert cannot be greater than the amount of life insurance you had prior to termination. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which you remain eligible under the Policy are not eligible for conversion.

To convert your life insurance, you must apply and pay the first premium to us within 31 days of the date any part of your life insurance under the Policy terminates (the "conversion period"). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of your life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

You may apply to convert the entire amount of life insurance that is terminating under the Policy, or a lesser amount. The maximum amount of life insurance coverage you are eligible to convert will be reduced by any amount of life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. Premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your class of risk, and your attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept your application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, your life insurance will continue under the terms of the Policy. If you die within the conversion period, any life insurance amount that you were entitled to convert will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

If you have made an absolute assignment of your insurance, only the current owner may apply for conversion.

INCONTESTABILITY

Any statement made by you is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you and a copy of such statement of insurability has been given to you or to the Beneficiary. Except for fraud, we will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your lifetime. Except for fraud, we will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your lifetime. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date when permitted by applicable law in the governing jurisdiction.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the Premium.

An error will not end insurance validly in effect, nor will it continue insurance validly ended.

MISSTATEMENT OF AGE

If Premiums are based on your age and you have misstated your age, then your correct age will be used to determine if insurance is in effect and, as appropriate, the Premium and/or benefits will be adjusted. We may require satisfactory proof of your age before paying any claim.

MISSTATEMENT OF TOBACCO USE STATUS

If Premiums are based on your tobacco use status and you have misstated your tobacco use status, then we will adjust the Premium according to the correct tobacco use status. The amount payable upon your death will be the amount that the Premium would have purchased using the correct tobacco use status. During the first two years your coverage under the Policy is effective, we will make this adjustment instead of contesting your insurance for this misstatement.

ASSIGNMENT

You may make an absolute assignment of ownership of your insurance under the Policy to any person or entity by sending us Written notice on a form that we accept. An absolute assignment transfers all your duties, rights, title and interest under the Policy to the new owner. The new owner can make any changes allowed under the Policy and Certificate.

An absolute assignment form is available from the Employer or us. Any assignment form must be Signed by both the current owner and the new owner. The Signed form must be received and accepted by us in order to be valid. An accepted assignment will take effect on the date the form is Signed by you, unless otherwise specified in the Signed form. An assignment does not affect any payment we make or action we take before receiving the Signed form. An assignment does not change the insurance or the Beneficiary designation.

If you want to continue an absolute assignment made under the Employer's prior group life insurance policy, a statement of intent form is available from the Employer or us. The form must be Signed by both you and the assignee. The Signed form must be received and accepted by us in order to be valid. A statement of intent does not affect any payment we make or action we take before receiving the Signed form. A statement of intent does not change the insurance or the Beneficiary designation.

We assume no responsibility for the validity of any assignment. You are responsible to see that the assignment is legal in your state and that it accomplishes the goals that you intend.

BENEFICIARY

The Beneficiary is named by you to receive any proceeds payable at your death. While your coverage is in force, you may change the Beneficiary designation by Written request on a form that is acceptable to us. A Beneficiary designation form is available from the Employer or us. An accepted designation will take effect as of the date it is Signed, unless you specify otherwise in the Signed designation, but will not affect any payment we make or action we take before receiving the Signed form. If you have made an absolute assignment of your insurance, only the current owner may change the Beneficiary designation.

If an irrevocable Beneficiary is named, the Beneficiary designation can only be changed with the consent of the irrevocable Beneficiary.

There can be one or more Beneficiaries. If two or more Beneficiaries are named and their shares are not specified in the Beneficiary designation, then the Beneficiaries will share any insurance proceeds equally. If a primary Beneficiary does not survive you, their share will be payable to the remaining primary Beneficiaries. One or more contingent

Beneficiaries may be named to receive the proceeds in the event that all of the primary Beneficiaries named do not survive you.

Please refer to the LIFE INSURANCE BENEFITS section of the Certificate for information about payment.

AGENCY

For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This Certificate was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this Certificate which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

ENTIRE CONTRACT

Coverage for insured Employees is provided under a contract of group term insurance between us and the Policyholder. The entire contract consists of all of the following:

- The Policy issued to the Policyholder including Part A and Part B.
- The Certificates which are made part of Part B under the Policy.
- Any riders, endorsements and/or amendments issued.
- The Policyholder's Signed application, a copy of which is attached to the Policy when issued.

CHANGES TO POLICY OR CERTIFICATE

The terms and provisions of the Policy and this Certificate may be changed at any time without the consent of you or anyone else with a beneficial interest in the Policy. We will issue riders, endorsements or amendments to effect such changes, and only those forms Signed by one of our executive officers will be valid. We will only make changes consistent with the standards of the Interstate Insurance Product Regulation Commission or the applicable regulatory body in the governing jurisdiction. We will provide a copy of the rider, endorsement or amendment to the Policyholder for attachment to the Policy, and also for the Employees if the change affects the Certificate(s).

Riders, endorsements and amendments are subject to prior approval by the Interstate Insurance Product Regulation Commission or the appropriate regulatory body in the governing jurisdiction. A rider, endorsement or amendment will not affect the insurance provided under the Certificate(s) until the effective date of the change, unless retroactivity is required by the applicable regulatory body.

No agent, representative or employee of ours or of any other entity, except one of our executive officers, may approve a change to or waive the terms of the Policy.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that you died while your insurance under the Policy is in force. The death benefit is the amount of life insurance for your class as shown on the SCHEDULE OF BENEFITS in effect on the date of your death minus any amount paid under the Accelerated Death Benefit Rider.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review the claim and proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this Certificate.

AUTOPSY

We reserve the right to make a reasonable request for an autopsy at our expense where permitted by law.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your death.

If there is no eligible Beneficiary, we will pay the proceeds to the first survivor(s), who is living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children.
3. Your parents.
4. Your siblings.
5. Your estate.

If the Beneficiary or survivor is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to that person's estate.

"Spouse" means your lawful spouse. It includes your domestic partner or civil union partner who is recognized as equivalent to a spouse in the state with governing jurisdiction of the Policy. It also includes your domestic partner as defined by the Employer if you have completed and Signed a declaration of domestic partnership on a form acceptable to the Employer.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.

- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

LEGAL ACTION

The time period during which any person can start legal action regarding any claim under the Policy is subject to applicable law in the governing jurisdiction. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide Written notice of the adverse benefit determination to the claimant as soon as possible, but no more than 90 days after receipt of the claim unless an extension is needed. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension before the end of the initial 90-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to the claimant's failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

A notice of an adverse benefit determination will be Written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
- A description of the claim review procedure and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action following an adverse benefit determination on review.

The claimant may request a review of an adverse benefit determination (an "appeal") at any time during the 60 day period following receipt of the notice of the determination. We will consider an appeal upon Written application of the claimant or his or her duly authorized representative. As part of the appeal the claimant also has the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to the claimant's claim for benefits. The claimant may, in the course of this appeal, review relevant documents and submit to us Written comments, documents, records and other information relevant to the claimant's claim for benefits.

Following our review of the appeal, we will provide the claimant with a Written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 60 days after the receipt of the appeal unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice of any such extension before the end of the 60-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to the claimant's failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be Written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits.
- A statement of the claimant's right to bring a civil action.

EXCLUSIONS AND LIMITATIONS

For Noncontributory life insurance, we pay a death benefit for all causes of death.

For Supplemental Contributory life insurance, if you commit suicide while sane or insane within two years of the date your insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period you were continuously covered under the Policy and any previous group term life policy(ies) issued to the Policyholder during your lifetime.

If you commit suicide while sane or insane within two years from the date an increase in Supplemental Contributory life insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

SPOUSE LIFE INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

SUPPLEMENTAL SPOUSE LIFE INSURANCE

Supplemental Spouse life insurance is Contributory by Employees.

Eligible Class(es)	Amount
Spouse	Choice of $25,000 or $50,000 or $100,000 or $150,000

MAXIMUM AMOUNT OF SUPPLEMENTAL SPOUSE LIFE INSURANCE

$150,000

The Supplemental Spouse life insurance amount will not exceed the Supplemental Employee life insurance amount in force.

You may not elect a higher amount of Supplemental Spouse life insurance than Supplemental Employee life insurance.

BENEFIT REDUCTIONS

The Spouse insurance amount will decrease as follows:

- To 60% of the original amount on the Policy anniversary that is on or next follows your Spouse's 70th birthday.
- To 40% of the original amount on the Policy anniversary that is on or next follows your Spouse's 75th birthday.
- To 25% of the original amount on the Policy anniversary that is on or next follows your Spouse's 80th birthday.
- To 17% of the original amount on the Policy anniversary that is on or next follows your Spouse's 85th birthday.

Reduced insurance amounts are not rounded.

DEFINITIONS

Evidence of Insurability means your Spouse's affirmation, on a form acceptable to us, of various factors that we will use to determine if your Spouse's coverage is approved. Those factors may include, but are not limited to, your Spouse's medical history and treatment, driving record, and/or family medical history. If we need more information, any costs will be at our expense.

Spouse means your lawful spouse. The person must also meet all of the following:

- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee.

The term includes your domestic partner or civil union partner who is recognized as equivalent to a spouse in the state with governing jurisdiction of the Policy. It also includes your domestic partner as defined by the Employer if you have completed and Signed a declaration of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

ENROLLMENT

If you have a Spouse eligible for coverage, you must enroll for Contributory Spouse coverage before Contributory coverage will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and your Spouse was covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage on your Spouse that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

You may need to provide Evidence of Insurability on your Spouse, as described below.

EVIDENCE OF INSURABILITY

Evidence of Insurability is required for coverage under the conditions described below. Coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of coverage. Any increase to coverage is subject to the Evidence of Insurability requirements that are in force on the effective date of the increase. We must approve any required Evidence of Insurability before coverage becomes effective.

Supplemental Spouse Life Insurance	Evidence Required
Coverage on the Policy effective date continued from the Employer's prior Policy…	Any amount exceeding the lesser of the most recent coverage from the Employer's prior Policy or the plan maximum
Initial eligibility under the Employer's plan for supplemental spouse coverage on or after the Policy effective date…	Any amount exceeding $50,000

Enrollment for supplemental spouse coverage on the Policy effective date, for employees who had supplemental spouse coverage under the Employer's prior Policy…	All increased amounts
Enrollment for supplemental spouse coverage on the Policy effective date, for employees who had no supplemental spouse coverage under the Employer's prior Policy…	All amounts
Any new or increased supplemental spouse coverage not described above, including enrollments more than 31 days after initial eligibility…	All increased amounts

EFFECTIVE DATE OF COVERAGE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you enroll for Spouse coverage on or before that date.
- The date you enroll for Spouse coverage.
- The date we approve your Spouse's Evidence of Insurability, if Evidence of Insurability is required.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.
- The date your Spouse is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date your Spouse's coverage would otherwise become effective.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The Policy anniversary that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The date we approve your Spouse's Evidence of Insurability, if Evidence of Insurability is required.
- The date your Spouse is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date the increased or additional coverage would otherwise start.

Any decrease in coverage other than benefit reductions noted on the SCHEDULE OF BENEFITS will take effect on the next Policy anniversary but will not affect a payable claim that occurs prior to the decrease.

SPOUSE CHANGE OF LEGAL RESIDENCE

If your Spouse is insured under this rider and your Spouse changes their legal residence to outside the United States or its territories or possessions, then you should notify the Policyholder to cancel this rider. Coverage under this rider will terminate at the beginning of the period during which your Spouse is no longer eligible, and any unearned Premiums that were collected will be refunded.

If your Spouse resumes legal residence in the United State or its territories or possessions, then Spouse coverage under this rider will become effective on the date your Spouse is again eligible for coverage.

If your Spouse resumes legal residence in the United States or its territories or possessions, then you may re-enroll for Contributory Spouse coverage this rider subject to the following:

- If you re-enroll for Contributory Spouse coverage within 2 months of the date your Spouse is again eligible for coverage, then the maximum amount of Contributory Spouse coverage available will be the lesser of the amount that was in effect on the day before coverage ended and the then current maximum amount of Contributory Spouse coverage available under this rider. Contributory Spouse coverage will become effective on the later of the following:
  - The date you re-enroll for Contributory Spouse coverage, if you are in Active Employment.
  - The date your Spouse is not hospitalized or confined at home under a doctor's care.
  - The date your Spouse is not receiving or applying to receive disability benefits from any source.
  - The date you return to Active Employment, if you are not in Active Employment when your Contributory Spouse coverage would otherwise become effective. **Exception:** Contributory coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.
- If you re-enroll for Contributory Spouse coverage more than 2 months after your Spouse is again eligible for coverage, then Evidence of Insurability on your Spouse will be required. If Evidence of Insurability is approved by us, Contributory Spouse coverage will become effective on the date specified by us.

TERMINATION OF COVERAGE

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date you voluntarily cancel this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The date your Spouse is no longer an eligible Spouse as defined by this rider.
- The end of the period for which Premiums for this rider are paid if the next Premium is not paid by its due date, subject to the Policy grace period.

We will pay benefits for a loss that occurs while your Spouse is insured under this rider.

CONVERSION

You may convert Spouse life insurance, without Evidence of Insurability, to an individual life insurance policy if Spouse life insurance under this rider stops for any reason other than nonpayment of Premium, your voluntary cancellation of this rider, your Spouse ceasing to be an eligible Spouse as defined, or your death. You may also convert any part of Spouse life insurance that reduces due to a BENEFIT REDUCTION as described on the SCHEDULE OF BENEFITS or your change from one eligible class to another or a Policy change. If you have made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Spouse may convert Spouse life insurance, without Evidence of Insurability, to an individual life insurance policy if Spouse life insurance under this rider stops because your Spouse is no longer an eligible Spouse as defined, or because of your death.

Only life insurance is eligible for conversion. The maximum amount of life insurance eligible for conversion cannot be greater than the amount of Spouse life insurance you had prior to termination. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which your Spouse remains eligible under the Policy are not eligible for conversion.

To convert Spouse life insurance, application must be made and the first premium paid to us within 31 days of the date any part of Spouse life insurance under this rider terminates (the "conversion period"). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of Spouse life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of

the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

Application for conversion may be for the entire amount of Spouse life insurance that is terminating under this rider, or a lesser amount. The maximum amount of Spouse life insurance coverage eligible for conversion will be reduced by any amount of Spouse life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. Premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your Spouse's class of risk, and your Spouse's attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept the application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, Spouse life insurance will continue under the terms of this rider. If your Spouse dies within the conversion period, any life insurance amount that was eligible for conversion will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

INCONTESTABILITY

Any statement made by you or your Spouse is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you or your Spouse and a copy of such statement of insurability has been given to you or to the Beneficiary. Except for fraud, we will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your Spouse's lifetime. Except for fraud, we will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your Spouse's lifetime. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date when permitted by applicable law in the governing jurisdiction.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

MISSTATEMENT OF AGE

If Premiums are based on your Spouse's age and you have misstated your Spouse's age, then your Spouse's correct age will be used to determine if insurance is in effect and, as appropriate, the Premium and/or benefits will be adjusted. We may require satisfactory proof of your Spouse's age before paying any claim.

BENEFICIARY

You are the Beneficiary for proceeds that become payable at your Spouse's death under this rider. If you have made an absolute assignment of your insurance, then during your lifetime the current owner is the Beneficiary. You, or the current owner if ownership was assigned, are automatically the Beneficiary for these proceeds and this designation may not be changed. See the Portability Rider for information about the eligible Beneficiary for continued coverage after your death or divorce. If the Beneficiary is not living on the date payment if made, benefits are payable to the Beneficiary's estate. Please refer to the LIFE INSURANCE BENEFITS section for more information about payment.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that your Spouse died while Spouse insurance under this rider is in force. See the CONVERSION provision for information about death benefits payable during the conversion period following your death. The death benefit is the amount of Spouse life insurance for the eligible class as shown on the SCHEDULE OF BENEFITS in effect on the date of your Spouse's death.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your Spouse's death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this rider.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Spouse's death. **Exception:** If your Spouse dies during the conversion period following your death and you would otherwise have been the Beneficiary, we will pay the proceeds to your estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your Spouse's death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

EXCLUSIONS AND LIMITATIONS

If your Spouse commits suicide while sane or insane within two years of the date Spouse insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period your Spouse was continuously covered under this rider and any previous group term life policy issued to the Policyholder during your Spouse's lifetime.

If your Spouse commits suicide while sane or insane within two years from the date an increase in Supplemental Spouse life insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

CHILDREN'S LIFE INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

SUPPLEMENTAL CHILDREN'S LIFE INSURANCE

Supplemental Children's life insurance is Contributory by Employees.

Eligible Class(es)	Amount
Child or Children	Choice of $10,000 or $15,000 or $20,000 or $25,000

MAXIMUM AMOUNT OF SUPPLEMENTAL CHILDREN'S LIFE INSURANCE

$25,000

The Supplemental Children's life insurance amount will not exceed the Supplemental Employee life insurance amount in force.

You may not elect a higher amount of Supplemental Children's life insurance than Supplemental Employee life insurance.

DEFINITIONS

Child or **Children** means a child from live birth but less than 26 years of age who is one of the following:

- Your natural or adopted child (including a child placed for adoption).
- Your stepchild.
- A child of your domestic partner or civil union partner who is recognized as equivalent to a spouse in the state with governing jurisdiction of the Policy.
- A child of your domestic partner as defined by the Employer if you have completed and Signed a declaration of domestic partnership on a form acceptable to the Employer.
- Your foster child or a child or grandchild for whom you are a legal guardian.

The child must also meet all of the following conditions:

- Be unmarried.
- Not be in a domestic partnership or civil union that is recognized as equivalent to marriage in the state with governing jurisdiction of the Policy.
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.
- Not be insured by an individual policy that was issued under any conversion right of this rider.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing.

Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit. If the Child becomes capable of self-sustaining employment and proof of the Child's incapacity can no longer be furnished to us, you may convert your Child's life insurance to an individual life insurance policy as described in the CONVERSION provision of this rider.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

ENROLLMENT

If you have a Child eligible for coverage, you must enroll for Contributory Children's coverage before Contributory coverage will become effective. We or the Employer will provide you with the forms or information needed to complete your enrollment.

No enrollment is required if the Policy replaces a group policy issued by us or by another insurance company, and your Children were covered under the prior policy on the day before that policy was replaced by our Policy. The amount of Contributory coverage on your Children that becomes effective on our Policy effective date will be at the same level as under the prior policy, subject to the terms of our Policy including any maximum coverage amounts under our Policy.

EFFECTIVE DATE OF COVERAGE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Children are eligible for coverage, if you enroll for Children's coverage on or before that date.
- The date you enroll for Children's coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.
- The date your Child is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date that Child's coverage would otherwise become effective. **Exception**: This does not apply to a newborn.

Your eligible newborn Child is automatically covered for the first 31 days after birth. This includes an adopted newborn Child who is placed with you within 31 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then Contributory coverage for the newborn will be at the lowest level available. If you do not already have Children's coverage under this rider, then Child coverage beyond the 31st day is subject to the conditions regarding application and Active Employment.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 31 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 31 days after birth, the "event" will be the date of placement. No additional premium is required.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Children's coverage begins, any increased or additional Contributory coverage will take effect on the latest of the following:

- The Policy anniversary that is on or next follows the date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment on the date the increased or additional coverage would otherwise start.
- The date your Child is no longer hospitalized, or confined at home under a doctor's care, or receiving or applying to receive disability benefits from any source, if any of these conditions are true on the date that Child's increased or additional coverage would otherwise start.

Any decrease in coverage will take effect on the next Policy anniversary but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The date the Child is no longer an eligible Child as defined by this rider. Eligibility of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date you voluntarily cancel this rider in Writing, as allowed by the Employer unless prohibited by federal and state law.
- The date you no longer have an eligible Child as defined by this rider.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the Policy's grace period.

If coverage for your Children ends and this rider terminates because you no longer have an eligible Child as defined by this rider, then you should notify the Policyholder to cancel this rider.

We will pay benefits for a loss that occurs while your Child is insured under this rider.

CONVERSION

You may convert Children's life insurance, without Evidence of Insurability, to an individual life insurance policy if a Child's life insurance under this rider stops for any reason other than nonpayment of Premium, your voluntary cancellation of this rider, your Child reaching the termination age under this rider, or your death. You may also convert any part of Children's life insurance that reduces due to your change from one eligible class to another or a Policy change. If you have made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Child may convert Children's life insurance, without Evidence of Insurability, to an individual life insurance policy if that Child's life insurance under this rider stops because your Child reaches the termination age under this rider, or because of your death. If a Child is too young to contract for life insurance after your death, then a parent or a court-appointed guardian of the Child may apply for conversion of that Child's coverage.

Only life insurance is eligible for conversion. Conversion does not include any additional benefits such as accelerated death benefits, accidental death and dismemberment benefits, or waiver of premium benefits. Any amounts of coverage for which your Child remains eligible under the Policy are not eligible for conversion.

To convert Children's life insurance, application must be made and the first premium paid to us within 31 days of the date any part of a Child's life insurance under this rider terminates (the "conversion period"). You will be given Written notice, in person or at your last known address, of your conversion right at least 15 days before the date any part of Children's life insurance ends. Your right to convert will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your right to convert extend beyond 60 days after the expiration of the conversion period. Any extension of time allowed for returning the completed application and first premium will not change the length of the conversion period itself.

Application for conversion may be for the entire amount of Children's life insurance that is terminating under this rider, or a lesser amount. The maximum amount of Children's life insurance coverage eligible for conversion will be reduced by any amount of Children's life insurance for which you become eligible under any group policy within 31 days after the beginning of the conversion period. Premiums for the conversion policy will be based on our rates then in use, the form and amount of insurance, your Child's class of risk, and your Child's attained age at the beginning of the conversion period. The conversion policy may be any individual life insurance policy then customarily offered by us for conversion, other than term insurance. The conversion policy will not include any additional benefits. When we accept the application and first premium, the conversion policy will become effective on the 32nd day after the date the life insurance under the Policy terminated.

During the conversion period, Children's life insurance will continue under the terms of this rider. If your Child dies within the conversion period, any life insurance amount that was eligible for conversion will be payable as a death benefit under the Policy and any premiums paid for conversion will be refunded to the Beneficiary.

INCONTESTABILITY

Any statement made by you or your Child is considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written statement of insurability which has been Signed by you or your Child and a copy of such statement of insurability has been given to you or to the Beneficiary. Except for fraud, we will not use such statement relating to insurability to contest life insurance after it has been in force for two years during your Child's lifetime. Except for fraud, we will not use such statement to contest an increase or benefit addition to such insurance, after the increase or benefit has been in force for two years during your Child's lifetime. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date when permitted by applicable law in the governing jurisdiction.

The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

BENEFICIARY

You are the Beneficiary for proceeds that become payable at your Child's death under this rider. If you have made an absolute assignment of your insurance, then during your lifetime the current owner is the Beneficiary. You, or the current owner if ownership was assigned, are automatically the Beneficiary for these proceeds and this designation may not be changed. See the Portability Rider for information about the eligible Beneficiary for continued coverage after your death. Please refer to the LIFE INSURANCE BENEFITS section for more information about payment.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

LIFE INSURANCE BENEFITS

We pay a death benefit to the Beneficiary if we receive Written proof that your Child died while Children's insurance under this rider is in force. See the CONVERSION provision for information about death benefits payable during the conversion period following your death. The death benefit is the amount of Children's life insurance on that Child for the eligible class as shown on the SCHEDULE OF BENEFITS in effect on the date of your Child's death.

NOTICE OF CLAIM AND PROOF OF LOSS

A claim form is available from the Employer or us. The process for completing the claim form and submitting the claim form will be explained in the claim form paperwork. Proof of loss, including any attachments indicated on the claim form as required, should be sent directly to us at the address indicated on the form. We may also require information from the Employer in order to verify eligibility.

Proof of loss consists of a certified copy of your Child's death certificate or other lawful evidence providing equivalent information, and proof of the claimant's interest in the proceeds.

We will review proof of loss we receive in order to determine our liability and the correct payee(s). If we approve the claim, we will pay the benefits subject to the terms of this rider.

PAYMENT OF PROCEEDS

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Child's death. **Exception:** If your Child dies during the conversion period following your death and you would otherwise have been the Beneficiary, we will pay the proceeds to your estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate.

We will pay the death benefit to the Beneficiary in one sum or in a method comparable to one sum. Other methods of payment may be made available to the Beneficiary at the time of claim.

Any payment we make in good faith will discharge our liability to the extent of such payment.

PAYMENT OF INTEREST

We pay interest on the death benefit proceeds, accruing from the date of your Child's death up to the date of payment. The minimum interest rate payable will be the interest rate applicable for funds left on deposit with us as of the date of death.

Interest will accrue at an annual rate of 10% plus the interest rate applicable for funds left on deposit beginning with the date that is 31 calendar days from the latest of the dates below and continuing up to the date of payment:

- The date we receive due proof of loss following death.
- The date we receive sufficient information to determine our liability, the extent of our liability, and the appropriate payee legally entitled to the proceeds.
- The date that legal impediments to payment of proceeds that depend on the action of parties other than us are resolved and sufficient evidence of this resolution is provided to us. Legal impediments to payment include but are not limited to: the establishment of guardianships and conservatorships; the appointment and qualification of trustees, executors and administrators; and the submission of information required to satisfy state or federal reporting requirements.

EXCLUSIONS AND LIMITATIONS

If your Child commits suicide while sane or insane within two years of the date that Child's insurance starts, we will refund to the Beneficiary any Premiums paid instead of paying a death benefit. The two year period includes the period your Child was continuously covered under this rider and any previous group term life policy issued to the Policyholder during your Child's lifetime.

If your Child commits suicide while sane or insane within two years from the date an increase in Supplemental Children's life insurance (other than a scheduled or automatic increase) became effective, we will pay a death benefit for the amount of insurance that was effective before the increase. We will refund to the Beneficiary any Premiums paid for the increased amount of insurance.

Executed at our Home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Amelia (Amy) J. Vaillancourt
President

Melissa A. O'Donnell
Secretary

WAIVER OF PREMIUM RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform for remuneration or profit any other job for which you are fit by education, training or experience. If we pay you an Employee benefit under the Accelerated Death Benefit Rider, you will automatically meet the definition of Total Disability under this rider.

Waiting Period means the 5 month period immediately following the date you stop Active Employment during which you are continuously Totally Disabled. If you return to work for a total of 30 days or less during the Waiting Period and then stop work again due to the same Total Disability, your Waiting Period will not be interrupted. If we pay you an Employee benefit under the Accelerated Death Benefit Rider, you will automatically satisfy the Waiting Period requirement under this rider.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.
- The date life insurance coverage is being continued under the terms of the Portability Rider.

This rider will not terminate while Premiums are being waived under the terms of this rider.

TERMINATION OF COVERAGE

The TERMINATION OF COVERAGE provision in your Certificate is revised to add this item to the terms under which your coverage ends:

- The date Premiums are no longer being waived under the Waiver of Premium Rider, if you are not in an eligible class on that date.

The TERMINATION OF COVERAGE provision in your Spouse Life Insurance Rider is revised to add this item to the terms under which your Spouse coverage ends:

- The date we approve a claim under the Waiver of Premium Rider.

The TERMINATION OF COVERAGE provision in your Children's Life Insurance Rider is revised to add this item to the terms under which your Children's coverage ends:

- The date we approve a claim under the Waiver of Premium Rider.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

WAIVER OF PREMIUM BENEFIT

If you become Totally Disabled while covered under this rider and meet the other conditions below, we will waive Premiums due under the Policy and continue insurance during your Total Disability, according to the terms of this rider. When we waive Premiums, the amount of continued life insurance equals the amount that would have been provided if you had not become Totally Disabled. That amount will reduce or stop according to the Certificate and riders in effect on the date Total Disability began. Premiums that are waived are not deducted from any proceeds that may become payable.

Continued life insurance includes the following if effective on the date before your Total Disability began:

- Employee life insurance.
- the Accelerated Death Benefit Rider.

Continued life insurance does not include:

- the Spouse Life Insurance Rider.
- the Children's Life Insurance Rider.
- the Portability Rider.
- any continuation rider(s).

Any rider or coverage that is not eligible for waiver of premium under this rider will terminate on the date that coverage would otherwise end due to your termination of Active Employment. See the CONVERSION provision of the Certificate and riders for more information about conversion.

Continued insurance is subject to all other terms of the Policy.

CONDITIONS FOR WAIVER OF PREMIUM

All of the following conditions must be met in order to waive Premiums:

- Total Disability begins before your 60th birthday.
- You are covered under this rider on the date your Total Disability begins.
- You are continuously Totally Disabled for the entire Waiting Period and up to the date we approve your claim for waiver of Premium. Premiums due for life insurance and this rider are subject to the provisions of any continuation riders.
- You provide notice of claim and proof of Total Disability to us as described below.

NOTICE OF CLAIM AND PROOF OF TOTAL DISABILITY

You must send us written notice of claim while you are living, while you are Totally Disabled, and within 9 months of the date your Total Disability begins. Failure to give notice within 9 months will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of your Total Disability. Proof of your Total Disability includes information from your Doctor, at your expense, regarding your condition and your inability to work. We may require additional information from the Employer in order to verify eligibility. We may also require you to be interviewed by our authorized representative. Proof of your Total Disability, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). Claim forms are available from the Employer or us.

We have the right to request a second or third medical opinion, at our expense, in order to determine if you are Totally Disabled. Any second medical opinion may include a physical examination by a Doctor or other medical practitioner of our choice. In the case of conflicting medical opinions, Total Disability will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to you and us.

If you die within 12 months of the date your Total Disability began and all of the following are true:

- You didn't previously submit a claim under this rider, and
- You would otherwise have met the CONDITIONS FOR WAIVER OF PREMIUM, and
- Life insurance for you would still have been in force under the Policy on the date of your death if a claim for waiver of Premium had been approved, then the Beneficiary can submit a claim for death benefit proceeds along with notice of claim under this rider and proof that your Total Disability continued without interruption from the last day you were in Active Employment until your death.

EFFECTIVE DATE OF WAIVER OF PREMIUM

When we approve your claim, Premiums are waived as of the date after the Waiting Period ends. We will refund any Premiums we received after that date to the Policyholder or to you, as appropriate. We will notify you in writing when your claim is approved.

We will notify you and the Employer if we deny your claim. If we deny your claim, conversion is available as described in the CONVERSION provision of the Certificate and riders.

If we approve a claim for which notice of claim was provided to us more than 12 months after the date your Total Disability began, then any refund of Premiums will not exceed 12 months of Premiums dating back from the date the notice of claim was received by us.

If you converted life insurance due to your termination of Active Employment and then a claim under this rider is approved, the conversion policy must be surrendered without claim. We will cancel the conversion policy as of the date of issue and refund any premiums paid. We will retain any beneficiary designation you made under your conversion policy as the Beneficiary under the group Policy, unless you change the Beneficiary as described under the BENEFICIARY provision in the Certificate. If the conversion policy is not surrendered without claim, then Premiums will not be waived under this rider. The same coverage(s) that would otherwise end due to your termination of Active Employment may not be both continued under this rider and converted.

PROOF OF CONTINUED TOTAL DISABILITY

After your claim is approved, we may periodically request additional proof of your continuing Total Disability, but not more frequently than once every six months.

TERMINATION OF WAIVER OF PREMIUM

We will stop waiving Premiums on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give us proof of Total Disability as requested.
- Your 65th birthday.

If Premiums are no longer waived, insurance under the Policy will stay in force only if all of the following conditions are met:

- Life insurance is in force for Active Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your Premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your Premium payments are resumed.

You will not be eligible for portability under any Portability Rider on the date we stop waiving your Premiums.

CONVERSION AFTER TERMINATION OF WAIVER OF PREMIUM

When Waiver of Premium under this rider ends, and if you are not otherwise eligible for insurance under the Policy, then conversion will be available as described in the CONVERSION provision of the Certificate and riders.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If we deny a claim in whole or in part (an “adverse benefit determination”), we will provide written notice of the adverse benefit determination to you as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, you will have 45 days to provide the specified information. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable you to receive the benefits sought and an explanation of why it is needed.
- A description and a copy of relevant claim review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

You may request a review of an adverse benefit determination (an “appeal”) at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of you or your duly authorized representative. As part of the appeal you also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to your claim. This includes

the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Prior to rendering an adverse decision on appeal, we will provide notice to you of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. We will also notify you if we have new or additional rationale for an adverse appeal determination. We will then provide you with a reasonable opportunity to review and respond to this new information before making our decision. The time period we have to make our determination will be tolled while we are waiting for your response.

Following our review of the appeal, we will provide you with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement of your right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

ACCELERATED DEATH BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

THE AMOUNT OF LIFE INSURANCE WILL BE REDUCED IF AN ACCELERATED DEATH BENEFIT IS PAID. PREMIUM PAYMENTS WILL ALSO BE REDUCED. THE RECEIPT OF ACCELERATED DEATH BENEFITS MAY BE A TAXABLE EVENT.YOU SHOULD SEEK ADDITIONAL INFORMATION ABOUT THE TAX STATUS OF THE PAYMENT FROM A PERSONAL TAX ADVISOR.

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SCHEDULE OF BENEFITS

Accelerated Death Benefit

You: ..... 50% of the amount of Basic and Supplemental Life Insurance in force, or $100,000, whichever is less.

You must have at least $10,000 of life insurance coverage in force.

DEFINITIONS

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Institution means any hospital, convalescent hospital, health clinic, nursing home, extended care facility, or other institution devoted to the care of sick, infirm, or aged persons.

Qualifying Event means either of the following:

- Terminal Illness.
- A medical condition that is reasonably expected to require continuous confinement in an Institution and you are expected to remain there for the rest of your life.

Terminal Illness means a medical condition that is expected to result in your death within 24 months and from which there is no reasonable chance of recovery.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

This rider will not terminate while this rider is being continued under the terms of another rider.

Termination of this rider will not prejudice the payment of benefits for a Qualifying Event that occurred while this rider was in force.

CONVERSION

When this rider terminates, conversion of this rider is not available.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

ACCELERATED DEATH BENEFIT

Accelerated death benefit proceeds is the amount we pay to you, while you are living, if you have a Qualifying Event. The accelerated death benefit proceeds are paid only once. This payout is the only settlement option available prior to your death.

The benefit is the amount of the accelerated death benefit shown on the SCHEDULE OF BENEFITS in effect on the date you request accelerated death benefit proceeds.

CONDITIONS FOR THE ACCELERATED DEATH BENEFIT

To receive a benefit payment under this rider, all of the following conditions must be met:

- Any required life insurance Premium is paid through the date you request proceeds under this rider.
- You request proceeds in writing while you are living and before you attain age 65. If you are unable to request payment yourself, your legal representative may request it on your behalf.
- You are insured for life insurance benefits under the Policy.
- You are insured for the minimum amount of life insurance as shown on the SCHEDULE OF BENEFITS in order to be eligible for benefits under this rider.
- The benefit percentage elected will equal no less than $5,000.
- You provide to us written proof from a Doctor that you have a Qualifying Event.
- You provide to us written consent for payment from any irrevocable beneficiary and, in community property states, from your spouse.

NOTICE OF CLAIM AND PROOF OF LOSS

You must send us written notice of claim while you are living and within 90 days of the date the Qualifying Event is diagnosed. Failure to give notice within 90 days will not invalidate or reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

Notice of claim includes proof of loss. Proof of loss includes information from your Doctor, at your expense, regarding your medical condition. We may require additional information from the Employer in order to verify eligibility. Proof of loss, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s). A claim form is available from the Employer or us.

We have the right to request a second or third medical opinion, at our expense, in order to determine if you are eligible under the terms of this rider. Any second medical opinion may include a physical examination by a Doctor designated by us. In the case of conflicting medical opinions, eligibility will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to you and us.

When you request proceeds under this rider and upon payment of the benefit proceeds, you will be provided with a disclosure demonstrating the effect of the acceleration on the death benefit and Premium, and any other effects on coverage. This disclosure will also be provided to any assignee of record or irrevocable beneficiary of record.

BENEFIT PAYMENT

We pay the benefit proceeds to you immediately upon receipt of due written proof of loss. If you are not the current owner of coverage under the Certificate or riders on the date proceeds are requested under this rider, then while you are living the benefit proceeds are payable to the current owner.

For coverage continued by your Spouse after your death or divorce, any benefit proceeds under this rider are payable to your Spouse. If your Spouse is not the current owner of coverage under the Spouse Life Insurance Rider and Children's Life Insurance Rider on the date accelerated death benefit proceeds are requested, then the benefit proceeds are payable to the current owner.

Benefit proceeds received for Terminal Illness will be paid as a lump sum.

For a Qualifying Event other than Terminal Illness, you may elect to receive the benefit proceeds as a lump sum or in monthly installments. You may elect monthly installments equal to 1-20% of the full amount of the benefit payable under this rider. The minimum monthly installment is $500. Monthly installments are paid once every 30 days until the full accelerated benefit amount has been paid out. Each monthly installment paid will reduce the remaining death benefit by the same amount.

Any payment we make in good faith will discharge our liability to the extent of such payment.

If you die after you request proceeds under this rider but before any proceeds are received, then the accelerated death benefit claim will be cancelled and any death benefit will be payable under the terms of the Certificate and riders. If any monthly installments are remaining at the time of death, the remaining amount will be payable as a death benefit under the terms of the Certificate and riders.

EFFECTS ON COVERAGE

When we pay this benefit, coverage is affected in the following ways:

- Your Basic and Supplemental Life Insurance amount is reduced by the accelerated death benefit proceeds paid under this rider.
- Your life insurance amount that may be converted is reduced by the accelerated death benefit proceeds paid under this rider.
- You will not be eligible to increase your Contributory life insurance amount.
- Premium is reduced based upon the remaining life insurance amount. Such Premium must be paid, unless waived under the Waiver of Premium Rider, to keep the life insurance coverage in force.
- You will not be able to reinstate your coverage to its full amount in the event of a recovery from a Qualifying Event.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.
- Your Children who are covered under your Children's Life Insurance Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

Temporary Layoff means you are absent from Active Employment for a period of time for which continuation of life insurance is available under the Employer's written plan for temporary layoffs, and the layoff is not intended to be permanent.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform any other job for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence, or
- Total Disability, or
- Temporary Layoff,

then life insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

FAMILY AND MEDICAL LEAVE

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of life insurance during an FMLA or State FML Leave of Absence, then coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

SICKNESS OR INJURY

If you are on a Leave of Absence due to your sickness or injury, including Total Disability, then coverage for all Covered Persons may be continued until the last day of the month which is on or next follows the date which is 12 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

MILITARY LEAVE

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and applicable state law, then coverage for all Covered Persons may be continued until the last day of the month which is on or next follows the date which is 12 months after the date you stopped Active Employment.

This continuation of coverage includes all riders that in effect on the date before the Leave of Absence began.

TEMPORARY LAYOFF

If you stop Active Employment due to a Temporary Layoff, then coverage for all Covered Persons may be continued until the last day of the month which is on or next follows the date which is 110 days after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before you stopped Active Employment.

OTHER LEAVE OF ABSENCE

If you are on a Leave of Absence for any other reason, then coverage for all Covered Persons may be continued until the last day of the month which is on or next follows the date which is 110 days after the date you stopped Active Employment.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy as an Active Employee.
- The date of your death.
- The date you become covered under another group life insurance policy as an employee or member.
- The date Premiums are waived under the Waiver of Premium Rider.
- The date the Policy terminates.
- The date coverage for all Active Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, other than by waiver of Premium, insurance under the Policy will stay in force only if all of the following conditions are met:

- Life insurance is in force for Active Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your Premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your Premium payments are resumed.

CONVERSION FOLLOWING TERMINATION OF CONTINUATION

When continuation under this rider ends other than for nonpayment of Premium or waiver of Premium, and if the Covered Person is not otherwise eligible for insurance under the Policy, then conversion of life insurance will be available as described in the CONVERSION provision of the Certificate and riders.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during any period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Active Employees under the Policy, then the terms of the Certificate and riders will apply.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA) – FOR TOTAL DISABILITY CLAIMS ONLY

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide written notice of the adverse benefit determination to you as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, you will have 45 days to provide the specified information. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable you to receive the benefits sought and an explanation of why it is needed.
- A description and a copy of relevant claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

You may request a review of an adverse benefit determination (an "appeal") at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of you or your duly authorized representative. As part of the appeal you also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to your claim. This includes the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Prior to rendering an adverse decision on appeal, we will provide notice to you of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. We will also notify you if we have new or additional rationale for an adverse appeal determination. We will then provide you with a reasonable opportunity to review and respond to this new information before making our decision. The time period we have to make our determination will be tolled while we are waiting for your response.

Following our review of the appeal, we will provide you with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the

special circumstances involved and the date a decision is expected. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information. If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement of your right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.”

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

TOTAL DISABILITY CONTINUATION RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:
- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.
- Your Children who are covered under your Children's Life Insurance Rider.

Doctor means a person who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical physician. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. This definition does not include you or your spouse, or your or your spouse's children, parents, grandparents, grandchildren, siblings and their spouses.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular job, and you are unable to perform any other job for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER
This rider terminates on the date your life insurance terminates.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS
This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

TOTAL DISABILITY CONTINUATION

If life insurance for a Covered Person would otherwise end because you are no longer in Active Employment due to Total Disability, and your continuation of insurance under any other rider has ended, then life insurance coverage for all Covered Persons may be continued under the Policy for a limited period of time. During this continued coverage period, the amount of continued life insurance equals the amount that would have been provided if you had not become Totally Disabled. That amount will reduce or stop according to the Certificate and riders in effect on the date Total Disability began. Premiums are due during the continuation period on the same basis as on the date before Total Disability began.

Continued life insurance includes the following if effective on the date before your Total Disability began:
- Employee life insurance.
- the Spouse Life Insurance Rider.
- the Children's Life Insurance Rider.
- the Accelerated Death Benefit Rider.
- the Waiver of Premium Rider.

Continued life insurance does not include:
- the Portability Rider.
- any other continuation rider(s).

Any rider or coverage that is not eligible for continuation under this rider will terminate on the date that coverage would otherwise end due to your termination of Active Employment. See the CONVERSION provision of the Certificate and riders for more information about conversion.

Continued insurance is subject to all other terms of the Policy.

CONDITIONS FOR TOTAL DISABILITY CONTINUATION
All of the following conditions must be met in order to continue coverage under this rider:
- You are covered under this rider on the date your Total Disability begins.
- You are continuously Totally Disabled for the entire period your coverage is in force during the continuation period of any rider.
- All Premiums due for life insurance and this rider are paid to us through the date we approve your claim under this rider.

NOTICE OF CLAIM AND PROOF OF TOTAL DISABILITY
We must accept your proof of Total Disability in order for this rider to apply. You may request a claim form from the Employer or us in order to submit your proof of Total Disability to us. Proof of your Total Disability includes information from your Doctor, at your expense, regarding your condition and your inability to work. We may require additional information from the Employer in order to verify eligibility. We may also require you to be interviewed by our authorized representative. Proof of your Total Disability, including any attachments indicated on the claim form(s) as required, should be sent directly to us at the address indicated on the form(s).

We have the right to request a second or third medical opinion, at our expense, in order to determine if you are Totally Disabled. Any second medical opinion may include a physical examination by a Doctor or other medical practitioner of

our choice. In the case of conflicting medical opinions, Total Disability will be determined by a third medical opinion that is provided by a Doctor who is mutually acceptable to you and us.

We will notify the Employer if we approve your claim. We will notify you and the Employer if we deny your claim. If we deny your claim, conversion is available as described in the CONVERSION provision of the Certificate and riders.

If we approve your claim and you had previously converted coverage to an individual policy(ies) when your Active Employment terminated, then the individual policy(ies) must be surrendered without claim (other than refund of Premium) in order for coverage to be continued under this rider. The same coverage(s) that would otherwise end due to your termination of Active Employment may not be both continued under this rider and converted. The Beneficiary for your coverage will be the most recent Beneficiary designated under either the group Policy or the individual conversion policy. See the Certificate and riders for more information about the Beneficiary.

After your claim is approved, we may periodically request additional proof of your continuing Total Disability, but not more frequently than once every six months.

If a Covered Person dies while the Policy is in force for Active Employees and all of the following are true:

- You didn't previously submit a claim under this rider, and
- You would otherwise have met the CONDITIONS FOR TOTAL DISABILITY CONTINUATION, and
- Life insurance for the Covered Person would still have been in force under the Policy on the date of the Covered Person's death if a claim under this rider had been approved,

then the Beneficiary can submit a claim for death benefit proceeds along with proof that your Total Disability continued without interruption from the last day you were in Active Employment until the Covered Person's death. Any Premiums that would have been due for continued coverage must be paid.

TERMINATION OF TOTAL DISABILITY CONTINUATION

Continued coverage under this rider will stop on the earliest of the following dates:

- The date you are no longer Totally Disabled.
- The date you do not give us proof of Total Disability as requested.
- Your 65th birthday; however, the continuation period will not be less than 6 months while the Policy is in force for Active Employees.
- The date the Policy terminates.
- The date coverage for all Active Employees under the Policy terminates.
- For your Spouse and Children's coverage, the date that person's life insurance would otherwise end according to the terms of the rider(s).

If coverage is no longer continued under this rider, insurance under the Policy will stay in force only if all of the following conditions are met:

- Life insurance is in force for Active Employees under the Policy, and
- You are in an eligible class for coverage under the Policy, and
- Your Premium payments are continued.

The amount of insurance will be subject to the Certificate and riders in effect on the date you become eligible as an Active Employee.

You will not be eligible for portability under the Portability Rider on the date continued coverage under this rider terminates.

CONVERSION FOLLOWING TERMINATION OF TOTAL DISABILITY CONTINUATION

When continued coverage under this rider ends other than for nonpayment of Premium, and if the Covered Person is not otherwise eligible for insurance under the Policy, then conversion will be available as described in the CONVERSION provision of the Certificate and riders.

DENIALS AND APPEALS FOR PLANS SUBJECT TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If we deny a claim in whole or in part (an "adverse benefit determination"), we will provide written notice of the adverse benefit determination to you as soon as possible, but no more than 45 days after receipt of the claim unless an extension is needed. An extension of 30 days will be allowed for processing the claim for matters beyond our control. You will be given notice of any such extension before the end of the initial 45-day period. If, before the end of the 30-day extension period, we are still unable to render a decision on the claim for matters beyond our control, a second extension of 30 days will be allowed for processing the claim. You will be given notice of any such second extension before the end of the first 30-day extension period. The notice(s) will state the circumstances requiring the extension and the date a decision is expected. The notice(s) will also specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. If additional information is needed, you will have 45 days to provide the specified information. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

A notice of an adverse benefit determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A description of additional information, if any, which would enable you to receive the benefits sought and an explanation of why it is needed.
- A description and a copy of relevant claim review procedure and the time limits applicable to such procedures, including a statement of your right to bring a civil action following an adverse benefit determination on review.
- A statement that if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, a copy of such rule, guideline, protocol or other criterion will be provided free of charge to you upon request.

You may request a review of an adverse benefit determination (an "appeal") at any time during the 180 day period following receipt of the notice of the determination. We will consider an appeal upon written application of you or your duly authorized representative. As part of the appeal you also have the right, upon request and free of charge, to reasonable access to and copies of all documents, records and other information relevant to your claim. This includes the identification of any medical or vocational experts whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination. You may, in the course of this appeal, review relevant documents and submit to us written comments, documents, records and other information relevant to your claim.

Our review of the appeal will be conducted by someone who is neither the individual who made the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. If the determination was based in whole or in part on a medical judgment, our review of the appeal will include consultation with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will be someone who is neither an individual who was consulted in connection with the original adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

Following our review of the appeal, we will provide you with a written decision of the final determination of the claim. This decision will be issued as soon as possible, but no more than 45 days after the receipt of the appeal unless an extension is needed. An extension of 45 days will be allowed for making this decision if special circumstances are present. You will be given notice of any such extension before the end of the 45-day period. The notice will state the special circumstances involved and the date a decision is expected. If an extension is needed due to your failure to submit information necessary to decide a claim, the extension period will be tolled from the date on which notification of the extension is sent to you until the date on which you respond to the request for additional information.

Prior to rendering an adverse decision on appeal, we will provide notice to you of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. We will also notify you if we have new or additional rationale for an adverse appeal determination. We will then provide you with a reasonable opportunity to review and respond to this new information before making our decision. The time period we have to make our determination will be tolled while we are waiting for your response.

If we send an adverse benefit determination following our review of the appeal, the notice of the determination will be written in an understandable manner and include the following:

- The specific reason(s) for the adverse benefit determination.
- Reference to the specific provision on which the determination is based.
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim.
- A statement of your right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
- The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Amelia (Amy) J. Vaillancourt
President



Melissa A. O'Donnell
Secretary

PORTABILITY RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

This rider is made a part of the Group Term Life Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:

- You, if you are covered for life insurance under the Policy.
- Your Spouse who is covered under your Spouse Life Insurance Rider.
- Your Children who are covered under your Children's Life Insurance Rider.

GENERAL PROVISIONS

ELIGIBILITY FOR RIDER

If you are covered under the Policy, then you are eligible for this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your life insurance coverage effective date.

EFFECTIVE DATE OF RIDER

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION OF RIDER

This rider terminates on the earliest of the following:

- The date your life insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

This rider will not terminate while your coverage is being continued under the terms of this rider.

CONFORMITY WITH INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION STANDARDS

This rider was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission standards. Any provision of this rider which, on the provision's effective date, conflicts with Interstate Insurance Product Regulation Commission standards for this product type, is automatically amended to conform to the Interstate Insurance Product Regulation Commission standards for this product type as of the provision's effective date.

PORTABILITY

If there are any Covered Persons on portability under this rider when the Policy would otherwise terminate, the Policy will remain in force to cover those Covered Persons on portability until the date there are no Covered Persons on portability.

EMPLOYEE PORTABILITY

Portability means you can apply to continue coverage under the same Policy after it would otherwise terminate, if certain conditions are met. Continued coverage under this rider includes the following:

- Employee life insurance under the Certificate
- Spouse life insurance under the Spouse Life Insurance Rider, if Employee life insurance is also continued
- Children's life insurance under the Children's Life Insurance Rider, if Employee life insurance is also continued
- Coverage under all riders except the Waiver of Premium Rider and any Continuation riders

CONDITIONS FOR EMPLOYEE PORTABILITY

All of the following conditions must be met:

- You must apply for a minimum of $5,000 in continued Employee coverage.
- If you apply for portability of Spouse coverage, you must apply for a minimum of $5,000 in continued Spouse coverage.
- If you apply for portability of Children's coverage, you must apply for a minimum of $1,000 in continued Children's coverage.
- You have not applied for conversion of life insurance on the same amounts.
- You apply for portability before the date you attain age 79.
- You apply for portability within 31 days of the date your Supplemental life insurance coverage would otherwise terminate due to any of the following:
  - You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Active Employees.
  - The Policyholder terminates coverage under the Policy for all Active Employees, and does not replace it with another life insurance plan.
  - You are no longer in an eligible class for coverage under the Policy.
  - Any other continuation provided under the Policy ends.

You will be given notice of your portability and conversion rights at least 15 days before the date any part of your life insurance ends. Your portability rights will expire on the later of 16 days after you are given such notice or the end of the conversion period, but in no event will your portability rights extend beyond 60 days after the expiration of the conversion period.

Portability is not available for any of the following:

- Any amounts of life insurance for which a conversion application has been received by us.
- Coverage that reduces due to your change from one eligible class to another.
- Coverage that reduces due to a Policy change.
- Coverage that is being continued under the Waiver of Premium Rider.
- Coverage that ends due to termination under the Waiver of Premium Rider.

You may apply for conversion of any terminating life insurance amounts that are not eligible for portability. See the CONVERSION provision of the Certificate and riders.

APPLICATION FOR EMPLOYEE PORTABILITY

You may apply for portability on the same amount of insurance that would otherwise terminate or a lesser amount according to the available amounts on the portability application. You must apply for portability of your insurance in order to continue Spouse and Children's insurance. The amount(s) that can be continued under this rider are subject to the following maximum(s):

- The lesser of 5 times your Basic Yearly Earnings or $750,000 total Employee life insurance
- $250,000 total Employee life insurance if you are age 60 or older
- $150,000 total Spouse life insurance, but not to exceed the total amount of Employee life insurance continued
- $25,000 total Children's life insurance, but not to exceed the total amount of Employee life insurance continued

You may apply for conversion of any terminating life insurance amounts that exceed the maximum amount(s) eligible for portability. See the CONVERSION provision of the Certificate and riders. You will not be eligible to increase the ported coverage amount(s). Ported coverage is subject to all the terms of the Policy.

If you die within 31 days of the date you become eligible for portability under this rider (the "conversion period"), any life insurance amount that you were entitled to convert will be payable according to the CONVERSION provision of the Certificate and riders. If your Spouse or Child dies during the conversion period, any Spouse or Children's life insurance amount that you were entitled to convert will be payable according to the CONVERSION provision of your Spouse Life Insurance Rider or Children's Life Insurance Rider. Any unearned Premiums paid for portability will be refunded to the Beneficiary.

You do not need to provide Evidence of Insurability in order to apply for portability. You may complete the Evidence of Insurability section of the application if you want to request a lower portability Premium rate. If we accept your application for portability but decline any Evidence of Insurability, you may either pay the standard portability Premium rate or apply for conversion of life insurance within 31 days of the date we provide you written notice of conversion. See the CONVERSION provision of the Certificate and riders. Your coverage must be ported under the terms of this rider in order for Spouse or Children's coverage to be ported.

Your application for portability must be approved by us. When we approve your application, ported coverage under this rider will be effective on the day after the conversion period ends. Premiums under this rider will be billed directly to you on a quarterly basis. Each quarterly Premium due will include a billing fee as indicated on the portability application or subsequent notice. Continued Premium payment is required to keep coverage in force. The initial Premium will be based on the portability Premium rates in effect at the time you apply for portability. We may change the portability Premium rates at any time upon 90 days written notice to you.

If you have made an absolute assignment of your insurance, only the current owner may apply for portability.

MISSTATEMENT OF EVIDENCE OF INSURABILITY FOR EMPLOYEE PORTABILITY

If your or your Spouse's Premium rates are based on Evidence of Insurability as provided on your application for portability, and you or your Spouse have misstated any information requested on the application for portability such that the lower Premium rates would not have been approved by us, then we will adjust your or your Spouse's Premium to the standard portability Premium rates. Any back Premium due as a result of this adjustment will be required. We will not adjust your or your Spouse's Premium after coverage has been continued under this rider for two years during your or your Spouse's lifetime.

GRACE PERIOD FOR EMPLOYEE PORTABILITY

You have a grace period of 31 days for the payment of any Premium due. During the grace period coverage will remain in force. If full Premium payment is not received by us by the due date, we will give written notification to you that if the Premium is not paid by the end of the grace period then all coverage will end on the last day of the grace period. If we fail to give such written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving written notice of such intent to you, and such notice will specify the date all coverage will terminate if the Premium remains unpaid. You are required to pay a pro rate Premium for any period coverage was in force during the grace period. Premium payment is required for any grace period, any extension of such period, and any period for which coverage was in effect and Premium was not paid.

TERMINATION OF EMPLOYEE PORTABILITY

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date you attain age 80.
- The date you die.
- The date we approve a claim under the Waiver of Premium Rider.

You may apply for conversion of any life insurance amount(s) that terminate when portability under this rider ends, other than for nonpayment of Premium or at your death. Your surviving Spouse and Children may apply for conversion of any Spouse and Children's life insurance amount(s) that terminate when you die. See the CONVERSION provision of the Certificate and riders.

Any unearned Premiums paid for ported coverage will be refunded.

PORTABILITY AT DEATH OR DIVORCE

If you die, your Spouse can apply to continue coverage under the same Policy if certain conditions are met. Continued coverage following your death includes the following:

- Spouse life insurance under the Spouse Life Insurance Rider
- Children's life insurance under the Children's Life Insurance Rider

If you divorce, your Spouse can apply to continue coverage under the same Policy if certain conditions are met. Your Spouse's continued coverage following divorce includes the following:

- Spouse life insurance under the Spouse Life Insurance Rider

For purposes of this rider, "divorce" includes annulment.

CONDITIONS FOR PORTABILITY AT DEATH OR DIVORCE

All of the following conditions must be met:

- Your Spouse must have been insured under your Spouse Life Insurance Rider on the date of your death or divorce.
- Your Spouse must apply for portability before the date your Spouse attains age 60.
- Your Spouse must apply for portability within 31 days of your death or divorce.

Your Spouse will be given notice of portability and conversion rights when your Spouse's life insurance ends due to death or divorce. Your Spouse's portability rights will expire on the later of 16 days after your Spouse is given such notice or the end of the conversion period, but in no event will your Spouse's portability rights extend beyond 60 days after the expiration of the conversion period.

Children may be covered following your death only if they would have been eligible for coverage under the eligibility rules in force prior to your death.

Conversion is available for any terminating life insurance amount(s) that are not eligible for portability. See the CONVERSION provision of the riders. Any amounts of life insurance for which an application for conversion has been received by us are not eligible for portability under this rider.

APPLICATION FOR PORTABILITY AT DEATH OR DIVORCE

Your Spouse may apply for portability of the same amount of insurance that would otherwise terminate or a lesser amount according to the available amounts on the portability application. Your Spouse must apply for portability of Spouse insurance in order to continue Children's insurance. Your Spouse may only apply for portability of Children's Insurance in the event of your death. The amount(s) that can be continued under this provision are subject to the following maximum(s):

- $150,000 total Spouse life insurance
- $25,000 total Children's life insurance, but not to exceed the total amount of Spouse life insurance continued

Conversion is available for any life insurance amounts that exceed the maximum amount(s) eligible for portability under this provision. See the CONVERSION provision of the riders. Your Spouse will not be eligible to increase the ported coverage amount. Ported coverage is subject to all the terms of the Policy, Certificate and any riders.

If your Spouse dies within 31 days of the date your Spouse becomes eligible for portability under this provision (the "conversion period"), any Spouse life insurance amount that was eligible for conversion will be payable according to the CONVERSION provision of the Spouse Life Insurance Rider. If your Child dies during the conversion period, any Children's life insurance amount that was eligible for conversion on that Child will be payable according to the CONVERSION provision of the Children's Life Insurance Rider. Any unearned Premiums paid for portability will be refunded to the Beneficiary.

Your Spouse does not need to provide Evidence of Insurability in order to apply for portability. Your Spouse may complete the Evidence of Insurability section of the application if your Spouse wants to request a lower portability Premium rate. If we accept your Spouse's application for portability but decline your Spouse's Evidence of Insurability, your Spouse may either pay the standard portability Premium rate or apply for conversion of life insurance within 31 days of the date we provide your Spouse written notice of conversion. See the CONVERSION provision of the riders. Spouse coverage must be ported under the terms of this rider in order for Children's coverage to be ported.

If we approve your Spouse's application for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under your Spouse Life Insurance Rider. If Children's coverage is ported after your death, your Spouse will also become the owner of the Children's coverage that was previously provided under your Children's Life Insurance Rider. Ported coverage under this provision will be effective on the day after the conversion period ends. Premiums under this provision will be billed directly to your Spouse on a quarterly basis. Each quarterly Premium due will include a billing fee as indicated on the portability application or subsequent notice. Continued Premium payment is required to keep coverage in force. The initial Premium will be based on the portability Premium rates in effect at the time your Spouse applies for portability. We may change the portability Premium rates at any time upon 90 days written notice to your Spouse.

If you have made an absolute assignment of your insurance, the current owner's rights under the Policy will terminate on the date of your death. The current owner's rights regarding your Spouse's insurance will terminate on the date of your divorce. Your Spouse as the new owner under this provision may make an absolute assignment of insurance, as described in the ASSIGNMENT provision of the Certificate.

BENEFICIARY FOR PORTABILITY AT DEATH OR DIVORCE

For coverage continued under this provision, the Beneficiary is named by your Spouse to receive any proceeds payable at your Spouse's death. While your Spouse's coverage is in force under this provision, your Spouse may change the Beneficiary by Written request on a form that is acceptable to us. A Beneficiary designation form is available from us. An accepted designation will take effect as of the date it is Signed but will not affect any payment we make or action we take before receiving the Signed form. If your Spouse has made an absolute assignment of insurance, only the current owner may change the Beneficiary designation for proceeds payable at your Spouse's death.

If an irrevocable Beneficiary is named for proceeds payable at your Spouse's death, the Beneficiary designation can only be changed with the consent of the irrevocable Beneficiary.

There can be one or more Beneficiaries for proceeds payable at your Spouse's death. If two or more Beneficiaries are named and their shares are not specified in the Beneficiary designation, then the Beneficiaries will share any insurance proceeds equally. If a primary Beneficiary does not survive your Spouse, their share will be payable to the remaining primary Beneficiaries. One or more contingent Beneficiaries may be named to receive the proceeds in the event that all of the primary Beneficiaries named do not survive your Spouse.

Your Spouse is the Beneficiary for all other proceeds payable. This Beneficiary designation may not be changed. If your Spouse has made an absolute assignment of insurance, then during your Spouse's lifetime those proceeds are payable to the current owner.

PAYMENT OF PROCEEDS FOR PORTABILITY AT DEATH OR DIVORCE

For coverage continued under this provision, a Spouse death benefit is payable if your Spouse dies while the Spouse Life Insurance Rider is in force. Other benefits are payable if a covered loss occurs while coverage is in force, and while your Spouse is living. See the CONVERSION provision of the Children's Life Insurance Rider for information about death benefits payable during the conversion period following your Spouse's death.

To be eligible to receive proceeds, the Beneficiary must be living on the date of your Spouse's or Child's death or loss under any rider. **Exception:** If your Child dies during the conversion period following your Spouse's death and your Spouse would otherwise have been the Beneficiary, we will pay the Child death benefit proceeds to your Spouse's estate.

If the Beneficiary is eligible to receive proceeds but dies before receiving them, we will pay the proceeds to the Beneficiary's estate. If there is no eligible Beneficiary, we will pay the proceeds to your Spouse's estate.

MISSTATEMENT OF EVIDENCE OF INSURABILITY FOR PORTABILITY AT DEATH OR DIVORCE

If your Spouse's Premium rates are based on Evidence of Insurability as provided on your Spouse's application for portability, and your Spouse has misstated any information requested on the application for portability such that the lower Premium rates would not have been approved by us, then we will adjust your Spouse's Premium to the standard portability Premium rates. Any back Premium due as a result of this adjustment will be required. We will not adjust your Spouse's Premium after coverage has been continued under this rider for two years during your Spouse's lifetime.

GRACE PERIOD FOR PORTABILITY AT DEATH OR DIVORCE

Your Spouse has a grace period of 31 days for the payment of any Premium due. During the grace period coverage will remain in force. If full Premium payment is not received by us by the due date, we will give written notification to your Spouse that if the Premium is not paid by the end of the grace period then all coverage will end on the last day of the grace period. If we fail to give such written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving written notice of such intent to your Spouse, and such notice will specify the date all coverage will terminate if the Premium remains unpaid. Your Spouse is required to pay a pro rate Premium for any period coverage was in force during the grace period. Premium payment is required for any grace period, any extension of such period, and any period for which coverage was in effect and Premium was not paid.

TERMINATION OF PORTABILITY AT DEATH OR DIVORCE

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which Premiums are paid if the next Premium is not paid by its due date, subject to the grace period.
- The date your Spouse attains age 70.
- The date your Spouse dies.
- For each Child's coverage, the date the Child is no longer an eligible Child as defined by the Children's Life Insurance Rider. Coverage of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.
- For Children's coverage, the date there are no longer any eligible Children covered under the Children's Life Insurance Rider.

If your Spouse is continuing coverage under this provision and then later your Spouse becomes eligible as an Active Employee under the Policy, then any amount(s) of coverage continued under this rider will be reduced by the amount(s) of coverage your Spouse has as an Active Employee. Any unearned Premiums paid for ported coverage will be refunded.

CONVERSION FOR TERMINATION OF PORTABILITY AT DEATH OR DIVORCE

Your Spouse may convert any life insurance amounts that stop when portability under this provision ends for any reason other than nonpayment of Premium, or your Spouse's death, or your Child reaching the termination age under the Children's Life Insurance Rider. Conversion is also available for any part of Spouse life insurance that reduces due to a BENEFIT REDUCTION as described on the SCHEDULE OF BENEFITS of any rider or a Policy change. Conversion is also available for any part of Children's life insurance that reduces due to a Policy change. See the CONVERSION provision of the rider(s). If your Spouse has made an absolute assignment of insurance, only the current owner may apply for conversion under this paragraph.

Your Child may convert any Children's life insurance amount that stops under the Children's Life Insurance Rider due to your Child reaching the termination age under that rider, or when portability under this rider ends due to your Spouse's death. If a Child is too young to contract for life insurance after your Spouse's death, then a parent or a court-appointed guardian of the Child may apply for conversion of that Child's coverage. See the CONVERSION provision of the rider.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Amelia (Amy) J. Vaillancourt
President

Melissa A. O'Donnell
Secretary

ADDITIONAL SERVICES RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp

GROUP POLICY NUMBER: 29316-4GAT2

EFFECTIVE DATE: July 1, 2025

This rider is made a part of the Group Term Life Insurance Certificate. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

NOTICE OF ADDITIONAL SERVICES

ReliaStar Life Insurance Company ("we," "us," "our") and the Policyholder may agree to additional services provided by third party vendors. Charges for these additional services and all or a portion of the cost for these additional services may be remitted to us by the Policyholder or directly billed to the insured person as agreed to by the Policyholder. Third party vendors are solely liable for providing additional services. We will not be responsible for providing or failing to provide the additional services to eligible individuals. Further, we will not be liable to eligible individuals for the negligent provision of the additional services by third party vendors. We may discontinue additional services with 30 days prior written notice to the Policyholder.

FUNERAL PLANNING AND CONCIERGE SERVICES
Funeral planning and concierge services offer funeral planning services before and after death.

TRAVEL ASSISTANCE
Available when travelling more than 100 miles from their primary residence or in another country, for trips 180 days or less, travel assistance offers Emergency Medical Transport Services, Medical Assistance Services, Travel Assistance Services including pre-trip information and Security Assistance Services.

WILL PREPARATION SERVICES
Will preparation services help individuals create a variety of end-of-life legal documents.

Executed at our home office: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

Amelia (Amy) J. Vaillancourt
President

Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

Web Site: www.insurance.ca.gov/01-consumers/101-help

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900
Minneapolis, Minnesota 55401
(612) 372-5432

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or the health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South Seventh Street
Minneapolis, Minnesota 55402
Telephone: (612) 322-8713

The maximum amount the Guaranty Association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in the present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant’s lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association’s limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

NOTICE OF PROTECTION PROVIDED BY
NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies. For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $500,000 for health benefit plans (see definition below)
  - $300,000 in disability income insurance benefits
  - $300,000 in long term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of type of coverage, is $300,000; however, may be up to $500,000 with regard to health benefit plans.

"Health benefit plan" is defined in North Dakota Century Code Section 26.1-38.1-02(10) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance, and long-term care insurance (LTC).

Benefits provided by a long-term care (LTC) rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life policy or annuity contract to which it relates.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org, or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota, 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit, or induce you to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:
- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):
- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual Annuities
- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:
- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

(i) With respect to one life, regardless of the number of policies or contracts:

- $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability

income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or

- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each payee of a structured settlement annuity or beneficiary if the payee is deceased, $300,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any,

(iii) the association is not obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for health benefit plans, in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual or with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(iv) the limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(v) benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

ReliaStar Life Insurance Company
Minneapolis, Minnesota

SOUTH DAKOTA CERTIFICATE ENDORSEMENT
for Group Term Life Insurance

Your Certificate has been changed to include this endorsement. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy, Certificate, riders and endorsements issued.

ACCIDENTAL DEATH RIDER OR ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

If your Certificate includes an Accidental Death Rider or AD&D Rider, then any reference to mental illness or infirmity in the definition of "Accidental Injury" does not apply.

The EXCLUSIONS are also revised as follows:

The exclusion for disease or infirmity is changed to read:
- Disease or infirmity of the body, or medical and surgical treatment for such disease or infirmity.

Any exclusion for felonies is changed to read:
- Committing a felony.

Any exclusion for participation in an illegal occupation or activity does not apply.

Any exclusion for intoxication does not apply.

Any exclusion for use of drugs does not apply.

Any exclusion for voluntary intake of poison, gas or fumes does not apply.

If your Certificate includes an Accidental Death Rider, any exclusion for suicide on that rider is changed to read:
- Death as a result of suicide, while sane, within two years of the date the Covered Person's insurance under this rider starts.

All other Accidental Death or AD&D exclusions remain unchanged.

Melissa A. O'Donnell
Secretary

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy owners, contract owners, and certificate owners will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy or contract. If coverage is provided, it may be subject to substantial limitations or exclusions, and required continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy or contract.

Coverage is NOT provided for your policy or contract for any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy or contract.

The South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
124 S. Euclid Avenue, 2nd Floor
Pierre, South Dakota 57501
Tel. (605) 773-3563
www.dlr.sd.gov/insurance

(Please turn to back of page)

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy or contract was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy owner, contract owner or certificate owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or contract or portion of a policy or contract which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer; or
- policies providing health care benefits for Medicare Parts C or D Coverage.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more that $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health benefit plans, not more than $500,000, but not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance, and (iii) for annuities, not more than $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to health benefit plans, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as A.M. Best Company, Fitch Ratings, Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Useful Links" on the website of the South Dakota Division of Insurance at www.dlr.sd.gov/insurance

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statues governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 for disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

To learn more about the above protections, please visit the Association's website at www.utlifega.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 20
Minneapolis, Minnesota 55440

Plan Name, Number and Name and Address of:
BMO U.S. Health and Welfare Benefit Plan
29316-4GAT2
BMO Financial Corp
320 South Canal Street Floor 8
Chicago, Illinois, 60606

Name, Address, and Telephone Number of the Plan Administrator:
BMO Financial Corp.
320 South Canal Street Floor 8
Chicago, Illinois, 60606
1-888-927-7700

Identification Numbers
IRS Employer Identification Number: 51-0275712
Plan Number: 507

Agent for Legal Process: Plan Administrator

Trustees: None

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: The employer and employee shared the cost of coverage.

Plan Year: January 1 through December 31

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Policyholder makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Policyholder reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR LIFE INSURANCE

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR WAIVER OF PREMIUM RIDER

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 45 days after receipt of the claim. Up to two extensions of 30 days each will be allowed for processing the claim for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice of any such extension. The notice will state the standards on which the entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, the additional information needed to resolve those issues, if any, and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision, internal rule, guideline or protocol which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 180-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) Prior to rendering an adverse decision on appeal, ReliaStar Life will provide notice to the claimant of any new or additional evidence considered, relied upon, or generated by the plan, insurers or other persons making the benefit determination. ReliaStar Life Insurance Company of New York will also notify the claimant if it has new or additional rationale for an adverse appeal determination. ReliaStar Life Insurance Company of New York will then provide the claimant with a reasonable opportunity to review and respond to this new information before making its decision. The time period ReliaStar Life Insurance Company of New York has to make its determination will be tolled while it is waiting for the claimant's response.
8) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. If ReliaStar Life Insurance Company of New York sends an adverse benefit determination following its review of the appeal, the notice of the determination will be written in an understandable manner and include the following:
   a. The specific reason(s) for the adverse benefit determination.
   b. Reference to the specific provision on which the determination is based.
   c. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim.
   d. A statement of the claimant's right to bring a civil action and any contractual statute of limitations period, including the specific calendar date on which such limitations period will expire.
   e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, then a copy of any such rule, guideline, protocol or other criterion will be provided free of charge.
   f. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

This decision will be issued as soon as practicable from the date of appeal, but not longer than 45 days unless an extension is needed. An extension of 45 days will be allowed for making the decision for matters beyond the Plan's control or if additional information is needed from the claimant. The claimant will be given notice if this extension is necessary, stating the reason for the extension, the date a decision is expected, and the additional information needed from the claimant, if any. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.

9) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

BMO

Short-Term Disability

Plan Details



reliancematrix

Quick Facts

Claims Administrator	Reliance Matrix Absence Management, Inc.
Claims Support	Reliance Matrix Member Services: 1-888-295-7862
Payroll Administrator	Strada
Payroll Support	Human Resources Center (HRC) at 1-888-927-7700
Governance	The Short-Term Disability plan is designed to comply with the federal regulations such as the Americans with Disabilities Act (ADA), Family and Medical Leave Act (FMLA), as well as applicable state leave regulations.

Overview

BMO's Short-Term Disability (STD) Plan is designed to provide you with income replacement if you are unable to work due to a non-work-related illness, injury, or medical condition. The plan helps ensure financial stability during a temporary period of disability by replacing all or a portion of your regular earnings during the time that you are unable to work.

The most common conditions covered by the STD plan include:

- Injuries and accidents (not work related)
- Surgery and recovery
- Complications during pregnancy or following childbirth
- Mental health conditions with medical diagnosis and documented treatment plan
- Serious Illnesses such as cancer, heart attack or stroke, pneumonia or complications from autoimmune diseases
- Treatment for substance abuse

Eligibility for Short-Term Disability Benefits

If you experience an illness or injury that renders you unable to work for more than 10 consecutive business days, you will be required to apply for STD benefits. You should begin this process by the 5th consecutive day of your absence to avoid delays in benefit eligibility determination, claims processing and payroll.

To qualify for STD income replacement benefits, you must meet all of the following criteria:

- Be considered a Benefits-eligible employee, as defined in BMO's Health and Welfare Plan Summary Plan Description
- Be under the ongoing care of a qualified physician for the illness or injury that prevents you from working

- Be receiving and adhering to appropriate medical treatment for your condition
- Be unable to perform the essential duties of your job or a similar role due to the illness or injury
- Submit a claim to the Claims Administrator and provide all required documentation in a timely manner
- Ensure your physician provides any requested medical records, forms, or notes related to your condition, both at the time of claim initiation and as needed throughout the duration of your claim
- Receive approval from the Claims Administrator for STD benefits

While receiving STD income replacement benefits, you are not permitted to work (whether paid or unpaid) for any other employer, individual, family-owned business, or as a volunteer.

Benefit Duration

Recovery time varies widely depending on the condition; therefore, the actual duration of STD benefits is primarily based on how long you are medically unable to perform your job duties. The Claims Administrator determines the duration of your approved leave and STD benefits based on documentation from your treating physician, evidence of functional limitations, your ongoing treatment plan, periodic medical updates, and standard recovery timelines for your specific condition.

Unpaid Waiting Period

The first 10 consecutive business days of your leave constitute an unpaid waiting period (also referred to as the elimination period).

In Workday, your status will be changed to “On Leave” effective the first day of your absence with an Absence Type of “Disability Waiting Period – Unpaid”. This will stop your regular pay.

During the unpaid waiting period, you may use your available sick time or vacation time to maintain 100% of your regular pay. This substitution is not automatic - you must enter the sick or vacation time you intend to use in Workday to receive the sick pay or vacation pay on your paycheck. If you are unable to enter this time yourself, you should ask your manager to do so on your behalf or contact the HRC for assistance.

If your STD claim is approved, you will transition to being paid STD beginning on the 11th day of your absence. If your STD claim is denied, you will stay on unpaid leave. Your Workday status will reflect either *FML – Unpaid* or *Other – Unpaid*, based on the type of leave you are on.

STD Benefit Period

Short-Term Disability (STD) income replacement benefits begin on the 11th consecutive

business day of your approved leave and may continue for up to 100 business days thereafter.

Unpaid Waiting Period	STD Benefit Period (up to 100 days)
Days 1 - 10	Days 11 – 110*

**STD benefits continue for as long as you remain disabled, as determined by the Claims Administrator, or until you reach the 100th business day of your STD period, whichever comes first. Holidays are included in the 100 days of STD.*

Maximum Benefit Period

Short-Term Disability (STD) income replacement benefits are provided for a maximum of 100 business days.

Once you reach 110 consecutive business days of absence (which includes the 10-day unpaid waiting period and the 100-day STD benefit period), your paid STD income replacement benefits will end.

At that point, you must take one of the following actions:

- Return to work, if medically cleared.
- Apply for Long-Term Disability (LTD) benefits, if your condition continues to prevent you from working.
- Request an unpaid leave of absence as an accommodation, if additional time off is needed but LTD is not appropriate.
- Voluntarily terminate your employment, if you choose not to pursue continued leave or return to work.

If no action is taken once STD benefits end, Employee Relations may be engaged to review your employment status and your continued need for leave will be assessed through an interactive process.

Returning to Work

You will be expected to return to work at the end of your approved STD benefit period, unless you are transitioning to Long-Term Disability (LTD).

Before you can return to work, your treating physician must confirm that you are medically fit to resume your duties. This includes specifying your return-to-work date and identifying any restrictions or accommodations that may be necessary.

If you are medically cleared to return to work, you must return to work on the date indicated by your treating physician. Failure to return to work as scheduled may result in placement on Unapproved, Unpaid Leave and could impact your employment status.

Partial Return to Work

During your recovery, it may be determined that you are able to resume work on a partial or limited basis as you transition back to your full schedule. A Partial Return to Work status allows you to work reduced hours while continuing to receive STD benefits, supporting a gradual and medically appropriate return to full duties.

While on Partial Return to Work status, your Workday status will still reflect (On Leave) status. This will be present until you can resume your standard hours.

While on a Partial Return to Work:

- You will continue to receive STD income replacement benefits for the hours you are medically unable to work.
- You will also be paid for the actual hours worked, up to your standard weekly schedule.
- Any day in which STD benefits are used (regardless of the number of hours) is counted as one full day toward your available 100 days of STD.

Timekeeping Requirements:

- All employees (Exempt and Non-Exempt) must enter their actual hours worked, in addition to any Holiday, Sick, and Vacation time, in Workday during a Partial Return to Work period in order to receive payment.
- Managers are responsible for reviewing and approving time entries at the end of each week to ensure timely payroll processing. You may need to prompt your manager to do this to ensure there are no payment delays for time worked.

Please note that regular hours worked entered into Workday are paid two weeks in arrears.

Any days in which partial STD benefits are used will count towards your long term-disability (LTD) elimination period.

Recurring or Multiple Disabilities

If you experience a second disability or a series of disabilities, your STD benefits may either continue or restart, depending on the timing and nature of the condition:

If You Return to Work and Become Disabled Again

- Same or Related Condition Within Six Months - If you become disabled from the same or a related illness or injury within six months of returning to work:
    - The second disability is considered a continuation of the first.
    - You do not need to satisfy the unpaid 10-day waiting period again.
    - The second disability will count toward your original 100 covered business days of STD.
- Same or Related Condition After Six Months - If the second disability occurs more than six months after you return to work:
    - It is considered a new disability.
    - You must satisfy a new 10-day unpaid waiting period.
    - You may use available sick or vacation time during this waiting period.
    - Your 100 covered business days of STD will restart.

- Unrelated Condition (Any Timeframe) - If the second disability is caused by an unrelated illness or injury, it is considered a new disability, regardless of how long you've been back at work:
    - A new 10-day unpaid waiting period applies.
    - You may use available sick or vacation time during this waiting period.
    - STD coverage will continue for up to 100 business days.

If You Experience a Second Disability While Already on Leave
If you are already receiving STD benefits for one condition and experience a second disability (whether related or unrelated) the second disability is considered a continuation of the first. Your STD coverage will continue under the original claim and count toward the same 100-day limit.

When STD Coverage or Benefits End

Your coverage and benefits under STD will end if any of the following events occur:

- Exhaustion or End of STD Benefit Period: You exhaust your STD benefits or reach the end of your approved STD benefit period, whichever comes first.
- Termination of Employment: You terminate employment for any reason (unless your termination is due to an involuntary separation from service or layoff, and BMO has agreed to extend coverage, in accordance with BMO policies).
- Retirement: You retire from BMO.
- Special Service Leave: You are on a Special Service Leave.
- Loss of Eligibility: You no longer meet the eligibility rules for benefits or specific to the STD plan.
- End of Disability: You are no longer considered disabled.
- Failure to Provide Proof: You refuse or fail to provide sufficient proof of your disability.
- Refusal of Medical Exam: You refuse to undergo a medical examination requested by the Claims Administrator.
- Death: You pass away.
- Program Termination: The applicable program is terminated by BMO.

STD Benefit Calculation and Schedule

Your STD benefit is calculated by the Claims Administrator using your base pay (or Base Benefit Rate (BBR) for certain commissioned employees) in place as of the last business day before your disability began, divided by 26 (which represents the number of pay periods in a calendar year).

Note that your STD pay amount may appear slightly higher than your usual bi-weekly pay, as BMO calculates bi-weekly pay by dividing annual salary by 26.0714286.

Once the STD pay amount is determined, the applicable 100% or 70% benefit rate is applied. Your *Years of Service* for STD benefit purposes is calculated based on the difference between the date your absence began and your Continuous Service Date, which can be found in Workday. This calculation determines your eligibility for 100% or 70% STD pay as outlined in the following table:

Years of Service	Number of Days at 100%	Number of Days at 70%
Less than 1	0	100
1	10	90
2	20	80
3	30	70
4	40	60
5	50	50
6	60	40
7	70	30
8	80	20
9	90	10
10 or more	100	0

Coordination with State Paid Leave Benefits

If you reside in a state that provides paid leave benefits, you are required to apply for those benefits when you initiate a Short-Term Disability (STD) claim. BMO coordinates your STD benefits with any payments you receive from your state program.

If your state benefit is less than the STD benefit amount, STD will pay the difference so that your total benefit equals either 100% or 70% of your base pay, depending on your eligibility.

The Claims Administrator will automatically apply the maximum state benefit as an offset to your STD payments unless you provide documentation showing a different amount. To ensure your STD benefits are calculated accurately, you must submit your state award letter to the Claims Administrator as soon as it becomes available.

Coordination with BMO's Paid Maternity Leave

For birth mothers, STD benefits do not apply separately when receiving BMO's Paid Maternity Leave benefit. Instead, the maternity leave benefit runs concurrently with the STD

payment schedule, meaning you will receive maternity leave pay in lieu of STD pay. You will not receive both STD and maternity pay at the same time.

Pregnancy Complications Before Birth

If you experience complications that require leave before the birth, you must apply for STD benefits:

- The 10 day unpaid waiting period prior to STD applies.
- You must submit medical documentation from your treating physician to the Claims Administrator.
- If approved, you will receive STD pay starting on the 11th consecutive day of disability.
- Upon delivery, you will transition to the maternity leave benefit for up to 16 weeks of income replacement.

Complications After Maternity Leave Ends

If complications arise after your paid maternity leave period and you are unable to return to work:

- You must apply for STD benefits to continue receiving pay.
- The 16 weeks of maternity leave count toward satisfying the STD unpaid waiting period, so no additional waiting period is required.
- You must submit medical documentation to the Claims Administrator as soon as possible to avoid delays in pay.
- Once approved, STD benefits will begin after the maternity leave ends.
- The 16 weeks of maternity leave count toward your 100-day STD limit. Any additional STD pay will follow the standard STD payment schedule, based on your years of service and length of leave.

STD Benefits Payments and Payroll Coordination

STD benefits are paid on the same bi-weekly schedule as your regular paycheck. The Claims Administrator will notify the Payroll Administrator of the amount of STD pay to issue each pay period. This may include:

- Your regular bi-weekly STD payment
- Any retroactive payments due based on the timing of your claim approval or extension
- Offsets for state-paid leave benefits, if applicable

All STD payments are subject to standard payroll deductions and tax withholdings.

You can verify your expected STD benefit payments by reviewing your Award Letter or contacting the Claims Administrator. You can also view your paychecks, including STD payments, directly in Workday under the Pay section.

Benefits Deductions During STD

While receiving approved STD benefits your benefits coverage (medical, dental, vision, life, and voluntary benefits) continues uninterrupted and you remain responsible for your benefit premiums and contributions. These deductions will automatically be taken from your STD pay.

If you miss a paycheck due to claim approval timing or receive insufficient earnings to cover your deductions, your missed deductions will accumulate in arrears. They will be recovered once you have sufficient pay, typically through one extra deduction per pay period until the balance is paid in full. Your HSA and FSA contributions will automatically recalculate and adjust based on the number of remaining pay periods in the calendar year.

If you are enrolled in Commuter Benefits, you are responsible for discontinuing your deduction while on STD and reinstating it, if desired, when you return to work. While you are on STD you must terminate your commuter election by the 10th of the month (or the 4th for Long Island and Metro North Railroad users in New York) in order to cancel for the following month's order.

Recovery of Overpayments

BMO reserves the right to offset any future STD benefits or regular paycheck earnings to recover any overpayments caused by a change in disability status, a retroactive leave request, substitution or removal of sick or vacation time, a full or part-time return to work, or an administrative error.

If future payments or earnings are not available to recover the overpayment, you may receive a letter requesting repayment of the overpaid amount.

Short-Term Disability Claims

Decisions about STD Claims are not made by BMO personnel. BMO has hired a Claims Administrator that specializes in evaluating and determining eligibility for disability benefits based on medical and vocational evidence to ensure claims are adjudicated with expertise, independence and impartiality.

Filing a Claim

STD benefits are not automatic, meaning you will need to take action to file a claim. If you expect your absence to last more than 10 consecutive business days, **you must contact the Claims Administrator, Reliance Matrix Absence Management, at 1-888-295-7862 to initiate your claim.** You can also file your claim online at www.matrixabsence.com. The process to apply for STD and gather the required documentation can take time, therefore

the earlier you contact Reliance Matrix, the sooner you will receive the materials needed to apply for STD.

You may file a claim yourself or through an authorized representative (someone you designate in writing to act on your behalf).

Claim materials must be completed by:

- You (the employee)
- The Claims Administrator
- Your health care provider

All completed materials must be submitted to the Claims Administrator for evaluation. You have 30 days from the date you initiate your claim to submit all required documentation. However, you are strongly encouraged to submit your forms and documentation as quickly as possible to avoid pay disruption, since STD pay will not begin until your claim is approved and payroll payments have been set up with the Payroll Administrator.

If no materials are received by day 30, your claim will be denied and will not be reopened, even if documentation is submitted later.

Claim Processing Timeline

- Most claims are processed within one month, though special circumstances may require additional time.
- The Claims Administrator will notify you of your claim status within 45 days of receiving a complete claim.
- If needed, a 30-day extension may be requested, with written notice provided before the end of the initial 45-day period.
- If circumstances beyond the plan's control prevent a decision within the first extension, a second 30-day extension may be granted, with written notice explaining the delay and expected decision date.
- STD pay will not begin until the Claims Administrator has approved your claim.

If your claim lacks sufficient information:

- You will be notified and given 45 days to submit the missing documentation.
- The claim response timeline is paused until you respond.
- If you do not submit the requested information within 45 days, your claim will be denied.

Medical Exams and Proof of Disability

During your leave of absence, the Claims Administrator may require periodic, independent medical exams performed by a physician or medical professional who is not your personal doctor and is selected by the Claims Administrator. These exams are intended to verify your

continuing eligibility for STD benefits. The plan may cover the cost of these exams. If you fail to provide proof of disability or refuse the required medical exams, your STD benefits may be terminated.

Exclusions

The STD plan does not cover conditions that result from any of the following:

- intentionally self-inflicted injuries or attempted suicide while sane or insane
- service in the armed forces of any country or international authority
- war or an act of war, whether declared or undeclared
- committing or attempting to commit a felony
- any disability that begins while on you are on a Special Service Leave
- any conditions resulting from a workplace illness or injury (which may be covered by BMO's Worker's Compensation program)

Claim Status and Decision

Approved Claims: Once your claim is approved, the Claims Administrator will issue a written decision that includes sufficient information to reasonably inform you of the outcome and the duration of your approval.

Denied or Terminated Claims: If your claim for benefits is denied or terminated in whole or in part, the claims administrator will provide you with a written notice that:

- Specifies the reason for the denial
- Refers to the pertinent plan or operating procedure provisions on which the denial is based
- Describes any additional material or information necessary for properly completing the claim
- Explains why such material or information is necessary
- Describes the claims review and appeal procedures and time limits that apply
- Discusses the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by you to the Claims Administrator of health care professionals treating you and vocational professionals who evaluated you
    - The views of medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with the adverse benefit determination, regardless of whether the advice was relied upon
    - A disability determination regarding you presented by you to the Claims Administrator made by the Social Security Administration
- If the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, provides either:

1. An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or
2. A statement that such explanation will be provided free of charge upon request

- Specifies the internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination, or states that such criteria do not exist
- Informs you that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim
- Prominently displays in any applicable non-English language how to access the language services provided by the Claims Administrator

Appealing a Short-term Disability Claim Decision

You or your authorized representative may appeal a denial of a claim for STD benefits by filing a written request with the Claims Administrator within 30 days of receiving the initial STD pay denial notice.

In connection with your appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to the claim
- You may submit written comments, records, documents, and other information relevant to your appeal, whether or not they were submitted with the initial claim
- The Claims Administrator may consult with medical or vocational experts in connection with deciding your appeal

Submitting your STD Appeal

Your STD Appeal should be sent to:

Matrix Absence Management Quality Assurance Review
C/O: RSLI
P.O. Box 13498
Philadelphia, PA 19101

The Claims Administrator will conduct a full and fair review of all submitted documents and evidence and will ordinarily render a final and binding decision within 45 days of receiving your appeal request. If special circumstances apply, the decision will be made as soon as possible, but no later than 90 days from the date of receipt. If an extension is needed, you will be notified in writing before the end of the initial 45-day period, including the reason for the delay and the expected decision date.

The STD plan is not an ERISA-governed plan therefore there are no additional appeal rights available once the Claims Administrator makes their final determination. While no further appeals are available, if you wish to share concerns about the Claims Administrator's decision, you may contact:

BMO Financial Corp.
ATTN: Head of US Benefits
395 N Executive Drive, 3rd Floor HR
Brookfield, WI 53005
usleaves@bmo.com

Decision-Making Disclaimer

To ensure there is no conflict of interest when making decisions on claims, our Claims Administrator, and its decision makers (including claims adjudicators, medical consultants, and vocational experts), are not rewarded or penalized (financially or otherwise) based on the number or nature of claims they approve or deny. There is no connection between the decisions they make and their employment status, performance ratings, compensation, or opportunities for promotion. This ensures that all benefit determinations are made impartially and in accordance with applicable plan provisions and governing regulations.

BMO

Long-Term Disability

Plan Details



reliancematrix

Quick Facts

LTD Claims and Pay Administrator	Reliance Matrix Absence Management, Inc.
LTD Claims and Pay Support	Reliance Matrix Member Services: 1-888-295-7862
Billing Administrator (for benefit premium payments)	Inspira Financial: 1-888-678-7835
Governance	The Long-Term Disability Plan is governed by the Employment Retirement Income Security Act of 1974 (ERISA).

Overview

BMO's Long-Term Disability (LTD) Plan is designed to provide income replacement if you are unable to work for an extended period due to serious, long-lasting medical or mental health conditions. The plan helps ensure financial stability by replacing a portion of your compensation after your Short-Term Disability (STD) period ends.

Common conditions covered by the LTD plan include debilitating injuries, musculoskeletal disorders, cancer, heart disease, organ transplants, neurological conditions, and severe mental health disorders - each of which can significantly impair your ability to perform your job over time.

Eligibility for Long-Term Disability Benefits

If you experience a serious medical condition that prevents you from working for an extended period, you may be eligible to transition to LTD benefits after exhausting your STD benefits.

To qualify for LTD income replacement benefits, you must meet all of the following criteria:

- Be a benefits-eligible employee, as defined in BMO's Health and Welfare Plan Summary Plan Description
- Have exhausted 100 days of STD leave and benefits. (Any days in which partial STD benefits are applied will count towards your LTD elimination period.)
- Be under the ongoing care of a qualified physician for the illness or injury that prevents you from working
- Be receiving and adhering to appropriate medical treatment for your condition
- Be unable to perform the essential duties of your job or a similar role due to the illness or injury for the first 24 months. To continue receiving LTD benefits beyond 24 months, you must be unable to perform the duties of any occupation for which you are, or may reasonably become, qualified based on your education, training, and experience
- Submit a claim to the Claims Administrator with all required documentation in a timely manner
- Ensure your physician provides any requested medical records, forms, or notes

related to your condition, both at the time of claim initiation and throughout the duration of your claim
- Receive approval from the Claims Administrator for LTD benefits

While receiving LTD income replacement benefits, you are not permitted to work (paid or unpaid) for any other employer, individual, family-owned business, or as a volunteer. However, you may engage in approved rehabilitation employment.

Benefit Duration

Recovery time varies widely depending on the condition; therefore, the actual duration of LTD leave is primarily based on how long you are medically unable to perform your job duties. The Claims Administrator determines the duration of LTD leave based on documentation from your treating physician, evidence of functional limitations, your ongoing treatment plan, periodic medical updates, and standard recovery timelines for your specific condition.

LTD Benefit Period

Long-Term Disability (LTD) income replacement benefits begin on the 111th consecutive business day following your approval of LTD benefits and leave and may continue up to your maximum benefit period.

Unpaid Waiting Period	STD Benefit Period (up to 100 days)	LTD Benefit Period*
Days 1 - 10	Days 11 – 110	Days 111+

**LTD benefits continue for as long as you remain disabled, as determined by the Claims Administrator, or until you reach your maximum benefit period, whichever comes first.*

Maximum Benefit Period

The maximum duration of your LTD income replacement benefits are based on the age when your disability began (age on the first date of your absence).

Age when disability began	LTD Benefits are paid up to
Before Age 60	Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months

69 through 74	12 months
75 or older	6 months

Once you reach Maximum Benefit period, your paid LTD income replacement benefits will end. If your employment status has not already been terminated at that point, your continued need for leave will be assessed through an interactive process coordinated by BMO's Employee Relations team.

Limits for specific conditions

Alcohol, Drug, or Substance Abuse

You may receive up to 24 months of LTD benefits in your lifetime for disabilities caused by alcohol, drug, or substance abuse or addiction. You must participate in a recovery program recommended by a physician to qualify.

Your LTD income replacement benefits will end at the earliest of:

- When you reach the 24-month limit
- When your LTD coverage ends
- When you stop or refuse to participate in the recovery program
- When you complete the recovery program

Mental or Nervous Disorders

(For disabilities beginning before January 1, 2024)

LTD benefits are limited to 24 months total, even if the disability periods are non-continuous or unrelated. This limit does not apply while you are confined to a hospital or institution.

Conditions subject to this limit include those defined in the Diagnostic and Statistical Manual of Mental Disorders, except:

- Schizophrenia
- Dementia
- Organic brain disease

Note that these limits do not apply to disabilities due to Mental or Nervous Disorders that begin after January 1, 2024.

Subjective Disorders and Related Conditions

LTD benefits are limited to 24 months total, even if the disability periods are non-continuous or unrelated. This limit does not apply while you are confined to a hospital.

Conditions subject to this limit include:

- Neuro-musculoskeletal and soft tissue disorders (e.g., sprains, strains)

- Chronic Fatigue Syndrome
- Fibromyalgia
- Fibrositis
- Chronic Pain
- Environmental Sensitivity Disorder

Exceptions (benefits may continue beyond 24 months if supported by objective evidence):

- Seropositive Arthritis
- Spinal Tumors, malignancy, or vascular malformations
- Radiculopathies
- Traumatic Spinal Cord Necrosis
- Musculopathies (confirmed by biopsy or EMG)

Returning to Work

If you recover from your disability and are medically cleared to work, you will be expected to return to work at the end of your approved LTD benefit period.

Before you can return to work, your treating physician must confirm that you are medically fit to resume your duties. This includes specifying your return-to-work date and identifying any restrictions or accommodations that may be necessary.

If you are medically cleared to return to work, you must return to work on the date indicated by your treating physician. Failure to return to work as scheduled may result in placement on Unapproved, Unpaid Leave and could impact your employment status.

Partial Return to Work

During your recovery, it may be determined that you are able to resume work on a partial or limited basis as you transition back to your full schedule, this is known as Rehabilitation Employment. A Partial Return to Work status allows you to work reduced hours while continuing to receive LTD benefits, supporting a gradual and medically appropriate return to full duties. You may continue to receive partial LTD benefits for up to 24 months while you transition back to your standard hours.

While on Partial Return to Work status, your Workday status will still reflect (On Leave) status. This status will be present until you can resume working your full scheduled weekly hours.

While on a Partial Return to Work:

- You will continue to receive LTD income replacement benefits for the hours you are medically unable to work on a monthly basis.
- You will also be paid for the actual hours worked, up to your standard weekly schedule.

Timekeeping Requirements:

- All employees (Exempt and Non-Exempt) must enter their actual hours worked in Workday during a Partial Return to Work period in order to receive payment.
- Managers are responsible for reviewing and approving time entries at the end of each week to ensure timely payroll processing. You may need to prompt your manager to do this to ensure there are no payment delays for time worked.

Please note that regular hours worked entered into Workday are paid two weeks in arrears.

Recurring or Multiple Disabilities

If you experience a second disability or a series of disabilities, your LTD benefits may either continue or restart, depending on the timing and nature of the condition:

If You Return to Work and Become Disabled Again

- Same or Related Condition Within Six Months - If you become disabled from the same or a related illness or injury within six months of returning to work:
  - The second disability is considered a continuation of the first.
  - You will resume your LTD benefits at the same amount that was in place at the time of your original disability.
- Same or Related Condition After Six Months - If the second disability occurs more than six months after you return to work:
  - It is considered a new disability.
  - You must satisfy a new 10-day unpaid waiting period and you will apply for Short-term Disability again.
  - You may transition to LTD again if your disability lasts longer than your maximum STD period.
- Unrelated Condition (Any Timeframe) - If the second disability is caused by an unrelated illness or injury, it is considered a new disability, regardless of how long you've been back at work:
  - A new 10-day unpaid waiting period applies.
  - You may use available sick or vacation time during this waiting period.
  - STD coverage will continue for up to 100 business days.

If You Experience a Second Disability While Already on Leave

If you are already receiving LTD benefits for one condition and experience a second disability (whether related or unrelated) the second disability is considered a continuation of the first. Your LTD coverage will continue under the original claim and count toward the same maximum benefit duration limits.

When LTD Coverage or Benefits End

Your coverage and benefits under LTD will end if any of the following events occur:

- Exhaustion or End of LTD Leave: You exhaust your LTD benefits Maximum Duration or reach the end of your approved LTD leave period, whichever comes first.
- Termination of Employment: You terminate employment for any reason (unless your termination is due to an involuntary separation from service or layoff, and BMO has agreed to extend coverage, in accordance with BMO policies).
- Retirement: You retire from BMO.
- Special Service Leave: You are on a Special Service Leave.

- Loss of Eligibility: You no longer meet the eligibility rules for benefits or specific to the LTD plan.
- End of Disability: You are no longer considered disabled and are cleared to return to work.
- Failure to Provide Proof: You refuse or fail to provide sufficient proof of your disability.
- Refusal of Medical Exam: You refuse to undergo a medical examination requested by the Claims Administrator.
- SSDI Repayment Agreement: You fail to sign the Social Security Disability Insurance (SSDI) Repayment Agreement.
- SSDI Overpayment: You fail to repay any SSDI overpayment amount.
- Death: You pass away.
- Program Termination: The applicable program is terminated by BMO.

LTD Monthly Benefit Calculation

BMO automatically provides Basic Long-Term Disability (LTD) coverage that replaces 60% of your Total Compensation. You can choose to enroll in the Supplemental LTD Plan to increase your coverage to 75% (60% Basic LTD + 15% Supplemental LTD).

Plan	Coverage	Automatic or Elected	Paid by
Basic LTD	60% of your Total Compensation*	Automatic	BMO
Supplemental LTD	15% of your Total Compensation*	Must be elected during initial enrollment, annual enrollment or a qualifying life event	You

Your LTD benefit is calculated as a monthly lump sum by the Claims Administrator, rounded to the nearest dollar, and based on your Total Compensation Base Benefits Rate (TCBBR) as of the last business day before your leave started. If your disability period is shorter than a full month, your payment will be pro-rated based on the number of days you are considered disabled.

*The maximum monthly LTD benefit (including both basic and supplemental coverage) is capped at $20,000.

Supplemental LTD Plan disclaimer:

- If your TCBBR is *$400,000 or more*, you will not receive any additional benefit from electing Supplemental LTD coverage.
- If your TCBBR is between *$320,000 and $399,999*, you may elect Supplemental coverage, but you will not receive the full 15% due to the monthly cap.

Note for Leaves Beginning Before January 1, 2024: If your disability leave (first date of absence) began before this date, your LTD benefit is based on your base pay (or Base Benefit Rate (BBR) for certain commissioned employees) as of the last business day before your leave started.

For more details on what is included in your TCBBR and how it is calculated, see the "Earnings Used for Benefits" section of the U.S. Health and Welfare Plans Summary Plan Description.

Coordination with other plans

Your LTD benefit may be reduced (offset) by payments you receive from the following sources:

- Social Security (on your own behalf)
- State or federal disability programs
- Workers' compensation
- Retirement or group disability plans paid by another employer

If these payments are less than your calculated LTD benefit, the LTD Plan will pay the difference so your total benefit equals 60% of your TCBBR, or 75% if you elected Supplemental LTD coverage.

Social Security and Medicare requirements during LTD

To remain eligible for LTD benefits and continued medical coverage through BMO, you are required to apply for Social Security Disability Insurance (SSDI) and enroll in Medicare Parts A and B when eligible. These steps are not optional and must be completed within the specified timeframes. BMO provides support through Allsup, Inc. to assist you with these processes at no cost to you.

Social Security Disability (SSDI)

- If your disability is expected to last 12 months or more and you haven't reached full retirement age, you must apply for SSDI.
- The approval process may take several months and could involve denials and appeals.
- You are required to file all levels of appeal.
- Allsup, Inc. will assist you with the SSDI application and appeals process at no cost to you.
- While Allsup is actively supporting your case, BMO will continue to pay your full LTD benefit.
- Once SSDI is approved:
    - Your LTD benefit will be reduced by the SSDI amount.
    - Any retroactive SSDI payments will also be offset, and you may need to repay a portion.
    - You must sign a Repayment Agreement when applying for LTD.

- If you do not apply for SSDI or file appeals, your LTD benefit will automatically be reduced by an estimated SSDI amount starting six months after your LTD start date.

Medicare Enrollment

- After 24 months on SSDI, you are automatically enrolled in Medicare Part A (Hospital Insurance).
- You must enroll in Medicare Part B (Medical Insurance), which has a monthly premium.
- You'll receive a Medicare packet and card from the Social Security Administration.
- Under the LTD Plan, you must be enrolled in Medicare Parts A & B to continue coverage under BMO's medical plan.
    - Medicare becomes the primary payer.
    - BMO's plan becomes the secondary payer.
- Allsup, Inc. will help you understand when and how to submit claims to Medicare.
- You must notify the Human Resources Centre with proof of Medicare enrollment to receive a credit toward your Part B premium, applied to your LTD benefit check (as long as you remain eligible and the benefit is offered).

Rehabilitation Employment

If you're receiving LTD benefits, you are encouraged, and may even be required, to participate in rehabilitation employment when medically appropriate. This program supports your return to work and must be recommended by your physician and approved by the Claims Administrator.

- You may continue to receive partial LTD benefits for up to 24 months while participating in an approved rehabilitation program.
- Your LTD benefit will be reduced by 70% of your outside earnings during this time.
- The combined amount of your reduced LTD benefit and rehabilitation earnings cannot exceed 100% of your pre-disability base pay.

LTD Benefits Payments

LTD benefits are paid on a monthly basis directly from the Claims Administrator. All LTD payments are subject to applicable tax withholdings. LTD Payments will be issued by the 20th day of each month.

You can verify your expected LTD benefit payments by reviewing your Award Letter or contacting the Claims Administrator.

Benefit Continuation and Premiums During LTD

When you transition to LTD you will have the option to maintain certain benefits for a specified length of time and some coverage will terminate.

Medical, Dental and Vision Plans

During LTD, you may continue your Medical, Dental and Vision coverage at Active Employee rates for a designated period of time depending on when your LTD Leave began.

LTD Start Date	Active Medical, Dental & Vision benefits continue until
Before January 1, 2025	The earlier of your LTD leave ending or December 31, 2027
January 1, 2025 – December 31, 2025	The earlier of your LTD leave ending or 36 months from the start of your LTD leave
January 1, 2026 and forward	The earlier of your LTD leave ending or your active employment ending with BMO

If you have Medical, Dental or Vision coverage during LTD, you will be billed by BMO's Direct Billing Administrator, Inspira Financial. You will be required to remit payment for your benefits to Inspira Financial in a timely basis to maintain your coverage. Failure to make payments will result in the cancellation of your coverage.

After your active coverage ends, you and your dependents may be able to continue coverage through COBRA and/or retiree medical, if eligible.

Life Insurance Plans

When you transition to LTD, you'll be automatically enrolled in Waiver of Premium (WOP) for Basic and Supplemental Life Insurance if:

- Approved for LTD before age 60
- Meet the plan's disability definition

Coverage continues at no cost until:

- You turn 65, or
- You're no longer disabled per the plan

Your Family Life Insurance ends upon WOP enrollment or 12 months from your total disability date (LTD effective date) if you are not eligible for WOP. You may be able to convert or port your coverage for your dependents. BMO will mail your conversion paperwork with your options by mail.

Voluntary Benefit Plans

Coverage for any Voluntary benefit plans you are enrolled in will terminate at the end of the month in which your STD ends for:

- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Legal Plan

Once your benefits have terminated, you may contact the Voluntary Benefits Claims Administrators and request conversion coverage.

Supplemental LTD

While you are receiving LTD benefits, you will not be required to pay for your supplemental LTD premium.

Health Savings Accounts (HSA)

When you transition to LTD you are no longer eligible to contribute to your HSA directly through BMO but you may contribute on an after-tax basis. Your HSA is yours to keep and will be converted to a Consumer Account.

You can continue to use your HSA funds for eligible expenses during LTD.

Flexible Spending Accounts (FSAs)

When you transition to LTD you are no longer eligible to contribute to the FSA plans.

Your Health Care and Limited Purpose FSAs will terminate at the end of the month your STD ends.

- You can claim expenses incurred while enrolled in the FSA.
- COBRA may be available for the rest of the plan year to allow you to continue to submit eligible expenses for reimbursement.

Your Dependent Care FSA will terminate the day after your STD leave ends.

- If you have a balance remaining, you can continue to claim expenses for the rest of the calendar year.
- COBRA is not available for Dependent Care FSA.

Commuter Benefits

You are not eligible to continue participation in the commuter program while on LTD.

Retirement and Savings Plans

When you transition to LTD you are no longer eligible to contribute to Retirement & Savings Plans.

401(k) Savings Plan:

- You become 100% vested upon LTD approval.
- All contributions (BMO's and your own) will stop during LTD.
- You can resume participation if you return to work.
- Loan payments are not deducted from LTD pay. You must make payments directly to the 401(k) Administrator to avoid default.
    - While on LTD, if you fall behind on making your loan payments, you have a period of one-year to bring your payments current before your loan defaults. For information on how to access your Empower account and make loan payments while on LTD, please refer to the BMO 401(k) Savings Plan Summary Plan Description.

Employee Stock Purchase Plan (ESPP):

- Your contributions to the ESPP will stop.
- Unused contributions will be used to purchase shares on the next quarterly purchase date.
- If you return to work, deductions resume at your previous rate.

BMO U.S. Pension Plan: If you are eligible for the Pension plan, your earned benefits are preserved and payable after LTD ends, you retire or leave BMO.

Employee Assistance Program (EAP)

You can continue using EAP services while on LTD.

Vacation and Sick Time

When you transition to LTD, you will no longer accrue Vacation or Sick time. Any unused, earned Vacation time will be paid out to you within 30 business days of being approved for LTD leave. Unused Sick time is not eligible for payout and cannot be used during LTD.

Recovery of Overpayments

BMO reserves the right to offset any future LTD benefits or regular paycheck earnings to recover any overpayments caused by a change in disability status, a retroactive leave request, substitution or removal of sick or vacation time, a full or part-time return to work, or an administrative error.

If future payments or earnings are not available to recover the overpayment, you may receive a letter requesting repayment of the overpaid amount. Failure or refusal to repay an overpayment may result in disciplinary action, termination of employment, or legal action.

Long-Term Disability Claims

Decisions about LTD Claims are not made by BMO personnel. BMO has hired a Claims Administrator that specializes in evaluating and determining eligibility for disability benefits based on medical and vocational evidence to ensure claims are adjudicated with independence and impartiality.

Filing a Claim

LTD benefits are not automatic, meaning you will need to take action to file a claim when you experience a medical condition that prevents you from working on a long-term basis. If you expect your absence to last more than your maximum STD benefit period, **you must contact the Claims Administrator, Reliance Matrix Absence Management, at 1-888-295-7862 to initiate your LTD claim.** The process to apply for LTD and gather the required documentation can take time, therefore the earlier you contact Reliance Matrix, the sooner you will receive the materials needed to apply for LTD.

Note that prior approvals for STD benefits does not guarantee approval of your LTD claim.

You may file a claim yourself or through an authorized representative (someone you designate in writing to act on your behalf).

Claim materials must be completed by:

- You (the employee)
- The Claims Administrator
- Your health care provider

All completed materials must be submitted to the Claims Administrator for evaluation. You have 30 days from the date you initiate your claim to submit all required documentation. However, you are strongly encouraged to submit your forms and documentation as quickly as possible to avoid pay disruption, since LTD pay will not begin until your claim is approved and payroll payments have been set up with the Payroll Administrator.

If no materials are received by day 30, your claim will be denied.

Claim Processing Timeline

- Most claims are processed within one month, though special circumstances may require additional time.
- The Claims Administrator will notify you of your claim status within 45 days of receiving a complete claim.
- If needed, a 30-day extension may be requested, with written notice provided before the end of the initial 45-day period.

- If circumstances beyond the plan's control prevent a decision within the first extension, a second 30-day extension may be granted, with written notice explaining the delay and expected decision date.
- LTD pay will not begin until the Claims Administrator has approved your claim.

If your claim lacks sufficient information:

- You will be notified and given 45 days to submit the missing documentation.
- The claim response timeline is paused until you respond.
- If you do not submit the requested information within 45 days, your claim will be denied.

Medical Exams and Proof of Disability

During your LTD leave, the Claims Administrator may require periodic, independent medical exams performed by a physician or medical professional who is not your personal doctor and is selected by the Claims Administrator. These exams are intended to verify your continuing eligibility for LTD benefits. The plan may cover the cost of these exams. If you fail to provide proof of disability or refuse the required medical exams, your benefits may be terminated.

Pre-existing Conditions

If you have a medical condition that existed before your eligibility for LTD coverage began, special rules apply. Pre-existing conditions includes any accidental bodily injury, sickness, mental illness, pregnancy, episode of substance abuse that existed prior to when you became eligible for LTD coverage; and/or symptoms, findings, aggravations related to these conditions.

New Employees: If you become disabled within your first six months of employment due to a condition you received medical care for during the three months before your coverage started, LTD benefits will not be paid for that condition.

Supplemental LTD Coverage: If you didn't enroll in supplemental LTD coverage when first eligible and later enrolled during Annual Enrollment or after a Qualifying Life Event, the same rule applies. If you become disabled within the first six months of supplemental coverage due to a condition you were treated for in the three months before your supplemental coverage began, benefits will not be paid for that condition.

Exclusions

The LTD plan does not cover conditions that result from any of the following:

- intentionally self-inflicted injuries or attempted suicide while sane or insane
- service in the armed forces of any country or international authority
- war or an act of war, whether declared or undeclared

- committing or attempting to commit a felony
- any disability that begins while on you are on a Special Service Leave
- any conditions resulting from a workplace illness or injury (which may be covered by BMO's Worker's Compensation program)

Claim Status and Decision

Approved Claims: Once your claim is approved, the Claims Administrator will issue a written decision that includes sufficient information to reasonably inform you of the outcome and the duration of your approval.

Denied or Terminated Claims: If your claim for benefits is denied or terminated in whole or in part, the claims administrator will provide you with a written notice that:

- Specifies the reason for the denial
- Refers to the pertinent plan or operating procedure provisions on which the denial is based
- Describes any additional material or information necessary for properly completing the claim
- Explains why such material or information is necessary
- Describes the claims review and appeal procedures and time limits that apply
- States that you have the right to bring a civil action under **Section 502(a) of ERISA** after you appeal the decision and receive a written denial on appeal
- Discusses the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by you to the Claims Administrator of health care professionals treating you and vocational professionals who evaluated you
    - The views of medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with the adverse benefit determination, regardless of whether the advice was relied upon
    - A disability determination regarding you presented by you to the Claims Administrator made by the Social Security Administration
- If the adverse benefit determination is based on a medical necessity, experimental treatment, or similar exclusion or limit, provides either:
    1. An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or
    2. A statement that such explanation will be provided free of charge upon request
- Specifies the internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the adverse determination, or states that such criteria do not exist
- Informs you that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim

- Prominently displays in any applicable non-English language how to access the language services provided by the Claims Administrator

Impact on your benefits

- LTD income replacement benefits stop on the denial date.
- Elected Medical, Dental and Vision benefits will terminate at the end of the month in which you receive the denial. COBRA Continuation coverage will be offered. If you don't elect COBRA and your claim is later approved, you must wait until Annual Enrollment or a qualifying life event to re-enroll.
- Your Life Insurance coverage will end and you will have conversion and portability options through the Plan Administrator.

Appealing a Long-term Disability Claim Decision

The Employee Retirement Income Security Act of 1974 (ERISA) gives you the right to appeal a denied LTD claim. If your claim is denied, you may request a full and fair secondary review of the decision by the Claims Administrator. This process ensures that you have an opportunity to present additional information and have your claim reconsidered before pursuing any further legal remedies. It is important to follow the appeal procedures outlined in this section to preserve your rights under ERISA.

Standard Appeal

You or your authorized representative may appeal a denial of a claim for LTD benefits by filing a written request with the Claims Administrator within 180 days of receiving the initial LTD denial notice. Your Standard Appeal is considered the first-level appeal.

In connection with your Standard Appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to the claim
- You may submit written comments, records, documents, and other information relevant to your appeal, whether or not they were submitted with the initial claim
- The Claims Administrator may consult with medical or vocational experts in connection with deciding your appeal

Access to Evidence

Before issuing a final denial, the claims administrator will provide you free copies of:

- Any new or additional evidence considered or generated during the review
- Any new rationale for the decision

This information will be shared in advance of the final decision so you have a reasonable opportunity to respond.

Decision Timeline

A decision is typically made within 45 days of receiving your appeal.

- If special circumstances apply, the review may take up to 90 days (you will be notified in writing).
- If additional information is needed from you, the timeline will be paused until you respond.
- The timeline may also pause to allow you time to review and respond to new evidence or rationale.

Reviewer Independence

The person reviewing your appeal will:

- Give **no deference** to the initial decision
- Be different from the original decision-maker and not their subordinate
- If medical judgment is involved, an independent medical professional with appropriate expertise will be consulted.

Final Decision Notice

If your appeal is concluded and the denial is upheld, the written notice will include:

- Specific reasons for the decision and references to plan provisions
- Your right to request all relevant documents free of charge
- Your right to bring a civil action under **ERISA Section 502(a)** and the deadline for doing so
- Explanation of why the decision disagrees with:
    - Your healthcare providers' opinions
    - Vocational experts' opinions
    - Social Security disability determinations
- Scientific or clinical rationale if based on medical necessity or experimental treatment
- Any internal rules or guidelines relied upon (or a statement that none exist)
- Language assistance information and any other notices required by law

Submitting your Standard Appeal

Your Standard Appeal should be sent to:

Matrix Absence Management Quality Assurance Review
C/O: RSLI
P.O. Box 13498
Philadelphia, PA 19101

Voluntary Appeal

If your Standard Appeal is denied, you have the right to request a second-level review by filing a Voluntary Appeal within 60 days of the final denial of your Standard Appeal. This step is entirely optional and does not affect your right to pursue legal action. You are not required to file a Voluntary Appeal before initiating a lawsuit. However, you must complete all levels of the Standard Appeal process before submitting a Voluntary Appeal.

In connection with your Voluntary Appeal:

- You may request, free of charge, copies of all documents, records, and other information relevant to the claim
- You may submit written comments, records, documents, and other information relevant to your appeal, whether or not they were submitted with the initial claim or Standard Appeal
- The Claims Administrator may consult with medical or vocational experts in connection with deciding your appeal
- The review will be independent and follow the same standards as the standard appeal.
- Filing a voluntary appeal tolls the statute of limitations on legal action while it is pending.

Access to Evidence

Before issuing a final denial on your Voluntary Appeal, the Claims Administrator will provide you free copies of:

- Any new or additional evidence considered or generated during the review
- Any new rationale for the decision

This information will be shared in advance of the final decision so you have a reasonable opportunity to respond.

Decision Timeline

A decision is typically made within 45 days of receiving your appeal.

- If special circumstances apply, the review may take up to 90 days (you will be notified in writing).
- If additional information is needed from you, the timeline will be paused until you respond.
- The timeline may also pause to allow you time to review and respond to new evidence or rationale.

Tolling

Tolling refers to pausing the time period within which the Claims Administrator must make a decision on your appeal. This pause occurs under specific circumstances to ensure you have a fair opportunity to provide necessary information or respond to new developments without exhausting your statute of limitations timeframe for legal action or running down the decision clock on your appeal.

When Tolling Applies:

1. Failure to Submit Required Information:
   If your appeal cannot be decided because you have not provided requested information, the decision timeframe will be tolled.
   - Tolling starts on the date the claims administrator sends you a notification of the extension.
   - Tolling ends when the administrator receives your response.
2. New Evidence or Rationale:
   If the claims administrator introduces new or additional evidence or a new rationale during your appeal, tolling may occur to give you time to respond.
   - Tolling begins on the date the administrator provides the new evidence or rationale.
   - Tolling ends when your response is received **or** on the date by which the administrator requested your response, whichever comes first.

Reviewer Independence

The person reviewing your appeal will:

- Give **no deference** to the initial decision
- Be different from the original decision-maker and not their subordinate
- If medical judgment is involved, an independent medical professional with appropriate expertise will be consulted.

Final Decision Notice

If your appeal is concluded and the denial upheld, the written notice will include:

- Specific reasons for the decision and references to plan provisions
- Your right to request all relevant documents free of charge
- Your right to bring a civil action under **ERISA Section 502(a)** and the deadline for doing so
- Explanation of why the decision disagrees with:
  - Your healthcare providers' opinions
  - Vocational experts' opinions
  - Social Security disability determinations
- Scientific or clinical rationale if based on medical necessity or experimental treatment

- Any internal rules or guidelines relied upon (or a statement that none exist)
- Language assistance information and any other notices required by law

Submitting your Voluntary Appeal

Your Voluntary Appeal should be sent to:

Matrix Absence Management Quality Assurance Review
C/O: RSLI
P.O. Box 13498
Philadelphia, PA 19101

Legal Rights and Civil Action

You may bring a civil action under ERISA Section 502(a) once you have completed the full Standard Appeal process. Any lawsuit must be filed within 6 months of the final decision. Only evidence submitted during the appeal process will be considered. If the Claims Administrator fails to follow ERISA procedures, you may be deemed to have exhausted administrative remedies and can proceed with legal action - unless the violation was minor and did not cause harm.

Finality of Decisions
All decisions made by the Claims Administrator regarding your claim are final and binding. If you initiate a judicial proceeding to appeal a claim denial or pursue any other action under Section 502 of ERISA (other than a breach of fiduciary duty claim), the evidence considered will be strictly limited to what was timely submitted to the Claims Administrator.

Time Limit for Filing
Any such judicial proceeding must be filed within six (6) months after the final decision of the Plan Administrator or Claims Administrator, as applicable.

Exhaustion of Administrative Remedies
If the Claims Administrator fails to strictly comply with ERISA requirements for your claim, you will be deemed to have exhausted the administrative remedies under the Plan, subject to certain exceptions. In this case, you may bring a civil action under Section 502(a) of ERISA on the basis that the claims administrator did not provide a reasonable claims procedure. Your claim or appeal will then be considered denied on review without discretionary judgment by a fiduciary.

Exceptions to Exhaustion
Administrative remedies will not be deemed exhausted for nominal violations that do not cause, and are not likely to cause, prejudice or harm, provided the Claims Administrator shows:

- The violation was for good cause or beyond its control; and
- The violation occurred during an ongoing, good-faith exchange of information.

This exception does not apply if the violation is part of a pattern or practice of noncompliance.

Request for Explanation
Before filing a civil action, you may request a written explanation of the violation. The Claims Administrator must respond within 10 days, including a specific description of its basis for asserting that the violation should not result in exhaustion of remedies.

Court Determination
If a court denies your request for immediate review because the Claims Administrator met the exception standards, your claim will be considered re-filed on appeal upon the Claims Administrator's receipt of the court's decision. The Claims Administrator will notify you of the resubmission within a reasonable time.

Decision-Making Disclaimer

To ensure there is no conflict of interest when making decisions on claims, our Claims Administrator, and its decision makers (including claims adjudicators, medical consultants, and vocational experts), are not rewarded or penalized based on the number or nature of claims they approve or deny. There is no connection between the decisions they make and their employment status, performance ratings, compensation, or opportunities for promotion. This ensures that all benefit determinations are made impartially and in accordance with applicable plan provisions and governing regulations.

YOUR ACCIDENT INSURANCE PLAN

For Employees of
BMO Financial Corp.

D9891 (12/24)

GROUP ACCIDENT INSURANCE CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

Claims: 855-730-2902 Customer Service: 877-236-7564

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CAC2

POLICY EFFECTIVE DATE: January 1, 2021

GOVERNING JURISDICTION: Illinois

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

Benefits are paid for Covered Accidents as defined in the Certificate. The Policy does not constitute comprehensive health insurance coverage (often referred to as "major medical insurance coverage"). In addition, the Policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid under the Policy for Covered Accidents as indemnity insurance and are not intended to cover medical expenses.

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate replaces any other Certificates we may have given you for the same level of coverage under the Policy.

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address. The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

Exclusions may apply. Please read your Certificate carefully.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

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Arizona Residents -
Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

California residents:
If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

Florida Residents -
The benefits of the Policy providing Your coverage are governed primarily by the law of a state other than Florida.

Idaho residents:
If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 10 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.

Maryland Residents -
Notice: This Certificate of insurance may not provide all benefits required for a policy issued and delivered in Maryland.

SCHEDULE OF BENEFITS

EMPLOYER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CAC2

ELIGIBLE CLASS(ES)
All Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

Insured Persons who are continuing coverage under the PORTABILITY provision are also an eligible class.

MINIMUM HOURS REQUIREMENT
Employees: 20 hours per week.

ELIGIBILITY WAITING PERIOD
Persons in an eligible class on or before the Policy effective date and continuously employed thereafter: End of the month in which you complete a continuous period of 30 days of Active Employment.

Persons entering an eligible class after the Policy effective date and continuously employed thereafter: End of the month in which you complete a continuous period of 30 days of Active Employment.

Persons entering an eligible class after being rehired more than 30 days but less than 13 weeks after their termination date who enroll within 31 calendar days of their rehire date: First day of the month following your date of rehire.

Persons entering an eligible class after being rehired more than 13 weeks following their termination date, but before the annual enrollment for the next calendar year, who enroll within 31 calendar days of their rehire date: End of the month in which you complete a continuous period of 30 days of Active Employment.

REHIRE
If your employment with the Employer ends and you are rehired within 30 days, your previous Active Employment while in an eligible class will apply toward the Eligibility Waiting Period. All other Policy provisions apply.

WHO PAYS FOR THE COVERAGE
You pay the cost of your coverage.

ACCIDENT BENEFITS

ACCIDENT HOSPITAL CARE	Low Plan	High Plan
Surgery - open abdominal, thoracic	$1,200	$1,500
Surgery - exploratory or without repair	$175	$200
Blood, Plasma, Platelets	$600	$625
Hospital Admission	$1,250	$1,750
Hospital Confinement	$275	$275
Critical Care Unit (CCU) Confinement	$450	$625
Rehabilitation Facility Confinement	$200	$225
Non-Induced Coma	$17,000	$18,500
Induced Coma	$150	$200
Transportation	$750	$800
Lodging	$180	$200
Family Care	$25	$30

ACCIDENT CARE	Low Plan	High Plan
Initial Doctor Visit	$90	$100
Urgent Care Facility Treatment	$225	$250
Ambulance		
Ground	$360	$400
Air	$1,500	$2,000
Follow-Up Doctor Treatment	$90	$100
Medical Equipment	$200	$275
Physical or Occupational Therapy	$45	$60
Speech Therapy	$45	$60
Mental Health Therapy	$50	$60
Prosthetic Device - one	$750	$1,250
Prosthetic Device - 2 or more	$1,200	$2,000
Prescription Medicine	$10.00	$20.00

Major Diagnostic Exams		
CT (computerized tomography) or CAT scan (computerized axial tomography)	$275	$300
MRI (magnetic resonance imaging)	$275	$300
EEG (electroencephalogram)	$275	$300
PET (positron emission tomography) scan	$275	$300
Ultrasound	$275	$300
Outpatient Surgery	$225	$250
X-ray	$100	$200

COMMON INJURIES	Low Plan	High Plan
Burns		
2nd degree - at least 36% of the total body surface area	$1,250	$1,500
3rd degree - at least 2% but less than 4% of the total body surface area	$7,500	$8,500
3rd degree - 4% or more of the total body surface area	$15,000	$20,000
Skin Grafts	50% of Burn Benefit	50% of Burn Benefit
Emergency Dental Work		
Crown	$350	$400
Extraction	$90	$125
Eye Injury		
Surgery	$350	$400
Removal of foreign object	$100	$110
Torn Hip, Knee or Shoulder Cartilage		
Surgery with no repair or if cartilage is shaved	$225	$250
Surgical repair	$800	$900
Laceration (total of all lacerations)		
treated, no sutures	$30	$50
sutures, up to 2 inches	$60	$90
sutures, 2 to 6 inches	$240	$350
sutures, over 6 inches	$480	$750
Ruptured Disk - surgical repair	$800	$900
Tendon/Ligament/Rotator Cuff		
One, surgical repair	$825	$925
2 or more, surgical repair	$1,225	$1,400

Exploratory Arthroscopic Surgery with no repair	$425	$600
Concussion	$225	$275
Paralysis		
Quadriplegia	$24,000	$27,000
Paraplegia	$16,000	$18,000
Hemiplegia	$15,000	$17,500
Monoplegia	$10,000	$12,500

	Low Plan	**High Plan**
Dislocations (Complete & Complete Requiring Surgical Repair)	**Complete / Complete Requiring Surgical Repair**	**Complete / Complete Requiring Surgical Repair**
Hip Joint	$3,200/$6,400	$4,000/$8,000
Knee	$2,000/$4,000	$2,500/$5,000
Ankle or Foot Bone(s) other than toes	$1,200/$2,400	$1,700/$3,400
Shoulder	$1,500/$3,000	$2,000/$4,000
Elbow	$900/$1,800	$1,250/$2,500
Wrist	$900/$1,800	$1,250/$2,500
Finger/Toe	$250/$500	$300/$600
Hand Bone(s) other than fingers	$900/$1,800	$1,250/$2,500
Lower Jaw	$900/$1,800	$1,250/$2,500
Collarbone	$900/$1,800	$1,250/$2,500
Incomplete Dislocations	25% of Complete Dislocation Amount	

Fractures (Non-Surgical Repair Fracture & Fracture Requiring Surgical Repair)	**Non-Surgical Repair Fracture / Fracture Requiring Surgical Repair**	**Non-Surgical Repair Fracture / Fracture Requiring Surgical Repair**
Hip	$2,500/$5,000	$5,000/$10,000
Leg	$1,800/$3,600	$2,700/$5,400
Ankle	$1,500/$3,000	$2,250/$4,500
Kneecap	$1,500/$3,000	$2,250/$4,500
Foot (excluding toes, heel)	$1,500/$3,000	$2,250/$4,500
Heel	$1,500/$3,000	$2,250/$4,500
Upper Arm	$1,750/$3,500	$2,400/$4,800
Forearm, Hand, Wrist (except fingers)	$1,500/$3,000	$2,250/$4,500
Finger, Toe	$200/$400	$300/$600
Vertebral Body	$2,800/$5,600	$4,000/$8,000
Vertebral Processes	$1,200/$2,400	$1,750/$3,500
Pelvis (except Coccyx)	$2,750/$5,500	$3,500/$7,000
Coccyx	$300/$600	$450/$900
Bones of Face (except nose)	$1,000/$2,000	$1,300/$2,600
Nose	$500/$1,000	$650/$1,300
Upper Jaw	$1,250/$2,500	$1,600/$3,200
Lower Jaw	$1,200/$2,400	$1,750/$3,500
Collarbone	$1,200/$2,400	$1,750/$3,500
Rib	$350/$700	$450/$900
Skull - simple (except bones of face)	$1,250/$2,500	$1,500/$3,000
Skull - depressed (except bones of face)	$2,500/$5,000	$4,000/$8,000
Sternum	$300/$600	$400/$800
Shoulder Blade	$1,500/$3,000	$2,250/$4,500

Chip Fractures	25% of Non-Surgical Repair Fracture Amount

ADDITIONAL BENEFIT(S)

Sports Accident Benefit	An additional 25% of the Accident Hospital Care, Accident Care, or Common Injuries benefit amount listed above, up to a maximum benefit of $1,000.

DEFINITIONS

Accident or **Accidental** means an unforeseen event that results in a bodily Injury.

Active Employment or Active Employee means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.

Certificate means this document, which describes the benefits and rights of Insured Persons under the Policy. It may include riders, endorsements or amendments.

Chip Fracture means a Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Confined or **Confinement** means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or Critical Care Unit or Rehabilitation Facility. Being admitted to an Observation Unit for 20 hours or more also meets the definition of Confined or Confinement.

There must be a charge for room and board for the confinement, other than in any government, military or veterans' facility or Observation Unit.

Covered Accident means an Accident that:
- occurs on or after your coverage effective date and the effective date of any riders,
- occurs while your coverage is in force, and
- is not excluded by name or specific description in the Policy.

Critical Care Unit means a specifically designated part of a Hospital commonly referred to as an intensive care unit which meets all of the following requirements:
- It provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care.
- It is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- It is permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- It is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis.
- It is assigned a Doctor on a full-time basis.

Critical Care Unit does not include a sub-acute intensive care unit that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward such as a step-down unit.

Dislocation means a separated joint.
- **Complete Requiring Surgical Repair** means a completely separated joint that requires surgical repair.
- **Complete** means a completely separated joint that does not require surgical repair.
- **Incomplete** means the joint is not completely separated.

Doctor means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

Eligibility Waiting Period means the continuous period of time as shown in the SCHEDULE OF BENEFITS that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Emergency Room means a specified area within a Hospital, or a standalone facility licensed as an emergency room with the state, that is designated for emergency care.

Employee means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States. The term includes a person whose coverage is being continued under the PORTABILITY provision, even if the person is no longer in Active Employment with the Employer.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Fracture means a broken bone that can be seen by x-ray.

- **Fracture Requiring Surgical Repair** means the fracture is repaired through a surgical incision.
- **Non-Surgical Repair** means the fracture is reduced or repaired without a surgical incision.

Hospital means an institution that is run for the care and treatment of sick or injured persons as inpatients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located.
- It is under the supervision of a medical staff and has one or more Doctors available at all times.
- It provides 24 hours a day service by registered graduate nurses (RNs).
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Injury means a bodily Injury that is the direct result of a Covered Accident and not related to any disease or bodily infirmity. Injuries must be independent of Sickness, disease or bodily infirmity.

Insured Person means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored by a Doctor, and that fully meets each of the following requirements:

- It is under the direct supervision of a Doctor or registered nurse.
- It is staffed by nurses assigned specifically to that unit.
- It provides care seven days per week, 24 hours per day.

Outpatient Surgery means surgical services received at a Hospital or free-standing facility such as a surgical center licensed by the state to render outpatient surgery. The surgical service must be performed by a board certified surgical specialist with anesthesia rendered by a separate provider.

Policy means the Written group insurance contract between the Policyholder and us, including the Certificates delivered to Insured Persons. It may include riders and endorsements.

Policyholder means the Employer to whom the Policy is issued, as shown on the first page of this Certificate, and who sponsors the coverage for its Employees.

Rehabilitation Facility means a free-standing facility providing coordinated multidisciplinary physical restorative services to inpatients under the direction of a Doctor knowledgeable and experienced in rehabilitative medicine. A Rehabilitation Facility must meet all the following requirements:

- It is licensed and operated pursuant to law.
- It provides treatment and care for ill and injured persons on an inpatient basis.
- It provides 24 hours a day service by registered graduate nurses (RNs).
- It is not an institution or any part used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Rehabilitation Facility includes a unit of a Hospital with beds set up and staffed and specifically designated for rehabilitative medicine.

Sickness means illness, infection, disease or any other abnormal physical condition that is not due to an Injury. Sickness includes pregnancy, infection and any other abnormal physical condition that is not caused by an Accident.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic or telephonic media, and which is consistent with applicable law.

Telemedicine means a medical encounter with a Doctor or licensed medical professional via telecommunication and information technologies (including, but not limited to, audio or video communications) for evaluation, diagnosis, or treatment as would be practiced in person. This does not include requests for prescription refills or medical records.

Urgent Care Facility means a specified area within a Hospital, or a standalone facility, licensed as an urgent care center with the state, that provides outpatient immediate and semi-urgent healthcare of non-life threatening injuries or illnesses. Urgent Care Facility does not include an Emergency Room as defined.

Written or **Writing** means a record which is on or transmitted by paper or electronic or telephonic media, and which is consistent with applicable law.

GENERAL PROVISIONS

ELIGIBILITY

If you are an Employee in an eligible class as shown on the SCHEDULE OF BENEFITS, the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The date you enter an eligible class.
- The day after you complete your Eligibility Waiting Period. **Exception:** If your Eligibility Waiting Period ends on the first day of the month, this eligibility date is the day you complete your Eligibility Waiting Period.

ENROLLMENT

If you are eligible for coverage, you must enroll for any coverage before it will become effective. The Employer or we will provide you with the forms or information needed to complete your enrollment. You may enroll when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us.

EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you enroll for coverage on or before that date.
- The date you enroll for coverage.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved non-medical leave of absence and paid time off for non-medical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates. See the PORTABILITY provision.
- The last day of the month during which you are no longer in an eligible class. See the PORTABILITY provision.
- The last day of the month during which your eligible class is no longer covered. See the PORTABILITY provision.
- The last day of the month during which you voluntarily cancel your coverage.
- The end of the period for which premiums are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The last day of the month during which you are no longer in Active Employment. See the PORTABILITY provision.

We will pay benefits for a loss that occurs while you are covered under the Policy even if the Policy has since terminated.

POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:

- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing accident coverage to all groups in the Policy issue state.

We reserve the right to review and terminate all class(es) covered under the Policy if any class(es) cease(s) to be covered.

If the Policyholder fails to pay the full premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay premiums, Written notice will be mailed to the Policyholder at least 60 days prior to the termination date.

The Policyholder may terminate the Policy by Written notice delivered to us at our home office prior to the termination date. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, the termination will not affect a payable claim.

PORTABILITY

Portability means you have the option to continue your coverage after it would otherwise terminate, if certain conditions are met.

You may continue your coverage if it would otherwise terminate due to any of the following:

- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Active Employees.
- Coverage terminates under the Policy for all Insured Persons except those individuals on portability, and the Policyholder does not replace it with similar insurance coverage.
- You are no longer eligible for coverage under the Policy.

The Employer or we will provide you with the information needed to continue your coverage under this provision. Continuation of coverage must be elected within 31 days of when it would otherwise terminate. Coverage continued under this provision is subject to all the terms of this Certificate.

You may decrease the continued coverage amount based on the amounts available on the SCHEDULE OF BENEFITS. You may not increase the continued coverage amount. Your continued coverage will not include any Additional Services Rider. Continued premium payment is required to keep coverage in force. Premiums will be billed directly to you. The initial premium will be based on the portability premium rates in effect at the time you are eligible to continue your coverage under this provision. We may change the portability premium rates at any time upon 60 days Written notice to you.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date you die.

- The date the Policy terminates because we stop providing accident coverage to all groups in the Policy issue state and coverage terminates for all Insured Persons and any other persons covered under any riders under the Policy. We will provide 60 days Written notice of termination.

GRACE PERIOD

The Policyholder has a grace period of 60 days for the payment of any premium due except the first premium payment. During the Policyholder's grace period the Policy will remain in force. If the full premium payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance Written notice of termination, or if we have given the Policyholder advance Written notice of termination as described under the POLICY TERMINATION provision.

If you are continuing your coverage under the PORTABILITY provision, you have a grace period of 31 days for the payment of any premium due. During your grace period, your coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to you that if the premium is not paid by the end of the grace period, all coverage will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to you, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your coverage was in force during the grace period.

REPRESENTATIONS NOT WARRANTIES

All statements made by the Policyholder and you are considered representations and not warranties.

INCONTESTABILITY

We will not use any statements made by you to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written application or enrollment form relating to your insurability. Except for fraud, we will not use such statements to contest insurance after it has been in force for two years from its effective date. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date if permitted by applicable law in the governing jurisdiction. The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

CLERICAL ERROR

Clerical error or omission by the Policyholder or us will not:

- Prevent you from being covered, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.
- End insurance validly in effect.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

ASSIGNMENT

No assignment of benefits under the Policy is valid, unless otherwise specified in the Policy.

AGENCY

For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the governing jurisdiction, is automatically amended to conform to the minimum requirements of such law.

CHANGES TO POLICY OR CERTIFICATE

The Policy may be amended at any time by Written agreement between the Policyholder and us. No change in the Policy will be valid until approved by one of our executive officers. Such approval must be in Writing and will be endorsed or attached to the Policy. Changes requiring regulatory approval will not be valid until approved by the appropriate regulatory body. We will issue new Certificates or riders or endorsements to effect such changes, and only those forms Signed by one of our executive officers will be valid.

No agent, representative or employee of ours or of any other entity, except one of our executive officers, may approve a change to waive any terms of the Policy.

ACCIDENT BENEFITS

ACCIDENT HOSPITAL CARE BENEFITS

We will pay an ACCIDENT HOSPITAL CARE benefit as shown on the SCHEDULE OF BENEFITS if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Blood, Plasma, Platelets: Transfusion, administration, cross matching, typing and processing of blood, plasma, platelets administered within 90 days after a Covered Accident. This benefit is payable once per Covered Accident.

Critical Care Unit Admission: Admission to a Critical Care Unit as a result of a Covered Accident. The admission must begin within 6 months after a Covered Accident. This benefit is payable once per Covered Accident. No benefit is payable for any of the following:

- Outpatient Surgery.

If you qualify for any of the following benefits on the same day, only one benefit in the higher amount will be payable:

- Hospital Admission
- Hospital Confinement
- Critical Care Unit (CCU) Confinement
- Rehabilitation Facility Confinement

Critical Care Unit Confinement: Confinement in a Critical Care Unit for at least 20 consecutive hours on an inpatient basis as the result of a Covered Accident. The Confinement must begin within 30 days after a Covered Accident. Benefits are payable daily for up to 15 days for a Covered Accident. Benefits are payable for only one Critical Care Unit Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement. If you qualify for any of the following benefits on the same day, only one benefit in the higher amount will be payable:

- Hospital Admission
- Hospital Confinement
- Critical Care Unit (CCU) Confinement
- Rehabilitation Facility Confinement

If you are discharged from the Critical Care Unit and then re-Confined within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Critical Care Unit Confinement(s).

Family Care: You have an eligible family member attending a family care center or receiving family care while you are Confined in a Hospital or Critical Care Unit as the result of a Covered Accident. Benefits are payable daily during and immediately following your Confinement for up to a total of 45 days. This benefit is payable once per day regardless of the number of eligible family members receiving care. Written proof of the expense incurred must be furnished along with any proof of claim.

“Eligible family member” for this benefit means a relative who is dependent on you for support and maintenance due to physical or intellectual disability and resides with you at the time of your Covered Accident. “Eligible family member” for this benefit also includes your dependent child under age 13. Written proof of an eligible family member must be furnished along with any proof of claim.

“Family care center” for this benefit means any child or adult care facility or private care that:

- Is licensed as such by the state.
- Provides non-medical care and supervision for children or adults.
- Is not operated by you or a member of your immediate family.

“Family care” for this benefit means care provided in a family care center as defined or provided in your home where:

- Non-medical care and supervision for children or adults is provided.
- The care and supervision is not provided by you or a member of your immediate family.

Hospital Admission: Admission to a Hospital as a result of a Covered Accident. The admission must begin within 6 months after a Covered Accident. This benefit is payable once per Covered Accident. No benefit is payable for any of the following:

- Outpatient Surgery.

If you qualify for any of the following benefits on the same day, only one benefit in the higher amount will be payable:

- Hospital Admission
- Hospital Confinement
- Critical Care Unit (CCU) Confinement
- Rehabilitation Facility Confinement

Hospital Confinement: Confinement in a Hospital for at least 20 consecutive hours on an inpatient basis as the result of a Covered Accident. The Hospital Confinement must begin within 6 months after a Covered Accident. Benefits are payable daily for up to 365 days for a Covered Accident. Benefits are payable for only one Hospital Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement. If you qualify for any of the following benefits on the same day, only one benefit in the higher amount will be payable:

- Hospital Admission
- Hospital Confinement
- Critical Care Unit (CCU) Confinement
- Rehabilitation Facility Confinement

If you are discharged from the Hospital and then re-Confined within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Hospital Confinement(s).

Induced Coma: An induced coma as the result of a Covered Accident. An induced coma is a temporary state of unconsciousness brought on by a controlled dose of medicine administer by a Doctor at a Hospital. Induced coma does not include general anesthesia administered for purposes of surgery. This benefit is payable for each day you are in an induced coma up to a maximum of 14 days.

Lodging: Hotel/motel stay by your companion while you are Confined in a Hospital or Critical Care Unit. The Hospital must be more than 100 miles from your home. The companion must be 16 years of age or older. This benefit is payable for up to 30 days per Covered Accident.

Non-induced Coma: You have been in a non-induced coma, as the result of a Covered Accident for at least 14 days. A non-induced coma is a state of unconsciousness that is not medically induced with:

- no reaction to external stimuli,
- no reaction to internal needs, and
- the use of life support systems.

This benefit is payable once per Covered Accident.

Pet Boarding: You have a pet or pets being boarded in a licensed animal boarding facility while you are Confined in a Hospital or Critical Care Unit. Benefits are only payable daily for the same day(s) that an admission or a Confinement benefit is payable. The pet or pets must be animals that live inside your primary residence with you at the time of your Confinement. Only one daily benefit is payable for all eligible pets. This benefit is payable up to a maximum of 30 days per Confinement.

Rehabilitation Facility Confinement: Confinement in a Rehabilitation Facility for 20 consecutive hours on an inpatient basis as the result of a Covered Accident. Benefits are payable daily for each subsequent and continuous day (or portion thereof) of inpatient Rehabilitation Facility Confinement, for up to 90 days per Covered Accident. Benefits are payable for only one Rehabilitation Facility Confinement at a time even if the Confinement is caused by more than one Covered Accident. Only one type of Confinement benefit is payable for each period of eligible Confinement. If you qualify for any of the following benefits on the same day, only one benefit in the higher amount will be payable:

- Hospital Admission

- Hospital Confinement
- Critical Care Unit (CCU) Confinement
- Rehabilitation Facility Confinement

If you are released and readmitted to a Rehabilitation Facility within 30 days due to the same Covered Accident or due to a related condition, the re-Confinement will be considered part of the previous Rehabilitation Facility Confinement(s).

Surgery: The surgery must take place within 30 days after a Covered Accident. The benefit amount varies based on the type of services received as shown on the SCHEDULE OF BENEFITS. This benefit is payable once per Covered Accident. If your surgery meets more than one of the surgery classifications, the higher amount will be payable. No benefit is payable for any type of hernia.

Transportation: Transportation for you for special treatment and Confinement in a Hospital or Critical Care Unit. The special treatment must be prescribed by a Doctor and not available locally. The transportation must be more than 100 miles one way. This benefit is payable up to 3 trips per Covered Accident. No benefit is payable for transportation by ground ambulance or air ambulance.

ACCIDENT CARE BENEFITS

We will pay an ACCIDENT CARE benefit as shown on the SCHEDULE OF BENEFITS if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Ambulance, Air: Transport by a licensed professional air ambulance company to or from a Hospital or between medical facilities, for treatment of Injuries received as the result of a Covered Accident. The transport must be within 48 hours after the Covered Accident. This benefit is payable once per Covered Accident.

Ambulance, Ground: Transport by a licensed professional ambulance company to or from a Hospital or between medical facilities, for treatment of Injuries received as the result of a Covered Accident. The transport must be within 90 days after the Covered Accident. This benefit is payable once per Covered Accident.

Follow-Up Doctor Treatment: Follow-up treatment by a Doctor must begin within 60 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is only available if you are eligible for the Initial Doctor Visit benefit or the Urgent Care Facility treatment benefit. Follow-up treatment may be provided by a Doctor via Telemedicine. This benefit is payable up to 6 times per Covered Accident.

Home Health Care: Care received at home from a nurse at the direction of a Doctor. Home health care must be prescribed to begin immediately after a surgical procedure or period of Confinement due to Injuries sustained in a Covered Accident. For purposes of this benefit, home health care does not include hospice care.

This benefit is payable each day you receive care at home up to a maximum of 5 days per Covered Accident.
Exception: A home health care benefit will not be paid any day that benefits are paid for an admission benefit or facility confinement benefit.

"Nurse," for this benefit only, means a person other than you or any family member, who is a licensed health care professional trained to care for people who are sick or infirm. A nurse may include a graduate Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

Initial Doctor Visit: Examination and treatment by a Doctor within 30 days after a Covered Accident. Examination and treatment includes care by a Chiropractor. Examination and treatment may be provided by a Doctor via Telemedicine. This benefit is payable once per Covered Accident.

Major Diagnostic Exams: A major diagnostic exam must be prescribed by a Doctor and must occur within 6 months after the Covered Accident. This benefit is payable once per Covered Accident.

Medical Equipment: The medical equipment must be prescribed by a Doctor and use must begin within 6 months after the Covered Accident. This benefit is payable once per Covered Accident. The types of eligible equipment are:

- Crutches.
- Wheelchair.
- Back Brace.
- Leg Brace.
- Walker.

Mental Health Therapy: Psychological or psychiatric care prescribed by a Doctor and provided in an office or Hospital or a Rehabilitation Facility on an inpatient or outpatient basis. Psychological or psychiatric care may also be provided via Telemedicine. The therapy must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 10 times per Covered Accident.

Outpatient Surgery: Miscellaneous surgery that is not covered by any other Injury benefit. The surgery must take place within 30 Days after a Covered Accident. No benefit is payable for any type of hernia. This benefit is payable up to 2 times per Covered Accident.

Physical or Occupational Therapy: Therapy must be prescribed by a Doctor and provided by a physical therapist or by an occupational therapist in an office or Hospital on an inpatient or outpatient basis. Therapy may also be provided by a physical therapist or occupational therapist via Telemedicine. The therapy must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 10 times per Covered Accident.

"Physical therapist" for this benefit means a person other than you or any family member, who is a licensed health care professional in the state in which treatment is received and providing treatment or advice in accordance with the license. A physical therapist provides services and practices according to the Code of Ethics of the American Physical Therapy Association.

"Occupational therapist" for this benefit means a person other than you or any family member, who is a licensed health care professional in the state in which treatment is received and providing treatment or advice in accordance with the license. An occupational therapist provides services designed to restore self-care, work, and leisure skills to patients/clients who have specific performance incapacities or deficits that reduce their abilities to cope with the tasks of everyday living. An occupational therapist evaluates and treats problems arising from developmental deficits, physical illness or injury, emotional disorders, the aging process, and psychological or social disability.

Prescription Medicine: Medicine prescribed by a Doctor due to Injuries received in a Covered Accident and filled at a pharmacy within 90 days of the Covered Accident. This benefit is payable once per Covered Accident. No benefit is payable for:

- Medication administered while Confined or during surgery.
- Medication administered on an outpatient basis.
- Medication that is recommended by a Doctor that is over-the counter or available without a prescription.
- Devices or medical equipment.
- Refills of prescription medicine for which we previously paid benefits.

Prosthetic Device: You receive a prosthetic device prescribed by a Doctor for use following the loss of use of a hand, a foot or the sight of an eye. The prosthetic device must be received within one year of a Covered Accident. The benefit amount varies based on the number of prosthetic devices received as shown on the SCHEDULE OF BENEFITS. This benefit is payable once per Covered Accident. Prosthetic devices do <u>not</u> include any of the following:

- Hearing aids.
- Dental aids including false teeth.
- Eye-glasses.
- Artificial joints.
- Cosmetic prostheses such as hair wigs.

Speech Therapy: Therapy for the treatment of speech and communication disorders. The approach used varies depending on the disorder. It may include physical exercises to strengthen the muscles used in speech (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

Speech therapy must be prescribed by a Doctor and provided by a speech therapist in an office or Hospital on an inpatient or outpatient basis. Therapy may also be provided by a speech therapist via Telemedicine. The therapy must begin within 180 days after a Covered Accident and be completed within 12 months after the Covered Accident. This benefit is payable up to 10 times per Covered Accident.

"Speech therapist" for this benefit means a person other than you or any family member, who is a licensed health care professional in the state in which treatment is received and providing treatment or advice in accordance with the license. A speech therapist is trained to evaluate and treat voice, speech, language, or swallowing disorders–e.g., hearing impairment, that affect speech (oral-motor-work) and communication.

Urgent Care Facility Treatment: Examination and treatment by a Doctor in an Urgent Care Facility within 7 days after a Covered Accident. This benefit is payable once per Covered Accident.

X-ray: An x-ray must be prescribed by a Doctor. This benefit is payable within 90 days of a Covered Accident and is payable once per Covered Accident.

COMMON INJURIES BENEFITS

We will pay a COMMON INJURIES benefit as shown on the SCHEDULE OF BENEFITS if you receive any of the services or meet any of the conditions described below as the result of Injuries received in a Covered Accident. The Injury must occur while you are covered under the Policy.

Burns: The burn must be treated by a Doctor within 3 days after a Covered Accident. The benefit amount varies based on the burn classification as shown on the SCHEDULE OF BENEFITS. If your burn meets more than one of the burn classifications, the higher amount will be payable. This benefit is payable once per Covered Accident.

Concussion: The concussion must be diagnosed by a Doctor within 3 days after a Covered Accident. The diagnosis must be confirmed by the use of some type of medical imaging procedure; i.e. x-ray, CT scan or MRI.

Dislocations: The Dislocation must be diagnosed by a Doctor within 90 days after a Covered Accident. The benefit amount will vary based on whether the Dislocation is Complete, Complete Requiring Surgical Repair or Incomplete as shown on the SCHEDULE OF BENEFITS. Dislocations that are Complete or Complete Requiring Surgical Repair must be repaired by a Doctor.

If you receive more than one Dislocation in the same Covered Accident, a benefit is payable for all Dislocations. However, the benefit will be no more than two times the benefit amount for the joint involved which pays the highest benefit amount.

If you receive a Dislocation and a Fracture in the same Covered Accident, a benefit is payable for both. However, the benefit will be no more than two times the amount for the bone or joint involved which pays the highest benefit amount.

This benefit is payable 2 times per joint per lifetime of the Policy. Subsequent Dislocations of the same joint after this maximum in a different Covered Accident are not covered.

Emergency Dental Work: Natural teeth must be damaged due to a Covered Accident and either extracted or repaired by the placement of a crown. The benefit amount varies based on the type of services received as shown on the SCHEDULE OF BENEFITS. This benefit is payable once per Covered Accident regardless of the number of teeth involved.

Eye Injury: The eye Injury must be treated by a Doctor within 90 days after a Covered Accident. The Injury must require surgery or the removal of a foreign object by a Doctor. The benefit amount varies based on the type of services received as shown on the SCHEDULE OF BENEFITS. This benefit is payable once per Covered Accident. No benefit is payable for examination with anesthesia or for an Injury to the eyelid which is the moveable fold of skin and muscle that covers the eye.

Fractures: The Fracture must be diagnosed by a Doctor within 90 days after a Covered Accident. The Fracture must require treatment by a Doctor. If the Doctor diagnoses the Fracture as a Chip Fracture, the benefit will be reduced to a percentage of what would have been paid for a Non-Surgical Repair Fracture of the same bone. The benefit amount

varies based on the type of services received as shown on the SCHEDULE OF BENEFITS.

If you receive more than one Fracture in a Covered Accident, a benefit is payable for all Fractures. However, the benefit will be no more than two times the benefit amount listed for the bone which pays the highest benefit amount.

If you receive a Fracture and a Dislocation in the same Covered Accident, a benefit is payable for both. However, the benefit will be no more than two times the amount for the bone or joint involved which pays the highest benefit amount.

Laceration: A laceration is a cut. The laceration must be treated by a Doctor within 3 days after a Covered Accident. The benefit amount will be based on the total length of all lacerations requiring repair that are received in any one Covered Accident as shown on the SCHEDULE OF BENEFITS. If the laceration is severe enough to require sutures but the Doctor chooses to repair it another way, the benefit will be determined as if the laceration was sutured. This benefit is payable once per Covered Accident. If your Injury qualifies as both a laceration and puncture wound, only one benefit in the higher amount will be payable.

Paralysis: Spinal cord Injuries sustained in a Covered Accident that result in the loss of use of one or more arms and legs.

- Hemiplegia = the complete and irreversible paralysis of both limbs on either side of the body
- Monoplegia= the complete and irreversible paralysis of one limb
- Paraplegia = the complete and irreversible paralysis of both legs.
- Quadriplegia = the complete and irreversible paralysis of both arms and both legs.

Paralysis must be confirmed by a Doctor and based on documented evidence of the Injury that caused the paralysis. The duration of the paralysis must be at least 30 days and expected to be permanent. The benefit amount varies based on the degree of paralysis as shown on the SCHEDULE OF BENEFITS. This benefit is payable once per Covered Accident.

Ruptured Disk: You must receive surgical repair of a ruptured disk by a Doctor. The surgical repair must occur within 2 years after the Covered Accident. This benefit is payable once per Covered Accident.

Skin Graft: The skin graft is for a burn for which a benefit was paid under the burn benefit in this section. This benefit is payable once per Covered Accident.

Traumatic Brain Injury: A brain Injury that is caused by a traumatic sudden impact to the head, neck or shoulders, or a penetration of the head.

The traumatic brain Injury must be initially treated by a Doctor within 90 days after a Covered Accident. The diagnosis by a Doctor must occur within 90 days after the Covered Accident. The diagnosis must include a Glasgow Coma Scale score of 8 or less (or equivalent) and the inability to perform independently 2 or more of the following activities of daily living:

- Eating;
- Bathing;
- Dressing;
- Toileting;
- Transferring; and
- Maintaining continence.

This benefit is payable once per Covered Accident.

Tendon/Ligament/Rotator Cuff: The tendon, ligament or rotator cuff must be torn, ruptured or severed and repaired through surgery within 90 days after a Covered Accident. The benefit amount varies based on the number of repairs required and the services received as shown on the SCHEDULE OF BENEFITS. This benefit is payable once per Covered Accident.

Torn Hip, Knee, Shoulder Cartilage: You must receive surgical repair of torn hip, knee or shoulder cartilage. The Injury must be treated by a Doctor within 60 days after a Covered Accident. Surgical repair of the tear must occur within 6 months after the Covered Accident. The benefit amount varies based on the type of service received as shown on the SCHEDULE OF BENEFITS. This benefit is payable once per Covered Accident. If you receive more than one cartilage tear in a Covered Accident, a separate benefit is payable for each location (hip, knee, or shoulder) of the tear.

Subsequent tears of the healing cartilage which occur after the original Covered Accident are not covered unless such tears are the result of Injuries received in a new and separate Covered Accident.

ADDITIONAL BENEFIT(S)

Sports Accident Benefit: An additional percentage of the Accident Hospital Care, Accident Care or Common Injuries benefit amount is payable if the Covered Accident is the result of participating in an organized sporting activity.

"Organized sporting activity" for this benefit means an amateur sports competition or organized practice for an amateur sports competition. The activity must be overseen by an amateur sporting organization that oversees scholastic, recreational or social sports activities. This includes:

- Participation in physical education as a class in a school setting.
- Coaching, officiating or refereeing for an amateur sporting organization.

Organized sporting activity does not include any activity that occurs before, between or after competitions or practices, including travel to or from a competition or practice.

"Amateur sporting organization" means a public or private school, sports association, community recreational association or other organization that as part of its oversight does the following:

- Sets up official rules and standards of play.
- Arranges for officials to oversee competition.
- Organizes inter-team competition, facilities and equipment.

EXCLUSIONS

Benefits are not payable for any loss resulting from any of the following:

- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- Any Sickness or declining process caused by a Sickness.
- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while you are operating a motorized vehicle while intoxicated. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon Written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism, drug abuse, or misuse of alcohol or taking of drugs, other than under the direction of a Doctor.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

NOTICE OF CLAIM
Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM
The claim form is available from the Employer or can be requested from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of claim without waiting for the form. If such Written proof of claim covers the occurrence, character and extent of the loss, and is provided within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM
The claim form(s) may require completion by you and the Employer and your attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM
You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require you to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children, in equal shares.
3. Your grandchildren, in equal shares.
4. Your parents, in equal shares.
5. Your siblings, in equal shares.
6. Your estate.

If a survivor entitled to receive a payment dies before receiving it, we will make payment to that person's estate.

If a survivor entitled to receive a payment has a special needs trust established, we will make payment to that person's trust instead of to the person directly.

"Spouse" in this provision means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a Spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. It also includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after Written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

SPOUSE ACCIDENT RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CAC2

This rider is made a part of the Group Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

ACCIDENT BENEFITS

The benefit amounts for your Spouse are the same as the benefit amounts for you as shown on the SCHEDULE OF BENEFITS section of the Certificate, based on your Spouse's Covered Accident.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

Spouse means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a Spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. It also includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:
- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

ENROLLMENT
If you have a Spouse eligible for Spouse coverage, you must enroll for any Spouse coverage before it will become effective. The Employer or we will provide you with the forms or information needed to complete your enrollment. You may enroll for Spouse coverage when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us.

EFFECTIVE DATE OF COVERAGE
Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:
- The date your Spouse is eligible for coverage, if you enroll for Spouse coverage on or before that date or if you enroll for Spouse coverage within 31 days of your Spouse becoming eligible for coverage.
- The date you enroll for Spouse coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE
Once your Spouse's coverage begins, any increased or additional coverage will take effect on the latest of the following:
- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE
Coverage for your Spouse under this rider ends on the earliest of the following:
- The date your Accident insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below if termination is due to death or involves Spouse coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below regarding Spouse coverage previously continued by you or your Spouse.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below regarding Spouse coverage previously continued by you or your Spouse.
- The last day of the month during which you voluntarily cancel coverage under this rider.
- The last day of the month during which your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.

We will pay benefits for a loss that occurs while your Spouse is insured under this rider even if the rider has since terminated.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, then your Spouse's coverage under this rider may also be continued at the same time. Continued premium payment is required to keep your Spouse's coverage in force. You may decrease the continued Spouse coverage amount based on the available amounts on the Certificate's SCHEDULE OF BENEFITS. You may not increase the continued Spouse coverage amount. Continued Spouse coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse may elect to continue Spouse coverage under this rider if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, your Spouse must elect portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse continues coverage under this provision, your Spouse will become the owner of their Spouse coverage under this rider. Your Spouse may decrease the continued Spouse coverage amount based on the amounts available on the Certificate's SCHEDULE OF BENEFITS. Your Spouse may not increase the continued Spouse coverage amount. Your Spouse's continued coverage will not include any Additional Services Rider. Coverage continued under this provision is subject to all the terms of this rider.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse elects portability. We may change the portability premium rates at any time upon 31 days Written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which premiums for this rider are paid if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date your Spouse voluntarily cancels coverage under this rider.
- The date your Spouse dies.
- The date the Policy terminates because we stop providing accident coverage to all groups in the Policy issue state and coverage for all Covered Persons under the Policy terminates. We will provide 60 days Written notice of termination.

GRACE PERIOD

Refer to the GRACE PERIOD provision in the Certificate if you are continuing coverage under the Certificate's PORTABILITY provision.

If your Spouse is continuing coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision, your Spouse has a grace period of 60 days for the payment of any premium due. During this grace period, your Spouse's coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to your Spouse that if the premium is not paid by the end of the grace period, then all coverage under this rider will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to your Spouse, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your Spouse's coverage was in force during the grace period.

ACCIDENT BENEFITS

Benefit amounts for your Spouse are the same as the benefit amounts for you as shown on the Certificate's SCHEDULE OF BENEFITS. We will pay benefits if your Spouse receives any of the services or meets any of the conditions described in the ACCIDENT BENEFITS sections of the Certificate, as the result of Injuries received in a Covered Accident. The Injury must occur while your Spouse is covered under the Policy.

Only one family care benefit is payable per eligible family member if you and your Spouse are simultaneously Confined in a Hospital or a Critical Care Unit.

Only one pet boarding benefit is payable per eligible pet if you and your Spouse are simultaneously Confined in a Hospital or a Critical Care Unit.

EXCLUSIONS

Benefits are not payable for any loss resulting from any of the following:

- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- Any Sickness or declining process caused by a Sickness.
- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while your Spouse is operating a motorized vehicle while intoxicated. Intoxication means your Spouse's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon Written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism, drug abuse, or misuse of alcohol or taking of drugs, other than under the direction of a Doctor.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

A claimant includes you or your Spouse if your Spouse has continued coverage under a PORTABILITY provision.

NOTICE OF CLAIM

Notice of claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or can be requested from us. If the form is not received from us within 15 days of the request, Written proof of claim may be sent to us without waiting for the form. If such Written proof of claim covers the occurrence, character and extent of the loss, and is provided within the time period below for proof of claim, the claimant will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by the claimant and the Employer and your Spouse's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

Written proof of claim must be sent to us within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, proof of claim must be provided no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Spouse to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

A claimant can start legal action regarding a claim no earlier than 60 days after Written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Spouse's coverage.

Executed at our home office:
250 Marquette Avenue
Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

CHILDREN'S ACCIDENT RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CAC2

This rider is made a part of the Group Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

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You pay the cost of coverage under this rider.

ACCIDENT BENEFITS

The benefit amounts for your Children are the same as the benefit amounts for you as shown on the SCHEDULE OF BENEFITS section of the Certificate, based on your Child's Covered Accident.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

Child or **Children** means a child from live birth but less than 26 years of age who is one of the following:

- Your natural or adopted child (including a child placed for adoption from the date of placement or pursuant to an interim court order of adoption, whichever comes first).
- Your stepchild.
- A child of your civil union partner who is recognized as equivalent to a Spouse by Illinois law.
- A child of your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.
- Your foster child or a child for whom you are a legal guardian.

The child must also meet all of the following conditions:
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches age 26. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing. Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

Spouse means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a Spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. It also includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

If both you and your Spouse are covered under the Policy as an Employee, then only one of you may cover your Children under this rider. If the parent who is covering the Children stops being insured as an Employee then the other parent may enroll for Children’s coverage under this rider within 60 days.

ENROLLMENT
If you have a Child or Children eligible for coverage, you must enroll for any coverage before it will become effective. You may enroll for Children’s coverage when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us. The Employer or we will provide you with the forms or information needed to complete your enrollment.

EFFECTIVE DATE OF COVERAGE
Your Children will be covered at 12:01 a.m. standard time at the Policyholder’s address on the latest of the following:
- The date your Children are eligible for coverage, if you enroll for Children’s coverage on or before that date.
- The date you enroll for Children’s coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Children’s coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for non-medical-related absences.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 30 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 30 days after birth, the "event" will be the date of placement. No additional premium is required.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Children's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE

Coverage for each of your Children under this rider ends on the earliest of the following:

- The last day of the month during which the Child is no longer an eligible Child as defined by this rider. Eligibility of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.
- The date coverage for all your Children ends as described below.

Coverage for all your Children under this rider ends on the earliest of the following:

- The date your Accident insurance terminates. See the PORTABILITY FOLLOWING DEATH provision below if termination is due to death.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below regarding Children's coverage previously continued by you or your Spouse.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below regarding Children's coverage previously continued by you or your Spouse.
- The last day of the month during which you voluntarily cancel coverage under this rider.
- The last day of the month during which you no longer have any eligible Children as defined by this rider.
- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.

We will pay benefits for a loss that occurs while your Child is insured under this rider even if this rider has since terminated.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, then your Children's coverage under this rider may also be continued at the same time. Continued premium payment is required to keep your Children's coverage in force. You may decrease the continued Children's coverage amount based on the available amounts on the Certificate's SCHEDULE OF BENEFITS. You may not increase the continued Children's coverage amount. Continued Children's coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH

If you die and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Accident Rider, then Children's coverage under this rider may be continued at the same time under your Spouse's coverage. After continuing coverage under this rider, each Child will be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

If your Spouse continues coverage under this provision, your Spouse will become the owner of the Children's coverage under this rider. Your Spouse may decrease the continued Children's coverage amount based on the amounts available on the Certificate's SCHEDULE OF BENEFITS. Your Spouse may not increase the continued Children's coverage amount. Your Children's continued coverage will not include any Additional Services Rider. Coverage continued under this provision is subject to all the terms of this rider.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse elects portability. We may change the portability premium rates at any time upon 31 days Written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date your Spouse voluntarily cancels coverage under this rider.
- The date your Spouse's coverage under the Spouse Accident Rider terminates.
- The date there are no longer any eligible Children as defined by this rider.
- The date the Policy terminates because we stop providing accident coverage to all groups in the Policy issue state and coverage for all Covered Persons under the Policy terminates. We will provide 60 days Written notice of termination.

GRACE PERIOD

Refer to the GRACE PERIOD provision in the Certificate if you are continuing coverage under the Certificate's PORTABILITY provision.

If your Spouse is continuing Children's coverage under the PORTABILITY FOLLOWING DEATH provision, your Spouse has a grace period of 60 days for the payment of any premium due. During this grace period, your Children's coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to your Spouse that if the premium is not paid by the end of the grace period, then all coverage under this rider will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to your Spouse, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your Children's coverage was in force during the grace period.

ACCIDENT BENEFITS

Benefit amounts for your Children are the same as the benefit amounts for you as shown on the Certificate's SCHEDULE OF BENEFITS. We will pay benefits if your Child receives any of the services or meets any of the conditions described in the ACCIDENT BENEFITS sections of the Certificate, as the result of Injuries received in a Covered Accident. The Injury must occur while your Child is covered under the Policy. Benefits are payable for each covered Child.

No family care benefit is payable for your Child's Covered Accident.

EXCLUSIONS

Benefits are not payable for any loss resulting from any of the following:

- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- Any Sickness or declining process caused by a Sickness.
- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while your Child is operating a motorized vehicle while intoxicated. Intoxication means your Child's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- War or any act of war, whether declared or undeclared (excluding acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon Written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism, drug abuse, or misuse of alcohol or taking of drugs, other than under the direction of a Doctor.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

A claimant includes you or your Spouse if your Spouse has continued coverage under the PORTABILITY FOLLOWING DEATH provision.

NOTICE OF CLAIM

Notice of claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer can be requested from us. If the form is not received from us within 15 days of the request, Written proof of claim may be sent to us without waiting for the form. If such Written proof of claim covers the occurrence, character and extent of the loss, and is provided within the time period below for proof of claim, the claimant will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by the claimant and the Employer and your Child's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

Written proof of claim must be sent to us within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, proof of claim must be provided no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Child to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require the claimant to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

A claimant can start legal action regarding a claim no earlier than 60 days after Written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Children's coverage.

Executed at our home office:
250 Marquette Avenue
Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CAC2

This rider is made a part of the Group Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:
- You, if you are covered for Accident insurance under the Policy.
- Your Spouse if covered under the Spouse Accident Rider.
- Your Children if covered under the Children's Accident Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in Writing by the Employer that is in accordance with the Employer's formal leave policies. Normal vacation time is not considered a Leave of Absence.

Total Disability or Totally Disabled means that due to an injury or sickness you are unable to perform the material duties of your regular occupation, and you are unable to perform any other occupation for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then you are eligible for coverage under this rider on the latest of the following:
- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.

EFFECTIVE DATE
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for coverage under this rider.

TERMINATION
Coverage under this rider ends on the earliest of the following:
- The date your Accident insurance terminates.

- The date coverage under this rider is terminated for all Active Employees under the Policy.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong.

PORTABILITY
If you continue your coverage under the Certificate's PORTABILITY provision, that continuation will not include this rider.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:
- Employer-approved Leave of Absence, or
- Total Disability,

then coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or terminate according to the Certificate and riders in effect the day prior to the continuation period. Your continued coverage will not include the Additional Services Rider.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be payable as described in the Certificate and riders.

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave
If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during a FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:
- The leave period permitted by FMLA.
- The leave period permitted by State FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

Sickness or Injury
If you are on a Leave of Absence due to your sickness or injury, including Total Disability, then insurance coverage for all Covered Persons may be continued during the Leave of Absence. This continuation period will not be less than 1 week while the Policy is in force for Employees.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

Military Leave
If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and applicable state law, then insurance coverage for all Covered Persons may be continued during the Leave of Absence. This continuation period will not be less than 1 week while the Policy is in force for Employees.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The date coverage under this rider is terminated for all Active Employees under the Policy.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong.
- The end of the period for which premiums are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date you are eligible under the Policy as an Active Employee.
- The date of your death.
- The date you become covered under another group accident insurance policy as an employee or member.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate.

When this continuation ends, insurance under the Policy will stay in force only if all of the following conditions are met:

- Accident insurance is in force for Active Employees under the Policy;
- You are in an eligible class for coverage under the Policy; and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate in effect on the date your premium payments are resumed.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during any period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Active Employees under the Policy, then the terms of the Certificate will apply.

PORTABILITY FOLLOWING TERMINATION OF CONTINUATION

When continuation under this rider ends, continued premium payment will be required to keep coverage in force. If you are not eligible as an Active Employee on that date, then your coverage can be continued under the Certificate's PORTABILITY provision. See the PORTABILITY provisions of the Spouse Accident Rider and Children's Accident Rider for information about continuing coverage after your death or divorce.

Executed at our home office:
250 Marquette Avenue
Suite 900
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

WELLNESS BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CAC2

This rider is made a part of the Group Accident Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

WELLNESS BENEFIT

You:	$50 per day
Your Spouse:	$50 per day
Your Children:	100% of your wellness benefit amount, per day, per Child

A wellness benefit is payable up to a maximum of one day per Covered Person per calendar year.

DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

Covered Person means:

- You, if you are covered for Accident insurance under the Policy.
- Your Spouse if covered under the Spouse Accident Rider.
- Your Children if covered under the Children's Accident Rider.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then you are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Accident coverage effective date.

Your Spouse is eligible for coverage under this rider on the later of the date above or the date your Spouse is eligible for coverage under the Spouse Accident Rider.

Your Children are eligible for coverage under this rider on the later of the date above or the date each Child is eligible for coverage under the Children's Accident Rider.

EFFECTIVE DATE
Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION
Coverage under this rider will terminate on the earliest of the following:
- The date your Accident insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below and in any riders if termination is due to death or involves coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below.
- For your Spouse's coverage, the date your Spouse's coverage under the Spouse Accident Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Accident Rider terminates.
- The date the Policy terminates because we stop providing accident coverage to all groups in the Policy issue state and coverage for all Covered Persons under the Policy terminates. We will provide 60 days Written notice of termination.

PORTABILITY
If you continue your coverage under the Certificate's PORTABILITY provision, then coverage under this rider will also be continued during portability. Continued coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE
If you die or divorce and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Accident Rider, then coverage under this rider can also be continued under your Spouse's coverage. Continued coverage under this provision is subject to all the terms of this rider.

ASSIGNMENT
At the time of claim under this rider, you can assign the payment of a benefit under this rider to a third party who is not the Policyholder.

BENEFITS

We will pay you a WELLNESS benefit as shown on the SCHEDULE OF BENEFITS if a Covered Person has a health screening test on or after the Covered Person's coverage effective date. A benefit is payable up to a maximum of one day per Covered Person per calendar year. The amounts are shown on the SCHEDULE OF BENEFITS.

Health screening tests include, but are not limited to:

- Blood test for triglycerides
- Pap smear or thin prep pap test;
- Flexible sigmoidoscopy
- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography
- PSA (prostate cancer)
- Electrocardiogram (EKG)
- Endoscopy
- Carotid Doppler
- Routine Eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through age 18
- Biometric screenings
- Molecular or antigen test (Coronavirus)

EXCLUSIONS

The EXCLUSIONS section of the Certificate and riders does not apply to this rider.

CLAIMS

The PHYSICAL EXAMINATION provision does not apply to this rider. A claimant includes you or your Spouse if your Spouse has continued coverage under a PORTABILITY provision.

NOTICE OF CLAIM

Notice of claim must be given to us during the same calendar year the health screening test occurs or within 30 days of the end of the calendar year, whichever is later. The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or can be requested from us. If the form is not received from us within 15 days of the request, Written proof of claim may be sent to us without waiting for the form. If such Written proof of claim covers the occurrence, character and description of the health screening test, and is provided within the time period below for proof of claim, the claimant will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by the claimant and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

Written proof of claim must be sent to us within 90 days after the date of the health screening test. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, proof of claim must be provided no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

A claimant can start legal action regarding a claim no earlier than 60 days after Written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to the coverage.

Executed at our home office:
250 Marquette Avenue
Suite 900
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

ALASKA CERTIFICATE ENDORSEMENT

for Group Accident Insurance

ALASKA LAW GOVERNS WITH RESPECT TO CERTIFICATES COVERING ALASKA RESIDENTS UNDER GROUP POLICIES ISSUED IN A STATE OTHER THAN ALASKA.

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

The definition of "Doctor" is changed to the following:

> **Doctor** means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received. In Alaska this includes: a state licensed physician, physician assistant, dentist, osteopath, optometrist, chiropractor, nurse midwife, advance nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, licensed clinical social worker, licensed professional counselor, or certified direct-entry midwife.

II. GENERAL PROVISIONS

If your Certificate and any riders include a PORTABILITY provision, and the time period for us to change portability premium rates with written notice is less than 45 days, then this time period is changed to be 45 days.

III. ACCIDENT BENEFITS

If the time period between the Covered Accident and **Surgery** in your Certificate is less than 5 days, then this time period is changed to be 5 days.

If the time period between the Covered Accident and the prescription and use of **Medical Equipment** in your Certificate is less than 5 days, then this time period is changed to be 5 days.

If your Certificate includes an **Outpatient Surgery** benefit and the time period between the Covered Accident and the surgery is less than 5 days, then this time period is changed to be 5 days.

IV. EXCLUSIONS

If your Certificate and any riders have an exclusion for alcoholism or drug abuse, then that exclusion is changed to the following:

- Alcoholism, drug abuse, or taking of drugs, other than under the direction of a Doctor.

If your Certificate and any riders have an exclusion related to an aircraft or hot air balloon, then the following statement is added:

Jumping or falling from an aircraft or hot air balloon in an emergency while a fare-paying passenger is not excluded.

If your Certificate and any riders have an exclusion related to recreational activities, then that exclusion is changed to the following:

- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting or kitesurfing.

V. OFF JOB ACCIDENT DISABILITY INCOME RIDER

If your Certificate includes the Off Job Accident Disability Income Rider, then the OVERPAID CLAIMS provision is changed to the following:

OVERPAID CLAIMS

We have the right to recover any overpayments we make under this Off Job Accident Disability Income Rider within 90 days after any overpayment was made. You must reimburse us in full. We will determine the method by which the repayment is to be made. We will not recover more money than the amount we paid you. However, we reserve the right to recover any prior or current overpayment from any past, current or new payable disability claim under this rider.

VI. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

Consumer Notice for Arkansas Residents

The nearest servicing office is the Minneapolis, Minnesota office of Voya Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.
The mailing address is:

PO Box 20
Minneapolis, Minnesota 55440-0122
Telephone: (800) 537-5024

You have the right to file a complaint with the Arkansas Insurance Department (AID). A complaint can be filed online at the AID website https://insurance.arkansas.gov.

You may also contact AID to request a complaint form be mailed to you by calling AID at (800) 852-5494 or (501) 371-2640.

You may also request in writing for a complaint form to be mailed to you. Mail your request to:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

This consumer notice is for information only and does not become a part or condition of this certificate or policy. Please insert this notice in your certificate or policy.

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

Web Site: www.insurance.ca.gov/01-consumers/101-help

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

IDAHO CERTIFICATE ENDORSEMENT

for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. CERTIFICATE COVER PAGE

The following statements are added to the cover page of your Certificate:

Notice to Buyer: This is an Accident-only Certificate and it does not pay benefits for loss from Sickness. Review your Certificate carefully.

RENEWABILITY
The coverage under this Certificate is conditionally renewable according to the terms and provisions of the Policy.

II. EXCLUSIONS

If your Certificate and any riders contain an exclusion for felony or illegal activity, then that exclusion is replaced by the following:

- Participation in a felony.

If your Certificate and any riders contain an exclusion for intoxication while operating a motor vehicle, then that exclusion does not apply.

If your Certificate and any riders contain an exclusion for alcoholism or drug abuse, then that exclusion is replaced by the following:

- Alcoholism or drug addiction.

If your Certificate and any riders contain an exclusion for riding in or driving any motor-driven vehicle in a race, stunt show or speed test, then that exclusion does not apply.

If your Certificate and any riders contain an exclusion related to aviation, then that exclusion is replaced by the following:

- Aviation for wage or profit. Flying as a fare-paying passenger is not excluded.

If your Certificate and any riders contain any exclusions for recreational activities or competitive athletic contests, then those exclusions do not apply.

III. ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

If your Certificate includes the AD&D Rider, and the Accidental Death benefit amount for Children is less than $1,000, then that benefit amount is changed to $1,000.

If your Certificate includes the AD&D Rider, and the Dismemberment benefit for loss of two or more fingers or toes is less than $1,000, then that benefit amount is changed to $1,000.

If your Certificate includes the AD&D Rider, and the Dismemberment benefit for loss of one finger or toe is less than $500, then that benefit amount is changed to $500.

IV. SICKNESS HOSPITAL CONFINEMENT RIDER

If your Certificate includes the Sickness Hospital Confinement Rider with a definition of Pre-Existing Condition, and that definition contains a time period of less than 6 months, then the time period in that definition is changed to 6 months.

V. OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

See the next page for the Outline of Coverage for Idaho Residents.

VI. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

ACCIDENT-ONLY COVERAGE

THE CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

Read Your Certificate Carefully. This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of the Policyholder, you, and ReliaStar Life Insurance Company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Accident-only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

The policy provides benefits if a covered person receives any of the services or meets any of the conditions included in the "Schedule of Benefits" as a result of injuries received in a covered accident. The general categories of benefits are: Accident Hospital Care, Accident Care and Common Injuries. A partial listing of losses follows. Please consult your certificate and riders for specific information about how these terms are used, any requirements that describe qualifying for a particular loss, and the benefit amounts. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of benefits available under the policy.

- Accident Hospital Care includes: surgery; blood, plasma, platelets; hospital admission; hospital confinement; coma; transportation; and lodging. At the Policyholder's option, it may also include: critical care unit confinement, rehabilitation facility confinement; or family care benefits.
- Accident Care includes: medical equipment; physical or occupational therapy; and prosthetic devices. At the Policyholder's option, it may also include: initial doctor visit; urgent care facility treatment; emergency room treatment; ambulance benefits; follow-up doctor treatment, chiropractic care; speech therapy; major diagnostic exams; or x-rays.
- Common Injuries includes: burns; skin grafts; emergency dental work; eye injuries; torn knee cartilage; lacerations; ruptured disk; tendon/ligament/rotator cuff; concussion; paralysis; dislocations and fractures.

Accident-only coverage is subject to exclusions which may prevent benefits from being paid. Also, benefit payment is contingent on proof of loss which may require additional information be provided prior to claim determination, and there is generally a requirement that services or conditions be met within a certain time period following a covered accident. The Policyholder may also choose to have an eligibility waiting period, during which time no coverage is in force. **Riders may have benefit reductions or termination provisions based on age.**

The exclusions that apply to all provisions for Accident-only coverage are provided in the "Exclusions" section of the certificate and any riders. The "Schedule of Benefits", the Benefits section(s) and the "Exclusions" section of the certificate and any riders provide specific information about the conditions for receiving benefits and any limitations. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of the exclusions and limitations under the policy.

Exclusions in the certificate:
Benefits are not payable for any loss caused in whole or directly by any of the following:

- Participation in a felony.
- Suicide, attempted suicide or any intentionally self-inflicted injury, while sane or insane.
- War or any act of war, whether declared or undeclared (other than acts of terrorism).
- Service in the armed forces or units auxiliary to it. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Alcoholism or drug addiction
- Aviation for wage or profit. Flying as a fare-paying passenger is not excluded.
- Any sickness or declining process caused by a sickness.

Your coverage will continue under the policy, while the policy remains in force, as long as you continue to meet the eligibility requirements and all premiums due are paid. You may have the option to continue your coverage by direct payment of premiums to ReliaStar Life Insurance Company after you no longer meet the eligibility requirements.

The eligibility requirements for a spouse and children may include age limitations, as provided in the riders. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of any age restrictions under the policy.

The Policyholder may change the terms of the policy at any time with ReliaStar Life Insurance Company's agreement. The Policyholder or ReliaStar Life Insurance Company may terminate the policy at any time. ReliaStar Life Insurance Company reserves the right to change premiums at any time according to the terms of the policy.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from the company.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MINNESOTA CONTINUATION CERTIFICATE ENDORSEMENT

for Group Accident Insurance or Group Limited Benefit Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

If the coverage in your Certificate is called Group Limited Benefit Insurance, then all references in this endorsement to the "Spouse Accident Rider" mean the Spouse Limited Benefit Rider, and all references to the "Children's Accident Rider" mean the Children's Limited Benefit Rider.

If any riders include an EXTENSION FOLLOWING DEATH and/or an EXTENSION FOLLOWING DEATH OR DIVORCE provision, then all references in this endorsement to "Portability" mean Extension.

If your Certificate includes an Adverse Outcome Accident Rider, then all references in this endorsement to "Catastrophic Accident Rider" mean the Adverse Outcome Accident Rider.

I. SPOUSE ACCIDENT RIDER

If your Certificate includes a Spouse Accident Rider, then the PORTABILITY FOLLOWING DEATH OR DIVORCE provision on that rider is replaced by the following:

> **MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE**
> If you die or divorce, your Spouse can elect to maintain Spouse coverage if certain conditions are met. Upon your Spouse's request, the Employer will provide your Spouse with information about the cost of maintaining coverage under this provision and how to elect continuation. Your Spouse must have been insured under this rider on the date of your death or divorce, and your Spouse must elect continuation and pay the first premium within 90 days of the date of your death or divorce.
>
> Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time your Spouse becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your Spouse.
>
> Coverage maintained under this provision will end on the earliest of the following:
> - The date coverage would otherwise terminate for the Spouse according to this rider's TERMINATION provision.
> - The date your Spouse becomes covered under any group accident policy as an employee, member or spouse.
> - The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

If your Spouse Accident Rider does not include a PORTABILITY FOLLOWING DEATH OR DIVORCE provision, then the provision above is added to the rider.

Any references to Portability in the BENEFIT PAYMENTS provision on the Spouse Accident Rider are replaced by the following:

> For MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits unpaid at your Spouse's death will be paid to your Spouse's estate.

If your Spouse Accident Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statement is added to the BENEFIT PAYMENTS provision on the rider.

II. CHILDREN'S ACCIDENT RIDER

If your Certificate includes a Children's Accident Rider, then the PORTABILITY FOLLOWING DEATH provision on that rider is replaced by the following:

MINNESOTA CONTINUATION FOLLOWING DEATH

If you die while this rider is in force, Children's coverage can be maintained if certain conditions are met. Your Children must have been insured under this rider on the date of your death. Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to your death.

If your Spouse has elected Minnesota continuation under the Spouse Accident Rider, then your Spouse may also elect continuation of this Children's Accident Rider at the same time. If you do not have an eligible Spouse insured under the Spouse Accident Rider at the time of your death, then each eligible Child insured under the Children's Accident Rider may elect Minnesota continuation and pay the first premium within 90 days of the date of your death.

Upon request of your Spouse, Child or the Child's legal guardian, the Employer will provide that person with information about the cost of maintaining coverage under this provision and how to elect this continuation.

Premiums will be billed directly to your Spouse, Child or Child's legal guardian as applicable. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time your Child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your Spouse, Child or Child's legal guardian as applicable.

If your Spouse or the Child's legal guardian dies while a Child's coverage is in force under this provision, then the Child or their new legal guardian must contact us within 31 days of the death for information about how to maintain the Child's coverage under this provision.

Each Child's coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the Child according to this rider's TERMINATION provision.
- The end of the period for which premium are paid for the Child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the Child becomes covered under any group accident policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

If your Children's Accident Rider does not include a PORTABILITY FOLLOWING DEATH provision, then the provision above is added to the rider.

The following provisions are also added to the Children's Accident Rider:

MINNESOTA CONTINUATION FOLLOWING DIVORCE

If you divorce and your former spouse has elected Minnesota continuation under the Spouse Accident Rider, then this Children's Accident Rider can be maintained under your former spouse's coverage for each child whose coverage would otherwise terminate due to the divorce. Upon your former spouse's request, the Employer will provide your former spouse with information about the cost of maintaining coverage under this provision and how to elect continuation.

Premiums will be billed directly to your former spouse. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time the child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your former spouse.

If your former spouse dies while a child's coverage is in force under this provision, then the child or their legal guardian must contact us within 31 days of the death for information about how to maintain the child's coverage under this provision.

Each child's coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the child according to this rider's TERMINATION provision.
- The end of the period for which premiums are paid for the child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the child becomes covered under any group accident policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD

If your Child's coverage under this rider would otherwise terminate because the child no longer meets the definition of Child in this rider, for a reason other than your death or divorce, then the child can elect to maintain Child coverage under this rider for a period of time. The child (or the child's legal guardian) must elect continuation and pay the first premium within 90 days of the date of loss of eligibility.

Upon request of the child or the child's legal guardian, the Employer will provide that person with information about the cost of maintaining coverage under this provision and how to elect this continuation.

Premiums will be billed directly to the child or child's legal guardian as applicable. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time the child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to the child or child's legal guardian as applicable.

If the child's legal guardian dies while the child's coverage is in force under this provision, then the child or their new legal guardian must contact us within 31 days of the death for information about how to maintain the child's coverage under this provision.

A child's coverage maintained under this provision will end on the earliest of the following:

- 36 months after the date continuation under this provision started.
- The date coverage would otherwise terminate for the child according to this rider's TERMINATION provision.
- The end of the period for which premiums are paid for the child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the child becomes covered under any group accident policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

Any references to Portability in the BENEFIT PAYMENTS provision on the Children's Accident Rider are replaced by the following:

> For MINNESOTA CONTINUATION FOLLOWING DIVORCE, benefits will be paid to your former spouse, and any accrued benefits unpaid at your former spouse's death will be paid to your former's spouse's estate. For MINNESOTA CONTINUATION FOLLOWING DEATH or MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD, benefits will be payable to the person responsible for premium payments for that child, and any accrued benefits unpaid at that person's death will be payable to that person's estate.

If your Children's Accident Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statements are added to the BENEFIT PAYMENTS provision on the rider.

III. CATASTROPHIC ACCIDENT RIDER

If your Certificate includes a Catastrophic Accident Rider, then the PORTABILITY FOLLOWING DEATH OR DIVORCE provision on that rider is replaced by the following:

> **MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE**
> If you die or divorce and your Spouse is approved by us for Minnesota continuation under the Spouse Accident Rider, then this rider can also be continued under your Spouse's coverage.

If your Catastrophic Accident Rider does not include a PORTABILITY FOLLOWING DEATH OR DIVORCE provision, then the provision above is added to the rider.

Any references to Portability in the BENEFIT PAYMENTS provision on the Catastrophic Accident Rider are replaced by the following:

> For MINNESOTA CONTINUATION FOLLOWING DIVORCE, benefits will be paid to your former spouse, and any accrued benefits unpaid at your former spouse's death will be paid to your former's spouse's estate. For MINNESOTA CONTINUATION FOLLOWING DEATH or MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD, benefits will be payable to the person responsible for premium payments for the individual, and any accrued benefits unpaid at that person's death will be payable to that person's estate.

If your Catastrophic Accident Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statements are added to the BENEFIT PAYMENTS provision on the rider.

IV. ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

If your Certificate includes an Accidental Death & Dismemberment (AD&D) Rider, then the PORTABILITY FOLLOWING DEATH OR DIVORCE provision on that rider is replaced by the following:

> **MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE**
> If you die or divorce and your Spouse is approved by us for Minnesota continuation under the Spouse Accident Rider, then this rider can also be continued under your Spouse's coverage.

If your AD&D Rider does not include a PORTABILITY FOLLOWING DEATH OR DIVORCE provision, then the provision above is added to the rider.

Any references to Portability in the BENEFIT PAYMENTS provision on the AD&D Rider are replaced by the following:

> For MINNESOTA CONTINUATION FOLLOWING DIVORCE, benefits will be paid to your former spouse, and any accrued benefits unpaid at your former spouse's death will be paid to your former's spouse's estate. For MINNESOTA CONTINUATION FOLLOWING DEATH or MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD, benefits will be payable to the person responsible for premium payments for the individual, and any accrued benefits unpaid at that person's death will be payable to that person's estate.

If your AD&D Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statements are added to the BENEFIT PAYMENTS provision on the rider.

V. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MAINE CERTIFICATE ENDORSEMENT

for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

The following are added after the TERMINATION OF COVERAGE provision:

If your coverage ends due to a lapse or default on your part, your coverage may be reinstated on the basis that you suffered from a cognitive impairment or functional incapacity at the time of cancellation. You or someone authorized to act on your behalf must submit a request for reinstatement to us within 90 days of cancellation along with medical proof, at your expense, that you suffered from a cognitive impairment or functional incapacity at the time of cancellation. Within 15 days of our request, all premiums due from the date of cancellation must also be received by us in order to consider your request for reinstatement. If we approve your request, your coverage will be reinstated at the same level as though the cancellation had not occurred.

THIRD PARTY NOTICE
You may designate an additional person to receive notice of any intent to terminate coverage. You may change this designation at any time. The form is available upon request from the Policyholder.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MASSACHUSETTS CERTIFICATE ENDORSEMENT

for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

The following statements are added to the TERMINATION OF COVERAGE provision:

> If your employment ends, your coverage will continue under the Policy for a period of 31 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.
>
> If your employment is terminated due to a plant closing or a partial closing (as defined in section 71A of Chapter 151A, Massachusetts Statutes), your coverage will continue under the Policy for a period of 90 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.

Massachusetts law requires the following disclosure to be provided to Massachusetts residents:

> **As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).**
>
> This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards,** even if it does include services that are not available in your other health plans.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MINNESOTA CERTIFICATE ENDORSEMENT

for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

If your Certificate includes a definition of **Child** or **Children**, then this definition is changed as follows:

If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The definition includes a child for whom you or your Spouse are a legal guardian. The definition also includes your grandchild who is financially dependent on you and resides with you continuously from birth.

Any reference in the definition to disability means developmental disability, mental illness or disorder, or physical disability.

II. GENERAL PROVISIONS

The POLICY TERMINATION provision is changed to add the following statement:

If the Policy is terminated, we will make a good faith effort to notify all Insured Persons at least 30 days before the termination date. We will not notify Insured Persons if we have reasonable evidence that the Policy has been or will be replaced by a substantially similar group policy, plan or contract.

III. EXCLUSIONS

The EXCLUSIONS section of your Certificate and any riders is changed as follows:

If any exclusion refers to illegal activity, then that exclusion is changed to the following:

- Participation or attempt to participate in a felony or illegal occupation.

If any exclusion refers to an Accident while intoxicated, then that exclusion is changed to the following:

- An Accident while you are operating a motorized vehicle while under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit. (Note: Under riders this refers to the Covered Person.)

If any exclusion refers to alcoholism or drug abuse, then that exclusion is changed to the following:

- Alcoholism or drug abuse.
- Being under the influence of any narcotic, unless the narcotic is taken under the direction of and as directed by a Doctor.

IV. CHILDREN'S ACCIDENT RIDER

If your Certificate includes a Children's Accident Rider, then the definition of **Child** or **Children** on the rider is changed as follows:

If the definition includes a minimum Child age of 14 days, then this minimum is changed to birth.

If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The definition includes a child for whom you or your Spouse are a legal guardian. The definition also includes your grandchild who is financially dependent on you and resides with you continuously from birth.

If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

Any reference in the definition to "disability" means developmental disability, mental illness or disorder, or physical disability.

V. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900
Minneapolis, Minnesota 55401
(612) 372-5432

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or the health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South Seventh Street
Minneapolis, Minnesota 55402
Telephone: (612) 322-8713

The maximum amount the Guaranty Association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in the present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant’s lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association’s limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MONTANA CERTIFICATE ENDORSEMENT

for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. NEWBORN CHILDREN

If you are covered under the Policy, your eligible newborn Child is automatically covered for the first 31 days after birth. The benefit amount is the same amount indicated on the Children's Accident Rider for all eligible Children.

No Benefit Waiting Period in any riders applies to your eligible newborn Child.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

NEW HAMPSHIRE CERTIFICATE ENDORSEMENT

for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. SCHEDULE OF BENEFITS

If any Confinement benefit in your Certificate or any rider is less than $50 per day, then this benefit is increased to be $50 per day.

If any Confinement benefit in your Certificate or any rider is for less than 31 days, then this benefit is increased to be 31 days.

II. EXCLUSIONS

The EXCLUSIONS section of your Certificate and any riders is changed as follows:

If any exclusion refers to illegal activity, then that exclusion is replaced by the following:

- Participation in a felony, riot or insurrection.

If any exclusion refers to alcoholism, drug abuse or the misuse of alcohol or taking of drugs, then that exclusion is replaced by the following:

- The voluntary consumption of drugs that are not prescribed by your Doctor or used in the manner intended.
- Substance use disorders.

If any of these exclusions appear:

- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.

then these exclusions do not apply to you or to any Covered Person.

If any exclusion refers to an aircraft or hot air balloon, then that exclusion is replaced by the following:

- Aviation, except as a fare-paying passenger.

If your Certificate or any rider contains an exception to this exclusion, then that exception still applies.

If any exclusion refers to semi-professional or professional competitive athletic contests, then that exclusion is replaced by the following:

- Professional sports.

III. CLAIMS

If the PROOF OF CLAIM provision in your Certificate and any riders indicates that there is a 1 year limit for providing proof of claim, then this statement does not apply to you.

IV. CHILDREN'S ACCIDENT RIDER

If your Certificate includes a Children's Accident Rider, the definition of **Child** or **Children** is changed as follows:

If the definition includes a maximum Child age of less than 26 years, then this maximum is changed to 26 years.

If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

V. SICKNESS HOSPITAL CONFINEMENT RIDER

If your Certificate includes a Sickness Hospital Confinement Rider, then that rider is changed as follows:

If your rider contains a definition of **Pre-Existing Condition**, and the time period in that definition is more than 6 months, then the time period in that definition for you and any Covered Person is limited to 6 months. As it relates to your Children, congenital anomalies are not considered a Pre-Existing Condition.

If your rider contains a PRE-EXISTING CONDITION EXCLUSION, and the length of that exclusion is more than 6 months, then the length of that exclusion for you and any Covered Person is limited to 6 months.

VI. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

SPOUSE ENDORSEMENT FOR NEW HAMPSHIRE RESIDENTS

Your Certificate(s) and Spouse rider(s) have been changed as follows. Please keep this endorsement with your Certificate(s). This endorsement is subject to all other terms of the Policy.

If your Certificate contains definitions of "You and Your" and "We, Us and Our", then all references to "you" and "your" in this endorsement mean "You and Your" as defined in your Certificate, and all references to "we" and "us" and "our" in this endorsement mean "We, Us and Our" as defined in your Certificate.

I. CONTINUATION FOLLOWING DIVORCE OR LEGAL SEPARATION

If you divorce or legally separate, and the final decree of divorce or legal separation does not expressly prohibit continuation of coverage for your former Spouse, then your former Spouse can elect to continue Spouse coverage for a limited time. The former Spouse must have been insured under our Policy as your Spouse on the date before the date of divorce or legal separation. In order to continue coverage under this provision, the former Spouse has 30 days after the date of divorce or legal separation in which to make the election, pay the first premium, and provide us with the final decree of divorce or legal separation.

When we put the former Spouse on continuation under this provision, the former Spouse becomes the owner of that Spouse coverage under the Policy. All Spouse benefits are payable to the former Spouse. Premiums will be billed directly to the former Spouse. Continued premium payment is required to keep coverage in force. The benefits and premium rates for Spouse coverage continued under this provision will remain the same as though the former Spouse were still eligible as your lawful Spouse. Spouse coverage may not be increased.

Spouse coverage continued under this provision will end on the earliest of the following:

- The 3-year anniversary of the final decree of divorce or legal separation.
- The date of the former Spouse's remarriage.
- The date of your remarriage.
- The date the former Spouse dies.
- The date you die.
- The end date of coverage, if any, as provided by the final decree of divorce or legal separation.
- The end of the period for which the former Spouse paid premiums, if the former Spouse stops making a required premium contribution, subject to the grace period.
- The date the Policy terminates.

If all of the following are true:

- the former Spouse's coverage was being continued under a similar provision of the Employer's prior group policy that provided the same type of coverage as our Policy,
- your coverage under the prior policy is replaced by coverage under our Policy, and
- the former Spouse's coverage under the prior policy stops due to the prior policy's termination,

then the former Spouse can elect to continue the Spouse coverage for the remainder of the time period described above while our Policy is in force. The benefits, premium rates and all other terms for continued Spouse coverage are subject to the terms of our Policy. In order to continue Spouse coverage, the former Spouse has 30 days after your coverage effective date under our Policy in which to make the election, pay the first premium, and provide us with proof of their eligibility for continuation under the prior policy.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:
- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):
- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual Annuities
- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:
- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

(i) With respect to one life, regardless of the number of policies or contracts:

- $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability

income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or

- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each payee of a structured settlement annuity or beneficiary if the payee is deceased, $300,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any,

(iii) the association is not obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for health benefit plans, in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual or with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(iv) the limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(v) benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

TEXAS CERTIFICATE ENDORSEMENT

for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

If your Certificate includes a definition of **Child** or **Children**, then this definition is changed as follows:

If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The definition includes your unmarried grandchild who is your dependent for federal income tax purposes on the date you are eligible for coverage. The definition also includes a child for whom you must provide medical support under a court order.

II. CHILDREN'S ACCIDENT RIDER

If your Certificate includes a Children's Accident Rider, then the definition of **Child** or **Children** on the rider is changed as follows:

If the definition includes a minimum Child age of 14 days, then this minimum is changed to birth.

If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The definition includes your unmarried grandchild who is your dependent for federal income tax purposes on the date the grandchild is first eligible under this rider. The definition also includes a child for whom you must provide medical support under a court order.

If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

III. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

Texas Residents: Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

ReliaStar Life Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Contact Center Manager at 1-800-955-7736

Toll-free: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Email: LifeClaims@voya.com

Mail: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puedo resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, pro su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tamblen debe presenter una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

ReliaStar Life Insurance Company

Para obtener informacion o para presenter una queja ante su compania de seguros:

Llame a: Customer Contact Center Manager at 1-800-955-7736

Telefono gratuito: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Correo electronico: LifeClaims@voya.com

Direccion postal: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada con los seguros o para presenter una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 for disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

To learn more about the above protections, please visit the Association's website at www.utlifega.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

WASHINGTON CERTIFICATE ENDORSEMENT

for Group Accident Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. ACCIDENT HOSPITAL CARE BENEFITS

The time period in the **Blood, Plasma, Platelets** provision between the Covered Accident and transfusion is changed to one year.

If your Certificate includes a **Critical Care Unit Confinement** benefit, then the time period in that provision between the Covered Accident and Confinement is changed to one year.

The time period in the **Hospital Admission** provision between the Covered Accident and admission is changed to one year.

The time period in the **Hospital Confinement** provision between the Covered Accident and Hospital Confinement is changed to one year.

The time period in the **Surgery** provision between the Covered Accident and surgery is changed to one year.

II. ACCIDENT CARE BENEFITS

If your Certificate includes an **Ambulance, Air** benefit, then the time period in that provision between the Covered Accident and transport is changed to one year.

If your Certificate includes an **Ambulance, Ground** benefit, then the time period in that provision between the Covered Accident and transport is changed to one year.

If your Certificate includes a **Chiropractic Treatment** benefit, then the time period in that provision between the Covered Accident and the examination and treatment is changed to one year. The time period between the Covered Accident and the completion of treatment is changed to 18 months.

If your Certificate includes an **Emergency Room Treatment** benefit, then the time period in that provision between the Covered Accident and treatment is changed to one year.

If your Certificate includes a **Follow-Up Doctor Treatment** benefit, then the time period in that provision between the Covered Accident and treatment is changed to one year. The time period between the Covered Accident and the completion of treatment is changed to 18 months.

If your Certificate includes an **Initial Doctor Visit** benefit, then the time period in that provision between the Covered Accident and treatment is changed to one year.

If your Certificate includes a **Major Diagnostic Exams** benefit, then the time period in that provision between the Covered Accident and the exam is changed to one year.

The time period in the **Medical Equipment** provision between the Covered Accident and the beginning use of the prescribed medical equipment is changed to one year.

The time period in the **Outpatient Surgery** provision between the Covered Accident and the surgery is changed to one year.

The time period in the **Physical or Occupational Therapy** provision between the Covered Accident and the beginning of therapy is changed to one year. The time period between the Covered Accident and the completion of therapy is changed to 18 months.

If your Certificate includes a **Speech Therapy** benefit, then the time period in that provision between the Covered Accident and the beginning of therapy is changed to one year. The time period between the Covered Accident and the completion of therapy is changed to 18 months.

If your Certificate includes an **Urgent Care Facility Treatment** benefit, then the time period in that provision between the Covered Accident and the examination and treatment is changed to one year.

If your Certificate includes an **X-ray** benefit, then the time period in that provision between the Covered Accident and the prescription is changed to one year.

III. COMMON INJURIES BENEFITS

The time period in the **Burns** provision between the Covered Accident and treatment is changed to one year.

The time period in the **Concussion** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Dislocations** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Eye Injury** provision between the Covered Accident and treatment is changed to one year.

The time period in the **Fractures** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Laceration** provision between the Covered Accident and treatment is changed to one year.

The time period in the **Ruptured Disk** provision between the Covered Accident and treatment is changed to one year. The time period between the Covered Accident and surgical repair is also changed to one year.

The time period in the **Tendon/Ligament/Rotator Cuff** provision between the Covered Accident and surgical repair is changed to one year.

The time period in the **Torn Knee Cartilage** provision between the Covered Accident and treatment is changed to one year. The time period between the Covered Accident and surgical repair is also changed to one year.

IV. ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) RIDER

If your Certificate includes an AD&D Rider, then the following changes apply:

The time period in the **Accidental Death** provision between the Covered Accident and death is changed to one year.

The time period in the **Common Carrier** provision between the Covered Accident and death is changed to one year.

The time period in the **Dismemberment** provision between the Covered Accident and loss is changed to one year.

The time period in the **Dismemberment** provision between the Covered Accident and loss of a finger or toe and subsequent loss of a hand or foot on the same side of the body is changed to one year.

V. CATASTROPHIC ACCIDENT RIDER

If your Certificate includes a Catastrophic Accident Rider, then the following changes apply:

The time period in the CATASTROPHIC ACCIDENT BENEFIT section between the Covered Accident and loss is changed to one year.

If the Catastrophic Accident Rider includes a **Home Modification Benefit** and/or a **Vehicle Modification Benefit**, then the time period in the HOME AND/OR VEHICLE MODIFICATION BENEFITS section between the Covered Accident and the prescription is changed to one year.

VI. EXCLUSIONS

If the EXCLUSIONS section of your Certificate and any riders has exclusions for intoxication, alcoholism and/or drug abuse, then these exclusions do not apply.

VII. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

Wisconsin Complaint Notice

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

ReliaStar Life Insurance Company
Customer Service
P.O. Box 20
Minneapolis, MN 55440-0020
1-877-236-7564

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103.

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 122
Minneapolis, Minnesota 55440-0122

Plan Name, Number and Name and Address of Plan Sponsor:
BMO U.S. Health and Welfare Benefit Plan
29316-4CAC2
BMO Financial Corp.
320 South Canal Street, Floor 8
Chicago, IL 60606

Name, Address, and Telephone Number of the Plan Administrator:
BMO Financial Corp.
Benefits Administration Committee
320 South Canal Street, Floor 8
Chicago, IL 60606
Human Resources Centre (HRC): 1-888-927-7700

Identification Numbers
IRS Employer Identification Number: 51-0275712
Plan Number: 507

Agent for Legal Process: Plan Administrator

Trustees: BNY Mellon Client Service Center, 500 Ross Street, 8th Floor, Pittsburgh, PA 15262-0001

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Premiums are 100% Employee paid.

Plan Year: January 1 through December 31

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR ACCIDENT INSURANCE

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant also the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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YOUR CRITICAL ILLNESS INSURANCE PLAN

For Employees of
BMO Financial Corp.

D9876 (10/23)

GROUP CRITICAL ILLNESS INSURANCE CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 877-236-7564

POLICYHOLDER:	BMO Financial Corp.
GROUP POLICY NUMBER:	29316-4CCI2
POLICY EFFECTIVE DATE:	January 1, 2021
GOVERNING JURISDICTION:	Illinois

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

Benefits are paid for Critical Illnesses as defined in the Certificate. The Policy does not constitute comprehensive health insurance coverage (often referred to as "major medical insurance coverage"). In addition, the Policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid under the Policy for Critical Illnesses as indemnity insurance and are not intended to cover medical expenses.

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate replaces any other Certificates we may have given you for the same level of coverage under the Policy.

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address. The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

Please read your Certificate carefully.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

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Arizona Residents:
Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

California residents:
If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution refunded, by returning the Certificate to the Policyholder for cancellation without claim.

Florida residents:
The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.

Idaho residents:
If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 10 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.

Maryland residents:
Notice: This Certificate of insurance may not provide all benefits required for a policy issued and delivered in Maryland.

SCHEDULE OF BENEFITS

EMPLOYER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CCI2

ELIGIBLE CLASS(ES)

All Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.

Temporary and seasonal workers are excluded from coverage.

Insured Persons who are continuing coverage under the PORTABILITY provision are also an eligible class.

MINIMUM HOURS REQUIREMENT

Employees: 20 hours per week.

ELIGIBILITY WAITING PERIOD

Persons in an eligible class on or before the Policy effective date and continuously employed thereafter: End of the month in which you complete a continuous period of 30 days of Active Employment.

Persons entering an eligible class after the Policy effective date and continuously employed thereafter: End of the month in which you complete a continuous period of 30 days of Active Employment.

Persons entering an eligible class after being rehired more than 30 days but less than 13 weeks after their termination date who enroll within 31 calendar days of their rehire date: First day of the month following your date of rehire.

Persons entering an eligible class after being rehired more than 13 weeks following their termination date, but before the annual enrollment for the next calendar year, who enroll within 31 calendar days of their rehire date: End of the month in which you complete a continuous period of 30 days of Active Employment.

REHIRE

If your employment with the Employer ends and you are rehired within 30 days, your previous Active Employment while in an eligible class will apply toward the Eligibility Waiting Period. All other Policy provisions apply.

WHO PAYS FOR THE COVERAGE

You pay the cost of your coverage.

BENEFIT AMOUNT

Choice of $10,000 or $20,000

CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	No maximum benefit amount
Cancer	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Sudden Cardiac Arrest	50%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	100%	No maximum benefit amount
Carcinoma in Situ (CIS)	25%	No maximum benefit amount

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Type 1 Diabetes	100%	1 times the BENEFIT AMOUNT
Severe Burns	100%	No maximum benefit amount
Transient Ischemic Attacks (TIA)	10%	No maximum benefit amount
Ruptured or Dissecting Aneurysm	10%	No maximum benefit amount
Abdominal Aortic Aneurysm	10%	No maximum benefit amount
Thoracic Aortic Aneurysm	10%	No maximum benefit amount
Open Heart Surgery for Valve Replacement or Repair	25%	No maximum benefit amount
Transcatheter Heart Valve Replacement or Repair	10%	No maximum benefit amount
Coronary Angioplasty	10%	No maximum benefit amount
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	No maximum benefit amount
Pacemaker Placement	10%	No maximum benefit amount

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	No maximum benefit amount
Skin Cancer	10%	The maximum is once per calendar year with a TOTAL MAXIMUM BENEFIT amount of 10 times the BENEFIT AMOUNT
Bone Marrow Transplant	50%	No maximum benefit amount
Stem Cell Transplant	50%	No maximum benefit amount

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight	100%	1 times the BENEFIT AMOUNT
Loss of Hearing	100%	1 times the BENEFIT AMOUNT
Loss of Speech	100%	1 times the BENEFIT AMOUNT
Coma	100%	No maximum benefit amount
Multiple Sclerosis	100%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson’s Disease	100%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer’s Disease	100%	1 times the BENEFIT AMOUNT
Huntington’s Disease (Huntington’s Chorea)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	100%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	No maximum benefit amount
Addison’s Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	50%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	50%	1 times the BENEFIT AMOUNT
Systemic Sclerosis (Scleroderma)	10%	1 times the BENEFIT AMOUNT

DEFINITIONS

Active Employment or Active Employee means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.

Abdominal Aortic Aneurysm means the diagnosis of an enlargement of the abdominal aorta of 5 cm or more, or of 4 cm or greater and rapidly expanding, for which a surgical repair has been advised.

Addison's Disease means the diagnosis of a long-term endocrine disorder that occurs when your body produces insufficient amounts of steroid hormones produced by your adrenal glands, confirmed via blood tests, urine tests, or medical imaging.

Advanced Dementia means a clinically established diagnosis of Alzheimer's Disease, or other type of permanent and progressive advanced dementia, with severe cognitive decline and with findings consistent with a Global Deterioration Scale (GDS) or Functional Assessment Staging (FAST) Stage 3 or more, or a Clinical Dementia Rating Scale (CDR) of 1.

Amyotrophic Lateral Sclerosis (ALS) means the diagnosis of a motor neuron disease, marked by progressive muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

Benign Brain Tumor means the diagnosis of a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological examination. The tumor must result in persistent neurological deficits including, but not limited to:
- Loss of vision;
- Loss of hearing; or
- Balance disruption.

For purposes of the Policy, the following are not considered Benign Brain Tumors:
- Tumors of the skull;
- Pituitary adenomas; and
- Germinomas.

Benign Brain Tumor does not include diagnosis of any of the following conditions prior to your coverage effective date:
- Neurofibromatosis I;
- Neurofibromatosis II;
- Von Hippel Lindau;
- Tuberous Sclerosis;
- Li Fraumani Syndrome;
- Cowden Disease; and
- Turcot Syndrome.

Bone Marrow Transplant means the clinical diagnosis of the need for a surgical transplant when you have been added to the *Be The Match* registry for a bone marrow transplant. It also includes a clinical diagnosis and actual transplant that occurs before you are able to be added to the *Be The Match* registry.

Cancer means the diagnosis of a group of diseases characterized by the uncontrolled growth and/or spread of abnormal cells. Cancer is limited to malignancies of solid tissue, blood or lymph tissue and includes leukemia, lymphoma and Hodgkin's disease.

The diagnosis of Cancer must be established according to the criteria of the American Board of Pathology or the American Joint Committee on Cancer. This requires looking at the suspect tumor, tissue or specimen at the microscopic level such that malignancy may be determined. A clinical diagnosis of Cancer will be accepted as evidence that Cancer exists when a pathological diagnosis cannot be made because it is medically inappropriate or life-threatening.

For the purposes of the Policy, the following are not considered Cancer:
- Basal cell carcinoma and squamous cell carcinoma of the skin;
- Carcinoma in Situ;
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm;
- Pre-malignant conditions or polyps; and
- Any other histologically benign or nonmalignant condition.

Carcinoma in Situ (CIS) means the diagnosis of tumor cells tending toward malignancy but that do not invade the underlying tissue (i.e. malignant cells confined to the epithelium without penetration of the basement membrane). This diagnosis must be confirmed by a study of the suspect tissue in a pathologic specimen that meets the American Joint Committee on Cancer or the American Board of Pathology criteria.

For purposes of the Policy, the following are not considered Carcinoma in Situ:
- Basal cell carcinoma and squamous cell carcinoma of the skin;
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm; and
- Pre-malignant conditions or conditions with malignant potential.

Certificate means this document, which describes the benefits and rights of Insured Persons under the Policy. It may include riders or endorsements.

Coma means the diagnosis of a continuous state of profound unconsciousness, characterized by having a Glasgow scale of 3; defined as the absence of:
- Eye opening;
- Verbal response; and
- Motor response.

The condition must require intubation for respiratory assistance and must not be medically induced.

You must be in a continuous state of profound unconsciousness for 14 consecutive days or longer. In the event you die while you are in a Coma and confined to a Hospital, this time period will be considered to have been met regardless of the actual number of days in a continuous state of profound unconsciousness.

"Confined to a Hospital" means that on the advice of a Doctor, you are assigned to a bed as a resident inpatient in a Hospital. There must be a charge for room and board, other than in any government, military or veterans' facility for which there is no charge for room and board.

Coronary Angioplasty means a diagnosis of significant coronary artery disease which is causing symptoms and for which a cardiologist advises a procedure, done through the blood vessels, to open a blocked coronary artery and/or remove a blood clot. This includes coronary balloon angioplasty, angiojet clot removal, and rotational and orbital atherectomy procedures.

Coronary Artery Bypass means the diagnosis of severe left main or multi-vessel coronary artery disease (such as a SYNTAX score $\geq$23) for which an open heart coronary artery bypass surgery – a surgical procedure that requires an incision through the chest and an incision in the heart and/or attached blood vessels – has been advised.

Critical Illness means any of the following as defined:

- Abdominal Aortic Aneurysm; or
- Addison's Disease; or
- Advanced Dementia; or
- Amyotrophic Lateral Sclerosis (ALS); or
- Benign Brain Tumor; or
- Bone Marrow Transplant; or
- Cancer; or
- Carcinoma in Situ; or
- Coma; or
- Coronary Angioplasty; or
- Coronary Artery Bypass; or
- Heart Attack; or
- Huntington's Disease (Huntington's Chorea); or
- Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement; or
- Infectious Disease; or
- Loss of Hearing; or
- Loss of Sight; or
- Loss of Speech; or
- Major Organ Transplant; or
- Multiple Sclerosis; or
- Muscular Dystrophy; or
- Myasthenia Gravis; or
- Open Heart Surgery For Valve Replacement or Repair; or
- Pacemaker Placement; or
- Parkinson's Disease; or
- Permanent Paralysis; or
- Ruptured or Dissecting Aneurysm; or
- Severe Burns; or
- Skin Cancer; or
- Stem Cell Transplant; or
- Stroke; or
- Sudden Cardiac Arrest; or
- Systemic Lupus Erythematosus (SLE); or
- Systemic Sclerosis (Scleroderma); or
- Thoracic Aortic Aneurysm; or
- Transcatheter Heart Valve Replacement or Repair; or
- Transient Ischemic Attacks (TIA); or
- Type 1 Diabetes.

Different Diagnosis means any of the following:

- A diagnosis of a Critical Illness that is for a different illness/condition than a previously diagnosed illness/condition.
- A diagnosis that is related to an illness/condition that existed prior to your coverage effective date if:
  - The subsequent diagnosis of the Critical Illness is for the same illness/condition as an illness/condition diagnosed prior to your coverage effective date under the Policy.
- A diagnosis that is related to a Critical Illness for which we previously paid benefits if:
  - The subsequent diagnosis of the Critical Illness, other than Cancer or Carcinoma in Situ or Skin Cancer is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy.
  - The subsequent diagnosis of Cancer or Carcinoma in Situ or Skin Cancer 1) is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, and 2) occurs more than 3 months after the date of the previous diagnosis.

Note: A second or confirmatory medical opinion is not a Different Diagnosis.

Exception: A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma and Infectious Disease, is not considered a Different Diagnosis regardless of the time period between diagnoses.

Note: A diagnosis of Carcinoma in Situ is considered a Different Diagnosis from Cancer.
Note: A diagnosis of Skin Cancer is considered a Different Diagnosis from Cancer or Carcinoma in Situ.

Doctor means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and who is providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Employee means a person who is a citizen or legal resident of the United States, and who is in Active Employment with the Employer in the United States. The term includes a person whose coverage is being continued under the PORTABILITY provision, even if the person is no longer in Active Employment with the Employer.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Heart Attack means the diagnosis of a clinical picture of myocardial infarction that was caused by a blockage of one or more coronary arteries. The medical evidence must be consistent with the diagnosis of heart muscle death. Significant electrocardiogram (EKG) changes must be seen, and one of the following must also establish the acute myocardial infarction:

- Cardiac enzyme changes as typically seen with myocardial damage found in the blood (elevated CK-MB isoenzyme fraction or elevated troponins).
- Confirmatory imaging test, such as a nuclear imaging test or echocardiogram that is consistent with a myocardial infarction.

In the event of death, an autopsy report and/or death certificate identifying heart attack or myocardial infarction as a cause of death will be accepted as evidence of a Heart Attack.

A Sudden Cardiac Arrest is not in itself considered a Heart Attack.

Hospital means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
- It is under the supervision of a medical staff and has one or more Doctors available at all times;
- It provides 24 hours a day service by registered graduate nurses (RNs); and
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; a rehabilitative facility; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care, or care or treatment for persons suffering from mental diseases or disorders, or care for the aged, or drug or alcohol addiction.

Huntington's Disease (Huntington’s Chorea) means the diagnosis of an inherited disease that causes the progressive degeneration of nerve cells in the brain. The Huntington’s Disease (Huntington’s Chorea) diagnosis must be based on symptoms and laboratory testing.

Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement means the diagnosis of ventricular tachycardia or fibrillation, or deemed at high risk for cardiac arrest, for which the initial placement of an implantable cardioverter-defibrillator (ICD) has been advised.

Infectious Disease means the diagnosis of an infectious disease that results in you being confined to a Hospital for five (5) or more consecutive days or confined to a transitional care facility for five (5) or more consecutive days. In the event you die while confined as the result of being diagnosed with an infectious disease, we will consider this time period to have been met regardless of the actual number of days confined.

Infectious Diseases include, but are not limited to:

- Polio;
- Rabies;
- Meningitis;
- Lyme's Disease;
- Bovine spongiform encephalopathy (Mad Cow Disease);
- Flesh eating bacteria;
- Methicillin-resistant Staphylococcus aureus (MRSA);
- Sepsis;
- Tuberculosis;
- Bacterial pneumonia;
- Diphtheria;
- Encephalitis.
- Legionnaire's Disease;
- Malaria;
- Necrotizing Fasciitis;
- Osteomyelitis;
- Tetanus;
- Ebola Virus Disease; and
- Coronavirus.

"Confined/confinement" means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or transitional care facility. There must be a charge for room and board, other than in any government, military or veterans' facility for which there is no charge for room and board. "Transitional care facility" means a facility which provides a bridge between the Hospital and home for restorative and rehabilitation care. It must provide skilled nursing care and must be either located in a community nursing home or a Hospital. Confined/confinement also includes assignment to an observation unit in a Hospital, if you stay for at least 20 consecutive hours.

Insured Person means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

Loss of Hearing means the diagnosis of profound deafness in both ears that is not correctable.

Loss of Sight means the diagnosis of clinically proven irreversible reduction of sight in both eyes with:

- Sight in the better eye reduced to a best corrected visual acuity of less than 6/60 (metric acuity) or 20/200 (Snellen or E-Chart Acuity); or
- Visual field restriction to 20 degrees or less in both eyes.

Loss of Speech means the clinical diagnosis of total and permanent loss of the ability to speak.

Major Organ Transplant means the irreversible failure of your heart, lung, pancreas, an entire kidney or the entire liver, or any combination of these conditions, as determined by a Doctor specialized in care of the involved organ. Acceptance to the UNOS (United Network for Organ Sharing) list is required for this determination, except for kidney failure. If you receive the transplant prior to placement on the network, the network requirement will be waived. If your Doctor determines you are not healthy enough to be placed on the UNOS list or you are rejected from the list, the network requirement will be waived. "Kidney failure" means chronic, irreversible failure of one or both kidneys for which a Doctor recommends either of the following:

- Regular hemodialysis or peritoneal dialysis (at least weekly) in order to sustain life, which is expected to continue for at least 6 months.
- Renal transplantation.

Multiple Sclerosis means the unequivocal diagnosis of multiple sclerosis following more than one episode of well-defined neurological symptoms and signs and confirmed by a neurological exam and MRI scan of the brain or spinal fluid analysis. Symptoms must persist for 6 months to ensure that the condition is permanent.

Muscular Dystrophy means the diagnosis of a group of muscle diseases that weaken the musculoskeletal system and are characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue.

Myasthenia Gravis means the diagnosis of a neuromuscular disease characterized by weakness and rapid fatigue of any of the muscles under your voluntary control.

Open Heart Surgery For Valve Replacement or Repair means the diagnosis of severe valvular heart disease for which open heart surgery – a surgical procedure that requires an incision through the chest and an incision in the heart and/or attached blood vessels -- has been advised.

Pacemaker Placement means the diagnosis of symptomatic sinus node dysfunction, high-grade atrioventricular (AV) block, or other serious cardiac arrhythmia for which the initial placement of a permanent pacemaker has been advised.

Parkinson's Disease means the diagnosis of a chronic, progressive neurodegenerative disorder characterized by any combination of four cardinal signs: rest tremor; rigidity; bradykinesia; and gait disturbance.

Permanent Paralysis means the diagnosis of total and permanent loss of the use of two or more limbs (arms or legs or combination) due to accident or sickness for a continuous period of at least 60 days.

Policy means the written group insurance contract between the Policyholder and us, including the Certificates delivered to Insured Persons. It may include riders and endorsements.

Policyholder means the Employer to which the Policy is issued, as shown on the first page of this Certificate, and which sponsors the coverage for its Employees.

Ruptured or Dissecting Aneurysm means the diagnosis of a balloon-like bulge in an artery that ruptures or dissects as confirmed by an ultrasound, CT scan, angiogram or MRI.

Same Diagnosis means any of the following:

- A second or confirmatory medical opinion of a diagnosis for an illness/condition.
- A diagnosis that is related to a Critical Illness for which we previously paid benefits if:
  - The subsequent diagnosis of Cancer or Carcinoma in Situ or Skin Cancer 1) is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, and 2) occurs within 3 months of the date of the previous diagnosis.

Exception: A subsequent diagnosis of the same illness/condition under the quality of life module, other than Coma and Infectious Disease, is considered the Same Diagnosis regardless of the time period between diagnoses.

Severe Burns means the diagnosis of cosmetic disfigurement of the surface of a body area not less than 35 square inches that is a full-thickness or third-degree burn. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic or telephonic media, and which is consistent with applicable law.

Skin Cancer means the diagnosis of tumor cells tending toward malignancy and which invade the underlying tissue.

The Skin Cancer diagnosis must be confirmed by a study of the suspect tissue in a pathologic specimen that meets the American Joint Committee on Cancer or the American Board of Pathology criteria.

Skin Cancer includes:
- Basal cell carcinoma and squamous cell carcinoma of the skin; and
- Melanoma that is diagnosed as Breslow's classification less than 0.75mm.

Stem Cell Transplant means the clinical diagnosis of a blood or bone marrow malignancy for which the need for a surgical stem cell transplant has been advised.

Stroke means the diagnosis of an acute cerebral event including infarction of brain tissue, cerebral and subarachnoid hemorrhage, cerebral embolism and cerebral thrombosis. The diagnosis of Stroke must be based on confirmatory neuroimaging confirmed at the time of discharge from a Hospital, or by autopsy report or death certificate in the event of death.

Stroke does not include:
- Transient ischemic attacks (TIA)
- Ischemic disorders of the vestibular system;
- Brain injury related to trauma or infection; or
- Brain injury associated with hypoxia/anoxia or hypotension.

Sudden Cardiac Arrest means the sudden, unexpected loss of heart function, breathing and consciousness resulting when the heart suddenly and unexpectedly stops beating because of an internal electrical disturbance of the heart. In the event of death, an autopsy report and/or death certificate may be used to confirm Sudden Cardiac Arrest.

Systemic Lupus Erythematosus (SLE) means the diagnosis of an autoimmune disease that occurs when your body's immune system attacks your own tissues and organs.

Systemic Sclerosis (Scleroderma) means the diagnosis of an autoimmune disease that involves the hardening and tightening of the skin and connective tissues.

Thoracic Aortic Aneurysm means the diagnosis of an enlargement of the thoracic aorta of 5.5 cm or more, or causing symptoms, or of 4.5 cm or greater and rapidly expanding, for which surgical repair has been advised.

Transcatheter Heart Valve Replacement or Repair means the diagnosis of significant valvular heart disease for which a procedure, performed through the blood vessels, to repair or replacement of one or more of the heart valves has been advised.

Transient Ischemic Attacks (TIA) means the diagnosis of a transient episode of neurologic dysfunction caused by focal brain, spinal cord, or retinal ischemia, without acute infarction, that is confirmed via documented neurological deficit and neuroimaging studies.

Type 1 Diabetes means an auto-immune destruction of insulin-producing cells in the pancreas that results in total loss of insulin production.

Written or **Writing** means a record which is on or transmitted by paper or electronic or telephonic media, and which is consistent with applicable law.

GENERAL PROVISIONS

ELIGIBILITY

If you are an Employee in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The date you enter an eligible class.
- The day after you complete your Eligibility Waiting Period. **Exception:** If your Eligibility Waiting Period ends on the first day of the month, this eligibility date is the day you complete your Eligibility Waiting Period.

ENROLLMENT

If you are eligible for coverage, you must enroll for any coverage before it will become effective. The Employer or we will provide you with the forms or information needed to complete your enrollment. You may enroll when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us.

EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you enroll for coverage on or before that date.
- The date you enroll for coverage.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, and paid time off for non-medical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates. See the PORTABILITY provision.
- The last day of the month during which you are no longer in an eligible class. See the PORTABILITY provision.
- The last day of the month during which your eligible class is no longer covered. See the PORTABILITY provision.
- The last day of the month during which you voluntarily cancel your coverage.
- The end of the period for which premiums are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The last day of the month during which you are no longer in Active Employment. See the PORTABILITY provision.
- The date the total maximum benefit amount has been paid for all Critical Illnesses.

We will pay benefits for a loss that occurs while you are covered under the Policy even if the Policy has since terminated.

POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:

- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.

- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

We reserve the right to review and terminate all classes covered under the Policy if any class(es) ceases to be covered.

If the Policyholder fails to pay the full premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay premiums, Written notice will be mailed to the Policyholder at least 60 days prior to the termination date.

The Policyholder may terminate the Policy by Written notice delivered to us at our home office prior to the termination date. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, the termination will not affect a payable claim.

PORTABILITY

Portability means you have the option to continue your coverage after it would otherwise terminate if certain conditions are met.

You may continue your coverage if it would otherwise terminate due to any of the following:
- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Active Employees.
- The Policyholder terminates coverage under the Policy for all Insured Persons, and does not replace it with similar insurance coverage.
- You are no longer eligible for coverage under the Policy.

The Employer or we will provide you with the information needed to continue your coverage under this provision. Continuation of coverage must be elected within 31 days of when it would otherwise terminate. Coverage continued under this provision is subject to all the terms of this Certificate.

You may not increase the continued coverage amount. Continued premium payment is required to keep coverage in force. Premiums will be billed directly to you. The initial premium will be based on the portability premium rates in effect at the time you are eligible to continue your coverage under this provision. We may change the portability premium rates at any time upon 60 days Written notice to you.

Coverage continued under this provision will end on the earliest of the following:
- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date you die.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days Written notice of termination.

GRACE PERIOD

The Policyholder has a grace period of 60 days for the payment of any premium due except the first premium payment. During the Policyholder's grace period, the Policy will remain in force. If the full premium payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance Written notice of termination, or if we have given the Policyholder advance Written notice of termination as described under the POLICY TERMINATION provision.

If you are continuing your coverage under the PORTABILITY provision, you have a grace period of 31 days for the payment of any premium due. During your grace period, your coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to you that if the premium is not paid by the end of the grace period, all coverage will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to you, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your coverage was in force during the grace period.

REPRESENTATIONS NOT WARRANTIES

All statements made by the Policyholder and you are considered representations and not warranties.

INCONTESTABILITY

We will not use any statements made by you to avoid insurance, reduce benefits or defend a claim unless the statement is included in a Written application or enrollment form relating to your insurability. Except for fraud, we will not use such statements to contest insurance after it has been in force for two years from its effective date. Fraud in the procurement of coverage under the Policy is only contestable after the coverage has been in force for two years from its effective date if permitted by applicable law in the governing jurisdiction. The statement on which any contest is based must be material to the risk accepted or the hazard assumed by us.

CLERICAL ERROR

Clerical error or omission by the Policyholder or us will not:

- Prevent you from being covered, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.
- End insurance validly in effect.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

MISSTATEMENT OF AGE

If premiums are based on your age and you have misstated your age, then your correct age will be used to determine if any insurance is in effect and, as appropriate, the premium and/or benefits will be adjusted. We may require satisfactory proof of your age before paying any claim.

MISSTATEMENT OF TOBACCO USE STATUS

If premiums are based on your tobacco use status and you have misstated your tobacco use status, then your correct tobacco use status will be used to adjust the premium and/or benefits as appropriate. The amount payable at the time of claim will be the amount that the premium would have purchased using the correct tobacco use status. During the first two years your coverage under the Policy is effective, we will make this adjustment instead of contesting your insurance for this misstatement.

ASSIGNMENT

No assignment of benefits under the Policy is valid unless otherwise specified in the Policy.

AGENCY
For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

CONFORMITY WITH STATE STATUTES
Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the governing jurisdiction is automatically amended to conform to the minimum requirements of such law.

CHANGES TO POLICY OR CERTIFICATE
The Policy may be amended at any time by Written agreement between the Policyholder and us. No change in the Policy will be valid until approved by one of our executive officers. Such approval must be in Writing and will be endorsed or attached to the Policy. Changes requiring regulatory approval will not be valid until approved by the appropriate regulatory body. We will issue new Certificates or riders or endorsements to effect such changes, and only those forms Signed by one of our executive officers will be valid.

No agent, representative or employee of ours or of any other entity, except one of our executive officers, may approve a change to waive any terms of the Policy.

CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on the SCHEDULE OF BENEFITS if you are diagnosed with a Critical Illness on or after your coverage effective date. The percentage of BENEFIT AMOUNT payable and any applicable maximum benefit amounts are listed for the Critical Illness on the SCHEDULE OF BENEFITS.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of this certificate. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on the SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable to you for each Critical Illness in the Certificate during your lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness.

When the total maximum benefit amount has been paid for a Critical Illness, no further benefits are payable for that Critical Illness. When the total maximum benefit amount has been paid for all Critical Illnesses, no further benefits are payable and your coverage (including all riders) terminates.

BASE MODULE

Benefits for Heart Attack, Sudden Cardiac Arrest, Cancer, Stroke, Major Organ Transplant, Coronary Artery Bypass and Carcinoma in Situ (CIS) are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Heart Attack or Sudden Cardiac Arrest or Coronary Artery Bypass must be made by a cardiologist or a Doctor familiar with the specific condition, or as indicated by an autopsy report or a death certificate. A diagnosis of Stroke must be made by a neurologist or a Doctor familiar with the diagnosis of Stroke, or as indicated by an autopsy report or a death certificate.

If you are on the UNOS (United Network for Organ Sharing) list for a combined transplant, only one Major Organ Transplant benefit will be payable for the diagnosis. Acceptance on the UNOS list is not required in the case of kidney failure. The “date of diagnosis” for this benefit will be the later of the following:

- The date of diagnosis of the Critical Illness, if it is determined you are not healthy enough to be placed on the UNOS list or you are rejected from the list.
- The date you are placed on the UNOS list for a combined transplant.
- The date of your transplant if the UNOS list requirement was waived.

MAJOR ORGAN MODULE

Benefits for Type 1 Diabetes, Severe Burns, Transient Ischemic Attacks (TIA), Ruptured or Dissecting Aneurysm, Abdominal Aortic Aneurysm, Thoracic Aortic Aneurysm, Open Heart Surgery for Valve Replacement or Repair, Transcatheter Heart Valve Replacement or Repair, Coronary Angioplasty, Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement and Pacemaker Placement are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Type 1 Diabetes must: 1) be made by a board-certified or board-eligible endocrinologist or other specialist in the treatment of diabetes, 2) be based on blood tests, and 3) require insulin administration for a continuous period of at least 3 months.

A diagnosis of Ruptured or Dissecting Aneurysm, or Transient Ischemic Attacks (TIA) must be confirmed by a neurologist or a Doctor familiar with the diagnosis of the specific condition.

A diagnosis of Abdominal Aortic Aneurysm, or Thoracic Aortic Aneurysm, or Open Heart Surgery for Valve Replacement or Repair, or Transcatheter Heart Valve Replacement or Repair, or Coronary Angioplasty, or Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement, or Pacemaker Placement must be made by a cardiologist or a Doctor familiar with the diagnosis of the specific condition.

One benefit for Open Heart Surgery for Valve Replacement or Repair is payable if the diagnosis is for replacement or repair of one or more valves.

One benefit for Transcatheter Heart Valve Replacement or Repair is payable if the diagnosis is for replacement or repair of one or more valves.

QUALITY OF LIFE MODULE

A Critical Illness under this module, other than Coma and Infectious Disease, is not eligible for multiple benefit payments.

Benefits for Permanent Paralysis, Loss of Sight, Loss of Hearing, Loss of Speech, Coma, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Advanced Dementia, including Alzheimer's Disease, Huntington's Disease (Huntington's Chorea), Muscular Dystrophy, Infectious Disease, Addison's Disease, Myasthenia Gravis, Systemic Lupus Erythematosus (SLE) and Systemic Sclerosis (Scleroderma) are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Loss of Sight must be certified by an ophthalmologist or a Doctor familiar with the diagnosis of Loss of Sight.

A diagnosis of Loss of Hearing must be made by an otolaryngologist or a Doctor familiar with the diagnosis of Loss of Hearing.

A diagnosis of Advanced Dementia must be made by a board certified or board eligible neurologist or a Doctor familiar with the diagnosis of Advanced Dementia.

A diagnosis of Muscular Dystrophy, or Myasthenia Gravis, or Multiple Sclerosis or Huntington's Disease (Huntington's Chorea) must be made by a neurologist or a Doctor familiar with the diagnosis of the specific condition. Genetic testing does not qualify as a diagnosis.

A diagnosis of Systemic Lupus Erythematosus (SLE) or Systemic Sclerosis (Scleroderma) must be confirmed by a rheumatologist or a Doctor familiar with the diagnosis of the specific condition.

Only one benefit for Infectious Disease is payable if the diagnosis of one or more Infectious Diseases is made during the same period of confinement.

Benefits for Parkinson's Disease are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date (including the effective date of any changes to coverage) or you become incapacitated, meaning:

- Exhibiting 2 or more of the following clinical manifestations:
  - Muscle rigidity;
  - Tremor; and
  - Bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses); **and**
- Resulting in the inability to perform independently 2 or more of the following activities of daily living:
  - Eating;
  - Bathing;
  - Dressing;
  - Toileting;
  - Transferring; and
  - Maintaining continence.

A diagnosis of Parkinson's Disease must be made by a psychiatrist, neurologist or a Doctor trained in the diagnosis of Parkinson's Disease.

ENHANCED CANCER MODULE

Benefits for Benign Brain Tumor, Skin Cancer, Bone Marrow Transplant and Stem Cell Transplant are payable when we receive due proof of such condition which is diagnosed on or after your coverage effective date (including the effective date of any changes to coverage).

CLAIMS

NOTICE OF CLAIM
Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM
The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of claim without waiting for the form. If such Written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM
The claim form(s) may require completion by you and the Employer and your attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM
You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION
We may require you to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS
Benefits are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible, but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children, in equal shares.
3. Your grandchildren, in equal shares.
4. Your parents, in equal shares.
5. Your siblings, in equal shares.
6. Your estate.

If a survivor entitled to receive a payment dies before receiving it, we will make payment to that person's estate.

"Spouse" in this provision means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. It also includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

If a survivor entitled to receive a payment has a special needs trust established, we will make payment to that person's trust instead of to the person directly.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after Written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

SPOUSE CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CCI2

This rider is made a part of the Group Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

SPOUSE BENEFIT AMOUNT

100% of Employee BENEFIT AMOUNT

The BENEFIT AMOUNT for your Spouse will not exceed 100% of your Employee BENEFIT AMOUNT.

SPOUSE CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	No maximum benefit amount
Cancer	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Sudden Cardiac Arrest	50%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	100%	No maximum benefit amount
Carcinoma in Situ (CIS)	25%	No maximum benefit amount

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Type 1 Diabetes	100%	1 times the BENEFIT AMOUNT
Severe Burns	100%	No maximum benefit amount
Transient Ischemic Attacks (TIA)	10%	No maximum benefit amount
Ruptured or Dissecting Aneurysm	10%	No maximum benefit amount
Abdominal Aortic Aneurysm	10%	No maximum benefit amount
Thoracic Aortic Aneurysm	10%	No maximum benefit amount
Open Heart Surgery for Valve Replacement or Repair	25%	No maximum benefit amount
Transcatheter Heart Valve Replacement or Repair	10%	No maximum benefit amount
Coronary Angioplasty	10%	No maximum benefit amount
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	No maximum benefit amount
Pacemaker Placement	10%	No maximum benefit amount

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	No maximum benefit amount
Skin Cancer	10%	The maximum is once per calendar year with a TOTAL MAXIMUM BENEFIT amount of 10 times the BENEFIT AMOUNT
Bone Marrow Transplant	50%	No maximum benefit amount
Stem Cell Transplant	50%	No maximum benefit amount

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight	100%	1 times the BENEFIT AMOUNT
Loss of Hearing	100%	1 times the BENEFIT AMOUNT
Loss of Speech	100%	1 times the BENEFIT AMOUNT
Coma	100%	No maximum benefit amount
Multiple Sclerosis	100%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson's Disease	100%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	100%	1 times the BENEFIT AMOUNT
Huntington's Disease (Huntington's Chorea)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	100%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	No maximum benefit amount
Addison's Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	50%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	50%	1 times the BENEFIT AMOUNT

Systemic Sclerosis (Scleroderma)	10%	1 times the BENEFIT AMOUNT

SPOUSE CRITICAL ILLNESS BENEFITS

The benefit percentages and maximums for your Spouse are the same as the benefit percentages and maximums for you as shown in the SCHEDULE OF BENEFITS section of the Certificate.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

Spouse means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. The term includes your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:

- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

ENROLLMENT

If you have a Spouse eligible for Spouse coverage, you must enroll for any Spouse coverage before it will become effective. The Employer or we will provide you with the forms or information needed to complete your enrollment. You may enroll for Spouse coverage when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us.

EFFECTIVE DATE OF COVERAGE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you enroll for Spouse coverage on or before that date.
- The date you enroll for Spouse coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved non-medical leave of absence and paid time off for non-medical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

Coverage for your Spouse under this rider terminates on the earliest of the following:

- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below if termination is due to death or regarding Spouse coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below regarding Spouse coverage previously continued by you or your Spouse.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below regarding Spouse coverage previously continued by you or your Spouse.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates.
- The last day of the month during which you voluntarily cancel coverage under this rider.
- The last day of the month during which your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.

We will pay benefits for a loss that occurs while your Spouse is insured under this rider even if the rider has since terminated.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, then your Spouse's coverage under this rider may also be continued at the same time. Continued premium payment is required to keep your Spouse's coverage under this rider in force. You may not increase the continued Spouse coverage amount. Continued Spouse coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse may elect to continue Spouse coverage under this rider if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, your Spouse must elect portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse continues coverage under this provision, your Spouse will become the owner of their Spouse coverage under this rider. Your Spouse may decrease the continued Spouse coverage amount based on the amounts available on this rider's SCHEDULE OF BENEFITS. Your Spouse may not increase the continued Spouse coverage amount. Coverage continued under this provision is subject to all the terms of this rider.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse elects portability. We may change the portability premium rates at any time upon 60 days Written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which premiums for this rider are paid if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date your Spouse voluntarily cancels coverage under this rider.
- The date your Spouse dies.

- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days Written notice of termination.

GRACE PERIOD
Refer to the GRACE PERIOD provision in the Certificate if you are continuing coverage under the Certificate's PORTABILITY provision.

If your Spouse is continuing coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision, your Spouse has a grace period of 31 days for the payment of any premium due. During this grace period, your Spouse's coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to your Spouse that if the premium is not paid by the end of the grace period, then all coverage under this rider will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to your Spouse, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your Spouse's coverage was in force during the grace period.

CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Spouse is diagnosed with a Critical Illness on or after your Spouse's coverage effective date. The percentage of BENEFIT AMOUNT payable and any applicable maximum benefit amounts are listed for the Critical Illness on this rider's SCHEDULE OF BENEFITS.

The benefits for your Spouse are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of the Certificate. A subsequent diagnosis of a Critical Illness that is for the same illness/condition as a Critical Illness for which benefits were payable under the Policy, may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Critical Illness. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable for each Critical Illness in this rider during your Spouse's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness.

When the total maximum benefit amount for your Spouse has been paid for a Critical Illness, no further benefits are payable for that Critical Illness. When the total maximum benefit amount has been paid for all Critical Illnesses, no further benefits are payable and your Spouse's coverage under this rider terminates.

Payment of any benefits for your Spouse's Critical Illness will not impact the available BENEFIT AMOUNT for your Critical Illness coverage. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Spouse's Critical Illness coverage as long as your coverage remains in force.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of claim without waiting for the form. If such Written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Spouse's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Spouse to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after Written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Spouse's coverage.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CHILDREN'S CRITICAL ILLNESS RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CCI2

This rider is made a part of the Group Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

You pay the cost of coverage under this rider.

CHILDREN'S BENEFIT AMOUNT

50% of Employee BENEFIT AMOUNT

The BENEFIT AMOUNT for your Children will not exceed 50% of your Employee BENEFIT AMOUNT.

CHILDREN'S CRITICAL ILLNESS BENEFITS

Base module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Heart Attack	100%	No maximum benefit amount
Cancer	100%	No maximum benefit amount
Stroke	100%	No maximum benefit amount
Sudden Cardiac Arrest	50%	No maximum benefit amount
Major Organ Transplant	100%	No maximum benefit amount
Coronary Artery Bypass	100%	No maximum benefit amount
Carcinoma in Situ (CIS)	25%	No maximum benefit amount

Major organ module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Type 1 Diabetes	100%	1 times the BENEFIT AMOUNT
Severe Burns	100%	No maximum benefit amount
Transient Ischemic Attacks (TIA)	10%	No maximum benefit amount
Ruptured or Dissecting Aneurysm	10%	No maximum benefit amount
Abdominal Aortic Aneurysm	10%	No maximum benefit amount
Thoracic Aortic Aneurysm	10%	No maximum benefit amount
Open Heart Surgery for Valve Replacement or Repair	25%	No maximum benefit amount
Transcatheter Heart Valve Replacement or Repair	10%	No maximum benefit amount
Coronary Angioplasty	10%	No maximum benefit amount
Implantable (or Internal) Cardioverter Defibrillator (ICD) Placement	25%	No maximum benefit amount
Pacemaker Placement	10%	No maximum benefit amount

Enhanced cancer module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Benign Brain Tumor	100%	No maximum benefit amount
Skin Cancer	10%	The maximum is once per calendar year with a TOTAL MAXIMUM BENEFIT amount of 10 times the BENEFIT AMOUNT
Bone Marrow Transplant	50%	No maximum benefit amount
Stem Cell Transplant	50%	No maximum benefit amount

Quality of life module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Permanent Paralysis	100%	1 times the BENEFIT AMOUNT
Loss of Sight	100%	1 times the BENEFIT AMOUNT
Loss of Hearing	100%	1 times the BENEFIT AMOUNT
Loss of Speech	100%	1 times the BENEFIT AMOUNT
Coma	100%	No maximum benefit amount
Multiple Sclerosis	100%	1 times the BENEFIT AMOUNT
Amyotrophic Lateral Sclerosis (ALS)	100%	1 times the BENEFIT AMOUNT
Parkinson's Disease	100%	1 times the BENEFIT AMOUNT
Advanced Dementia, including Alzheimer's Disease	100%	1 times the BENEFIT AMOUNT
Huntington's Disease (Huntington's Chorea)	100%	1 times the BENEFIT AMOUNT
Muscular Dystrophy	100%	1 times the BENEFIT AMOUNT
Infectious Disease	25%	No maximum benefit amount
Addison's Disease	10%	1 times the BENEFIT AMOUNT
Myasthenia Gravis	50%	1 times the BENEFIT AMOUNT
Systemic Lupus Erythematosus (SLE)	50%	1 times the BENEFIT AMOUNT

Systemic Sclerosis (Scleroderma)	10%	1 times the BENEFIT AMOUNT

CHILDREN'S CRITICAL ILLNESS BENEFITS

The benefit percentages and maximums for your Children are the same as the benefit percentages and maximums for you as shown in the SCHEDULE OF BENEFITS section of the Certificate. Benefit percentages for the Additional Child Diseases are shown below.

Additional Child Diseases module

Covered illness/condition	Percent of BENEFIT AMOUNT payable	Total maximum benefit amount for coverage
Cerebral Palsy	100%	1 times the BENEFIT AMOUNT
Congenital Birth Defects	100%	1 times the BENEFIT AMOUNT
Cystic Fibrosis	100%	1 times the BENEFIT AMOUNT
Down Syndrome	100%	1 times the BENEFIT AMOUNT
Gaucher Disease, Type II or III	100%	1 times the BENEFIT AMOUNT
Infantile Tay Sachs	100%	1 times the BENEFIT AMOUNT
Niemann-Pick Disease	100%	1 times the BENEFIT AMOUNT
Pompe Disease	100%	1 times the BENEFIT AMOUNT
Sickle Cell Anemia	100%	1 times the BENEFIT AMOUNT
Type 1 Diabetes	100%	1 times the BENEFIT AMOUNT
Type IV Glycogen Storage Disease	100%	1 times the BENEFIT AMOUNT
Zellweger Syndrome	100%	1 times the BENEFIT AMOUNT

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

Additional Child Diseases means in addition to the benefits provided for Critical Illnesses as defined in the Certificate, this rider also covers the following child diseases:

- Cerebral Palsy.
- Congenital Birth Defects.
- Cystic Fibrosis.
- Down Syndrome.
- Gaucher Disease, Type II or III.
- Infantile Tay Sachs.
- Niemann-Pick Disease.

- Pompe Disease.
- Sickle Cell Anemia.
- Type 1 Diabetes.
- Type IV Glycogen Storage Disease.
- Zellweger Syndrome.

This definition does not include premature birth or stillbirth caused or contributed to by a Critical Illness or Additional Child Disease.

Cerebral Palsy means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of Cerebral Palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or by a seizure disorder.

Child or **Children** means a child from live birth, but less than 26 years of age, and who is one of the following:
- Your natural or adopted child (including a child placed for adoption from the date of placement or pursuant to an interim court order of adoption, whichever comes first).
- Your stepchild.
- A child of your civil union partner who is recognized as equivalent to a spouse by Illinois law.
- A child of your domestic partner as defined by the Employer if you have completed and Signed an affidavit of domestic partnership on a form acceptable to the Employer.
- Your foster child or a child or grandchild for whom you are a legal guardian.

The child must also meet all of the following conditions:
- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches age 26. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing. Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

Congenital Birth Defects means the malformation of an organ or organ system that results in the recommendation of surgery.

Examples include, but are not limited to, the following:
- Heart defects.
- Lung defects.
- Spina Bifida.
- Cleft lip or palate.
- Limb malformations.

Congenital Birth Defects includes developmental disorders of the brain or being born blind without the recommendation of surgery.

Congenital Birth Defects does not include prematurity.

Critical Illness has the same meaning as in the Certificate. This definition does not include premature birth or stillbirth caused or contributed to by a Critical Illness or Additional Child Disease.

Cystic Fibrosis means a definite diagnosis of cystic fibrosis by a licensed family practitioner, pediatrician or pulmonologist where the Child has chronic lung disease and pancreatic insufficiency. The diagnosis made via a sweat test should be based upon sweat chloride concentrations greater than 60 mmol/L on two independent tests.

Down Syndrome means diagnosis of down syndrome through a study of the 21st chromosome.

Down Syndrome includes:
- Trisomy 21 - an individual has three instead of two #21 chromosomes.
- Translocation - an extra part of the 21st chromosome is attached to another chromosome.
- Mosaicism - the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

Gaucher Disease, Type II or III means a definitive diagnosis of Gaucher Disease, Type II or III through a blood test reviewing beta-glucosidase leukocyte (BGL).

Infantile Tay Sachs means a definitive diagnosis of Infantile Tay Sachs through a blood test reviewing Hexosaminidase A levels.

Niemann-Pick Disease means a definitive diagnosis of Niemann-Pick, Type A, B, or C, through blood test or genetic test.

Pompe Disease (Type II Glycogen Storage Disease) means a definitive diagnosis of Pompe Disease (Type II Glycogen Storage Disease) through enzyme testing or genetic testing.

Sickle Cell Anemia means the diagnosis of a blood disorder that results in an abnormality in the oxygen-carrying protein hemoglobin found in red blood cells, which is confirmed via blood testing.

Sickle Cell Anemia does not include the sickle cell trait.

Spouse means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. The term includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

Type 1 Diabetes means an auto-immune destruction of insulin-producing cells in the pancreas that results in total loss of insulin production.

Type IV Glycogen Storage Disease means a definitive diagnosis or Type IV Glycogen Storage Disease through testing of glycogen branching enzyme deficiency in the liver, muscle, or skin, or through genetic testing.

Zellweger Syndrome means a definitive diagnosis of Zellweger Syndrome through genetic testing.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

If both you and your Spouse or Domestic Partner are covered under the Policy as an Employee, then only one of you may cover your Children under this rider. If the parent who is covering the Children stops being insured as an Employee then the other parent may enroll for Children's coverage under this rider within 60 days.

ENROLLMENT

If you have a Child or Children eligible for coverage, you must enroll for any coverage before it will become effective. You may enroll for Children's coverage when you become newly eligible, or following a qualifying life event as allowed by the Employer, or during an enrollment period chosen by the Employer and approved by us. The Employer or we will provide you with the forms or information needed to complete your enrollment.

EFFECTIVE DATE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Children are eligible for coverage, if you enroll for Children's coverage on or before that date.
- The date you enroll for Children's coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved non-medical leave of absence and paid time off for non-medical-related absences.

If you have coverage on yourself, your eligible newborn Child is automatically covered for the first 30 days after birth. This includes an adopted newborn Child who is placed with you within 30 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then coverage for the newborn will be at the lowest level available. If you do not already have Children's coverage under this rider, then Child coverage beyond the 30th day is subject to the conditions regarding application and Active Employment and having no approved Employee claims under the Policy.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 30 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 30 days after birth, the "event" will be the date of placement. No additional premium is required.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Children's coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment.
- The date you return to Active Employment, if you are not in Active Employment due to injury or sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

Coverage for each of your Children under this rider ends on the earliest of the following:

- The last day of the month during which the Child is no longer an eligible Child as defined by this rider. Eligibility of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.
- The date coverage for all your Children ends as described below.

Coverage for all your Children under this rider ends on the earliest of the following:

- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH provision below if termination is due to death.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below regarding Children's coverage previously continued by you or your Spouse.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below regarding Children's coverage previously continued by you or your Spouse.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates.
- The last day of the month during which you voluntarily cancel coverage under this rider.
- The last day of the month during which you no longer have any eligible Children as defined by this rider.
- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.

We will pay benefits for a loss that occurs while your Child is insured under this rider even if this rider has since terminated.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, then your Children's coverage under this rider may also be continued at the same time. Continued premium payment is required to keep your Children's coverage under this rider in force. You may not increase the continued Children's coverage amount. Continued Children's coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH

If you die and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Critical Illness Rider, then Children's coverage under this rider may be continued at the same time under your Spouse's coverage. Following portability of this rider, Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

If your Spouse continues coverage under this provision, your Spouse will become the owner of the Children's coverage under this rider. Your Spouse may not increase the continued Children's coverage amount. Coverage continued under this provision is subject to all the terms of this rider.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse elects portability. We may change the portability premium rates at any time upon 60 days Written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which premiums for this rider are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date your Spouse voluntarily cancels coverage under this rider.
- The date your Spouse's coverage under the Spouse Critical Illness Rider terminates.
- The last day of the month during which there are no longer any eligible Children as defined by this rider.
- For each Child, the date your Child's total maximum benefit amount has been paid for all Critical Illnesses and Additional Child Diseases.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days Written notice of termination.

GRACE PERIOD
Refer to the GRACE PERIOD provision in the Certificate if you are continuing coverage under the Certificate's PORTABILITY provision.

If your Spouse is continuing Children's coverage under the PORTABILITY FOLLOWING DEATH provision, your Spouse has a grace period of 31 days for the payment of any premium due. During this grace period, your Children's coverage will remain in force. If the full premium payment is not received by us by the due date, we will give Written notification to your Spouse that if the premium is not paid by the end of the grace period, then all coverage under this rider will terminate on the last day of the grace period. If we fail to give such Written notice, coverage will continue in effect until the date such notice is given. We may extend the grace period by giving Written notice of such intent to your Spouse, and such notice will specify that all coverage will terminate on that date if the premium remains unpaid. A pro rata premium payment is required for any period your Children's coverage was in force during the grace period.

CRITICAL ILLNESS BENEFITS

We will pay the BENEFIT AMOUNT as shown on this rider's SCHEDULE OF BENEFITS if your Child is diagnosed with a Critical Illness or an Additional Child Disease on or after your Child's coverage effective date. The percentage of BENEFIT AMOUNT payable and any applicable maximum benefit amounts are listed for the Critical Illness on this rider's SCHEDULE OF BENEFITS. Benefits are payable for each covered Child.

The benefits for your Children are the same as the benefits for you as shown in the CRITICAL ILLNESS BENEFITS section of the Certificate. Benefits for the Additional Child Diseases module are shown below.

To be eligible for a benefit payment, the diagnosis must be a Different Diagnosis as defined in the DEFINITIONS section of the Certificate. A subsequent diagnosis of a Critical Illness or Additional Child Disease that is for the same illness/condition as a Critical Illness or Additional Child Disease for which benefits were payable under the Policy may be eligible as a Different Diagnosis as defined.

A Critical Illness that meets the definition of a Same Diagnosis is not eligible for benefits.

Benefits are payable up to the total maximum benefit amount shown on this rider's SCHEDULE OF BENEFITS for each Critical Illness and Additional Child Disease. This includes multiple payments for Different Diagnoses. The total maximum benefit amount is the maximum amount payable for each Critical Illness and Additional Child Disease in this rider during your Child's lifetime.

Any partial benefits paid will reduce the total maximum benefit amount for that Critical Illness or Additional Child Disease.

When the total maximum benefit amount for a Child has been paid for a Critical Illness or Additional Child Disease, no further benefits are payable for that Child for that Critical Illness or Additional Child Disease. When the total maximum benefit amount for a Child has been paid for all Critical Illnesses and Additional Child Diseases, no further benefits are payable for that Child. When the total maximum benefit has been paid for all Children for all Critical Illnesses and Additional Child Diseases, no further benefits are payable and your Children's coverage under this rider terminates.

Payment of any benefits for your Child's Critical Illness or Additional Child Disease will not impact the available BENEFIT AMOUNT for your Critical Illness coverage. Payment of any benefits for your Critical Illness will not impact the available BENEFIT AMOUNT for your Child's Critical Illness coverage as long as your coverage remains in force.

A diagnosis of any Critical Illness or Additional Child Disease must be made after your Child's live birth and by a Doctor familiar with the diagnosis of the specific condition.

ADDITIONAL CHILD DISEASES MODULE

Benefits for Cerebral Palsy, Congenital Birth Defects, Cystic Fibrosis, Down Syndrome, Gaucher Disease, Type II or III, Infantile Tay Sachs, Niemann-Pick Disease, Pompe Disease, Sickle Cell Anemia, Type 1 Diabetes, Type IV Glycogen Storage Disease and Zellweger Syndrome are payable when we receive due proof of such condition which is diagnosed on or after your Child's coverage effective date (including the effective date of any changes to coverage).

A diagnosis of Type 1 Diabetes must: 1) be made by a board-certified or board-eligible endocrinologist or other specialist in the treatment of diabetes; 2) be based on blood tests; and 3) require insulin administration for a continuous period of at least 3 months.

If Type 1 Diabetes is included in the Major Organ Module as well as this rider, only one benefit is payable.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of diagnosis). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of claim without waiting for the form. If such Written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Child's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Child to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after Written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Children's coverage.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CCI2

This rider is made a part of the Group Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse if covered under the Spouse Critical Illness Rider.
- Your Children if covered under the Children's Critical Illness Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in Writing by the Employer that is in accordance with the Employer' formal leave policies. Normal vacation time is not considered a Leave of Absence.

Total Disability or **Totally Disabled** means that due to an injury or sickness you are unable to perform the material duties of your regular occupation, and you are unable to perform any other occupation for which you are fit by education, training or experience.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then you are eligible for coverage under this rider on the latest of the following:

- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

EFFECTIVE DATE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for coverage under this rider.

TERMINATION

Coverage under this rider terminates on the earliest of the following:

- The date your Critical Illness insurance terminates.
- The date coverage under this rider is terminated for all Active Employees under the Policy.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, that continuation will not include this rider.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence, or
- Total Disability,

then coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or terminate according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be payable as described in the Certificate and riders.

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during a FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by State FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

Sickness or Injury

If you are on a Leave of Absence due to your sickness or injury, including Total Disability, then insurance coverage for all Covered Persons may be continued during the Leave of Absence. This continuation period will not be less than 1 week while the Policy is in force for Employees.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

Military Leave

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") and applicable state law, then insurance coverage for all Covered Persons may be continued during the Leave of Absence. This continuation period will not be less than 1 week while the Policy is in force for Employees.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The date coverage under this rider is terminated for all Active Employees under the Policy.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong.
- The end of the period for which premiums are paid, if the next premium is not paid by its due date, subject to the GRACE PERIOD provision.
- The date you are eligible under the Policy as an Active Employee.
- The date of your death.
- The date you become covered under another group critical illness or specified disease insurance policy as an employee or member.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, insurance under the Policy will stay in force only if all of the following conditions are met:

- Critical Illness insurance is in force for Active Employees under the Policy;
- You are in an eligible class for coverage under the Policy; and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during any period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Active Employees under the Policy, then the terms of the Certificate and riders will apply.

PORTABILITY FOLLOWING TERMINATION OF CONTINUATION

When continuation under this rider ends, continued premium payment will be required to keep coverage in force. If you are not eligible as an Active Employee on that date, then your coverage can be continued under the Certificate's PORTABILITY provision. See the PORTABILITY provisions of the Spouse Critical Illness Rider and Children's Critical Illness Rider for information about continuing coverage after your death or divorce.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

WELLNESS BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CCI2

This rider is made a part of the Group Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

WELLNESS BENEFIT

You:	$50
Your Spouse:	$50
Your Children:	100% of your wellness benefit amount per Child

A wellness benefit is payable up to a maximum of one time per Covered Person per calendar year.

DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

Covered Person means:

- You, if you are covered for Critical Illness insurance under the Policy.

- Your Spouse if covered under the Spouse Critical Illness Rider.
- Your Children if covered under the Children's Critical Illness Rider.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then you are eligible under this rider on the latest of the following:

- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

Your Spouse is eligible for coverage under this rider on the later of the date above or the date your Spouse is eligible for coverage under the Spouse Critical Illness Rider.

Your Children are eligible for coverage under this rider on the later of the date above or the date each Child is eligible for coverage under the Children's Critical Illness Rider.

EFFECTIVE DATE

Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION

Coverage under this rider will terminate on the earliest of the following:

- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below and in the riders if termination is due to death or regarding coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates.
- For your Spouse's coverage, the date your Spouse's coverage under the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.

PORTABILITY

If you continue your coverage under the Certificate's PORTABILITY provision, then coverage under this rider will also be continued during portability. Continued coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Critical Illness Rider, then coverage under this rider will also be continued under your Spouse's coverage. Continued coverage under this provision is subject to all the terms of this rider.

ASSIGNMENT

At the time of claim under this rider, you can assign the payment of a benefit under this rider to a third party who is not the Policyholder.

BENEFITS

We will pay you a wellness benefit (shown on the SCHEDULE OF BENEFITS) if a Covered Person has a health screening test on or after the Covered Person's coverage effective date. A benefit is payable up to a maximum of one time per Covered Person per calendar year. The amounts are shown on the SCHEDULE OF BENEFITS.

Health screening tests include, but are not limited to:

- Blood test for triglycerides
- Pap smear or thin prep pap test
- Flexible sigmoidoscopy
- CEA (blood test for colon cancer)
- Bone marrow testing
- Serum cholesterol test for HDL & LDL levels
- Hemoccult stool analysis
- Serum Protein Electrophoresis (myeloma)
- Breast ultrasound, sonogram, MRI
- Chest x-ray
- Mammography
- Colonoscopy
- CA 15-3 (breast cancer)
- Stress test on bicycle or treadmill
- Fasting blood glucose test
- Thermography
- PSA (prostate cancer)
- Electrocardiogram (EKG)
- Endoscopy
- Carotid Doppler
- Routine eye exam
- Routine dental exam
- Well child/preventive exams for ages 1 through 18
- Biometric screenings
- Molecular or antigen test (Coronavirus)

CLAIMS

The PHYSICAL EXAMINATION provision does not apply to this rider.

NOTICE OF CLAIM

Written notice of your claim must be given to us during the same calendar year the health screening test occurs or within 30 days of the end of the calendar year, whichever is later. The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of claim without waiting for the form. If such Written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of the health screening test. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after Written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

INFECTIOUS CONDITION ADDITIONAL BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CCI2

This rider is made a part of the Group Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE

The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

INFECTIOUS CONDITION BENEFITS

Infectious Condition Diagnosis Benefit

You:	$100
Your Spouse:	$100
Your Children:	$100

Infectious Condition Hospital Confinement Benefit

You:	$1,000
Your Spouse:	$1,000
Your Children:	$1,000

DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

Covered Person means:
- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse if covered under the Spouse Critical Illness Rider.
- Your Children if covered under the Children's Critical Illness Rider.

Diagnose/Diagnosis means a diagnosis by a Doctor based on generally accepted procedures and criteria. Diagnosis includes a lab report certified by a Doctor in the United States of a positive result of a test approved by the FDA such as a Nucleic Acid Amplification Test (including reverse-transcription polymerase chain reaction assays), antigen test, or serology test.

Infectious Condition means the Diagnosis of the following condition:
- COVID-19.

Confined means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or transitional care facility. There must be a charge for room and board, other than in any government, military or veterans' facility for which there is no charge for room and board. "Transitional care facility" means a facility which provides a bridge between the Hospital and home for restorative and rehabilitation care. It must provide skilled nursing care and must be either located in a community nursing home or a Hospital. Confined also includes assignment to an observation unit in a Hospital, if you stay for at least 20 consecutive hours.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then you are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

Your Spouse is eligible for coverage under this rider on the later of the date above or the date your Spouse is eligible for coverage under the Spouse Critical Illness Rider.

Your Children are eligible for coverage under this rider on the later of the date above or the date each Child is eligible for coverage under the Children's Critical Illness Rider.

EFFECTIVE DATE

Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION
Coverage under this rider will terminate on the earliest of the following:
- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below and in the riders if termination is due to death or regarding coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below.
- For your Spouse's coverage, the date your Spouse's coverage under the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.

PORTABILITY
If you continue your coverage under the Certificate's PORTABILITY provision, then coverage under this rider will also be continued during portability. Continued coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE
If you die or divorce and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Critical Illness Rider, then coverage under this rider will also be continued under your Spouse's coverage. Continued coverage under this provision is subject to all the terms of this rider.

BENEFITS

We will pay you an Infectious Condition Diagnosis Benefit if a Covered Person is Diagnosed with an Infectious Condition on or after the Covered Person's coverage effective date. The benefit amounts are shown on this rider's SCHEDULE OF BENEFITS. A benefit is payable up to a maximum of one time per Covered Person per calendar year.

If a Covered Person is Diagnosed with an Infectious Condition that results in them being Confined to a Hospital, we will also pay you an Infectious Condition Hospital Confinement Benefit. We will pay you an Infectious Condition Hospital Confinement Benefit if a Covered Person is Diagnosed with an Infectious Condition on or after the Covered Person's coverage effective date that results in them being Confined to a Hospital. The benefit amounts are shown on this rider's SCHEDULE OF BENEFITS. A benefit is payable up to a maximum of one time per Covered Person per calendar year.

CLAIMS

NOTICE OF CLAIM
Written notice of your claim should be given to us within 30 days after the date of loss (date of Diagnosis). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM
The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of loss without waiting for the form. If such Written proof of loss covers the occurrence, character and extent of the loss within the time period below for proof of loss, you will be deemed to have complied with the requirements for providing proof of loss.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF LOSS

You must send us Written proof of your loss within 180 days after the date of the health screening test. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of loss no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PAYMENT OF CLAIMS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment immediately upon receipt of due written proof of loss. Any accrued benefits that are payable at your death will be paid according to the PAYMENT OF CLAIMS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after Written proof of loss has been given to us, and no later than three years from the time proof of loss is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

SPECIFIED CONDITIONS RIDER
For Mental Illness

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CCI2

This rider is made a part of the Group Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE
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SPECIFIED CONDITIONS BENEFITS

Specified Condition Facility Confinement Benefit

	Level $10,000	Level $20,000
You:	$2,500	$5,000
Your Spouse:	$2,500	$5,000
Your Children:	$1,250	$2,500

Total Maximum
A Specified Condition Facility Confinement benefit is payable up to a total maximum of one time per a Covered Person’s lifetime.

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DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

Covered Person means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse if covered under the Spouse Critical Illness Rider.
- Your Children if covered under the Children's Critical Illness Rider.

Confined or Confinement means that on the advice of a Health Care Provider, your assignment to a bed as a resident inpatient in a Hospital, Rehabilitation Facility or Transitional Care Facility. Being admitted to an Observation Unit for 20 hours or more also meets the definition of Confined or Confinement.

There must be a charge for room and board for the Confinement, other than in any government, military or veterans' facility or Observation Unit.

Diagnose/Diagnosis means a diagnosis by a Health Care Provider based on generally accepted procedures and criteria.

Facility means a Hospital, Observation Unit, Rehabilitation Facility, or Transitional Care Facility.

Health Care Provider means a Doctor or provider who specializes in behavioral health disorders. This includes a medical doctor, psychiatrist, psychologist, psychiatric-mental health nurse, physician assistant, licensed clinical social worker, or licensed professional counselor.

Hospital means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located;
- It is under the supervision of a medical staff and has one or more Doctors available at all times;
- It provides 24 hours a day service by registered graduate nurses (RNs); and
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or care for the aged.

Observation Unit means a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored by a Doctor, and that fully meets each of the following requirements:

- It is under the direct supervision of a Doctor or registered nurse.
- It is staffed by nurses assigned specifically to that unit.
- It provides care seven days per week, 24 hours per day.

Rehabilitation Facility means a free-standing facility which meets the definition of Hospital but is specifically designated to provide coordinated multidisciplinary physical restorative services to inpatients including the treatment of mental diseases or disorders, or drug or alcohol addiction. Services must be provided under the direction of a Doctor knowledgeable and experienced in the type of rehabilitative medicine being provided.

Rehabilitation Facility includes a unit of a Hospital with beds set up and staffed and specifically designated for rehabilitative medicine.

Specified Condition means a mental illness condition as specified below.

For purposes of this benefit, mental illness condition means a health condition that involves significant changes in emotion, thinking, or behavior--or a combination of these; resulting in distress and/or problems functioning in social, work or family activities.

A Specified Condition is limited to:

- Bipolar disorder
- Depressive disorder

Transitional Care Facility means a facility which provides a bridge between the Hospital and home for restorative and rehabilitation care. It must provide skilled nursing care and must be either located in a community nursing home or a Hospital.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then you are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

Your Spouse is eligible for coverage under this rider on the later of the date above or the date your Spouse is eligible for coverage under the Spouse Critical Illness Rider.

Your Children are eligible for coverage under this rider on the later of the date above or the date each Child is eligible for coverage under the Children's Critical Illness Rider.

EFFECTIVE DATE
Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION
Coverage under this rider will terminate on the earliest of the following:
- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below and in the riders if termination is due to death or regarding coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below.
- For each Covered Person, the date the total maximum number of benefits payable for Specified Condition Facility Confinements has been reached for that Covered Person.
- For your Spouse's coverage, the date your Spouse's coverage under the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.
- The date the Policy terminates because we stop providing critical illness coverage to all groups in the Policy issue state and coverage for all Covered Persons under the Policy terminates. We will provide 60 days Written notice of termination.

PORTABILITY
If you continue your coverage under the Certificate's PORTABILITY provision, then coverage under this rider will also be continued during portability. Continued coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE
If you die or divorce and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Critical Illness Rider, then coverage under this rider will also be continued under your Spouse's coverage. Continued coverage under this provision is subject to all the terms of this rider.

SPECIFIED CONDITION BENEFITS

Specified Condition Facility Confinement Benefit

If a Covered Person is Diagnosed with a Specified Condition that results in them being Confined to a Facility, we will pay you a Specified Condition Facility Confinement benefit. This benefit is payable if the Confinement occurs on or after the Covered Person's coverage effective date regardless of when the Specified Condition is Diagnosed. The benefit amounts are shown on this rider's SCHEDULE OF BENEFITS.

A Specified Condition Facility Confinement benefit is payable up to a total maximum of one time per a Covered Person's lifetime.

If a Covered Person qualifies for a benefit under the Certificate or Spouse Rider or Child Rider and this rider for the same Diagnosis, only one benefit in the higher amount will be payable.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of Confinement). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or can be requested from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of loss without waiting for the form. If such Written proof of loss covers the occurrence, character and extent of the loss, and is provided within the time period below for proof of loss, you will be deemed to have complied with the requirements for providing proof of loss.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Health Care Provider. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require the Covered Person to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require the Covered Person to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after Written proof of loss has been given to us, and no later than three years from the time proof of loss is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

SPECIFIED CONDITIONS RIDER
For Neurodevelopmental Disorders

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CCI2

This rider is made a part of the Group Critical Illness Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE
The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

SPECIFIED CONDITIONS BENEFITS

Specified Condition Diagnosis Benefit

	Level $10,000	Level $20,000
Autism Spectrum Disorder Level 3	$5,000	$10,000

RL-CI4-SCR-23-IL SCH

DEFINITIONS

General terms are defined in the DEFINITIONS section of the Certificate and riders.

Autism Spectrum Disorder Level 3 means a Diagnosis of autism spectrum disorder classified as severity level 3.

Covered Person means:

- You, if you are covered for Critical Illness insurance under the Policy.
- Your Spouse if covered under the Spouse Critical Illness Rider.
- Your Children if covered under the Children's Critical Illness Rider.

Diagnose/Diagnosis means a diagnosis by a Health Care Provider based on generally accepted procedures and criteria.

Health Care Provider means a Doctor or provider who specializes in behavioral health disorders. This includes a medical doctor, psychiatrist, psychologist, psychiatric-mental health nurse, physician assistant, licensed clinical social worker, or licensed professional counselor.

Specified Condition means a neurodevelopment disorder as specified below.

For purposes of this benefit, neurodevelopment disorder means a condition characterized by developmental deficits or differences in brain function that results in impairments of personal, social, academic, or occupational functioning.

A Specified Condition is limited to:

- Autism Spectrum Disorder Level 3

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then you are eligible under this rider on the latest of the following:
- The Policy effective date.
- The date coverage under this rider is available to the eligible class of Insured Persons to which you belong.
- Your Critical Illness coverage effective date.

Your Spouse is eligible for coverage under this rider on the later of the date above or the date your Spouse is eligible for coverage under the Spouse Critical Illness Rider.

Your Children are eligible for coverage under this rider on the later of the date above or the date each Child is eligible for coverage under the Children's Critical Illness Rider.

EFFECTIVE DATE
Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION
Coverage under this rider will terminate on the earliest of the following:
- The date your Critical Illness insurance terminates. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below and in the riders if termination is due to death or regarding coverage previously continued by your Spouse.
- The date coverage under this rider is terminated for all Active Employees under the Policy. See the PORTABILITY provisions below.
- The date coverage under this rider is terminated for the eligible class of Active Employees to which you belong. See the PORTABILITY provisions below.
- For your Spouse's coverage, the date your Spouse's coverage under the Spouse Critical Illness Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Critical Illness Rider terminates.
- The date the Policy terminates because we stop providing critical illness coverage to all groups in the Policy issue state and coverage for all Covered Persons under the Policy terminates. We will provide 60 days Written notice of termination.

PORTABILITY
If you continue your coverage under the Certificate's PORTABILITY provision, then coverage under this rider will also be continued during portability. Continued coverage under this provision is subject to all the terms of this rider.

PORTABILITY FOLLOWING DEATH OR DIVORCE
If you die or divorce and your Spouse continues coverage under the PORTABILITY FOLLOWING DEATH OR DIVORCE provision of the Spouse Critical Illness Rider, then coverage under this rider will also be continued under your Spouse's coverage. Continued coverage under this provision is subject to all the terms of this rider.

SPECIFIED CONDITION BENEFITS

Specified Condition Diagnosis Benefit

We will pay you a Specified Condition Diagnosis benefit if a Covered Person is Diagnosed with a Specified Condition on or after the Covered Person's coverage effective date. The benefit amounts are shown on this rider's SCHEDULE OF BENEFITS.

If a Covered Person qualifies for a benefit under the Certificate or Spouse Rider or Child Rider and this rider for the same Diagnosis, only one benefit in the higher amount will be payable.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss (date of Diagnosis). The notice may be given to us at our home office or to our authorized administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or can be requested from us. If you do not receive the form from us within 15 days of your request, you may send us Written proof of loss without waiting for the form. If such Written proof of loss covers the occurrence, character and extent of the loss, and is provided within the time period below for proof of loss, you will be deemed to have complied with the requirements for providing proof of loss.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Health Care Provider. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us Written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require the Covered Person to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require the Covered Person to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 60 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after Written proof of loss has been given to us, and no later than three years from the time proof of loss is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

ALASKA CERTIFICATE ENDORSEMENT

for Group Critical Illness Insurance

ALASKA LAW GOVERNS WITH RESPECT TO CERTIFICATES COVERING ALASKA RESIDENTS UNDER GROUP POLICIES ISSUED IN A STATE OTHER THAN ALASKA.

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

If your Certificate and any riders include a PORTABILITY provision, and the time period for us to change portability premium rates with written notice is less than 45 days, then this time period is changed to be 45 days.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

Consumer Notice for Arkansas Residents

The nearest servicing office is the Minneapolis, Minnesota office of Voya Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.
The mailing address is:

PO Box 20
Minneapolis, Minnesota 55440-0122
Telephone: (800) 537-5024

You have the right to file a complaint with the Arkansas Insurance Department (AID). A complaint can be filed online at the AID website https://insurance.arkansas.gov.

You may also contact AID to request a complaint form be mailed to you by calling AID at (800) 852-5494 or (501) 371-2640.

You may also request in writing for a complaint form to be mailed to you. Mail your request to:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

This consumer notice is for information only and does not become a part or condition of this certificate or policy. Please insert this notice in your certificate or policy.

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

Web Site: www.insurance.ca.gov/01-consumers/101-help

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

IDAHO CERTIFICATE ENDORSEMENT

for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. CERTIFICATE COVER

The following statements are added to the cover page of your Certificate:

Notice to Buyer: This is a specified disease Certificate. This Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate carefully with the outline of coverage.

RENEWABILITY
The group Policy is conditionally renewable for an additional year on each Policy anniversary according to the TERMINATION OF COVERAGE and POLICY TERMINATION provisions.

II. SCHEDULE OF BENEFITS

Every benefit amount and total maximum benefit amount (if any) in your Certificate and any riders is a multiple of $1,000. If any amount does not equal a multiple of $1,000, then that amount is rounded to the nearest $1,000.

If your Certificate or any riders include a BENEFIT REDUCTIONS provision or reductions due to age, then the reduced benefit amount is rounded to the nearest $1,000.

If your Certificate or any riders includes a benefit for Bone Marrow Transplant, then all references to “Bone Marrow Transplant” are changed to: “Bone Marrow Disease, Infection or Damage.”

If your Certificate or any riders includes a benefit for Coronary Artery Bypass, then all references to “Coronary Artery Bypass” are changed to: “Critical Coronary Artery Disease.”

If your Certificate or any riders includes a benefit for Major Organ Transplant, then all references to “Major Organ Transplant” are changed to “Major Organ Failure.”

III. DEFINITIONS

If your Certificate includes a definition of **Abdominal Aortic Aneurysm**, then that definition is revised to remove any reference to surgical repair being advised.

If your Certificate includes a definition of **Bone Marrow Transplant**, then that definition is replaced by the following:

Bone Marrow Disease, Infection or Damage means the clinical diagnosis of bone marrow disease, infection or damage from chemotherapy that has resulted in irreversible bone marrow failure.

If your Certificate contains a definition of **Carcinoma in Situ (CIS)**, then the following is added to the definition:

A clinical diagnosis of Carcinoma in Situ will be accepted as evidence that Carcinoma in Situ exists when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the diagnosis of Carcinoma in Situ.

If your Certificate includes a definition of **Coronary Artery Bypass**, then that definition is replaced by the following:

> **Critical Coronary Artery Disease** means the diagnosis of severe left main or severe multi-vessel coronary artery disease with a SYNTAX score of $\geq$ 22.

If the definition of **Hospital** in your Certificate excludes a hospice unit, including any bed designated as a hospice or swing bed, then that exclusion does not apply.

If your Certificate includes a definition of **Major Organ Transplant**, then that definition is replaced by the following:

> **Major Organ Failure** means the diagnosis by a Doctor of irreversible failure of your heart, lung, pancreas, an entire kidney or the entire liver, or any combination of these conditions.

If your Certificate contains a definition of **Pre-Existing Condition**, and the time period in that definition is more than 6 months, then the time period in that definition is limited to 6 months.

If your Certificate contains a definition of **Skin Cancer**, then the following is added to the definition:

> A clinical diagnosis of Skin Cancer will be accepted as evidence that Skin Cancer exists when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the diagnosis of Skin Cancer.

If your Certificate includes a definition of **Thoracic Aortic Aneurysm**, then that definition is revised to remove any reference to surgical repair being advised.

IV. GENERAL PROVISIONS

The following provision is added to your Certificate:

> **CONSUMER NOTICE**
> If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance:
>
> Idaho Department of Insurance
> Consumer Affairs
> 700 W. State Street, 3rd Floor
> P.O. Box 83720
> Boise, Idaho 83720-0043
>
> (800) 721-3272
> www.DOI.Idaho.gov

V. CRITICAL ILLNESS BENEFITS

If your Certificate includes benefits for Major Organ Transplant (or Major Organ Failure), with reference to the UNOS (United Network Organ Sharing) list, then all references to the UNOS list do not apply.

If your Certificate includes benefits for Parkinson's Disease, then any references to clinical manifestations or activities of daily living are replaced by:

> …unable to care for yourself and will continue to decline even with the best medical therapy.

If your Certificate includes benefits for Occupational HIV or Hepatitis B or C, then the following is added:

> This benefit does not in any way alter or replace the Employer's obligations under the Workers' Compensation Law.

If your Certificate includes a Child Care Benefit, then the reference to "child" or "children" includes a child placed for adoption.

VI. EXCLUSIONS AND LIMITATIONS

If your Certificate and any riders contain an exclusion for felony or illegal activity, then that exclusion is replaced by the following:

- Participation in a felony.

If your Certificate and any riders contain an exclusion for alcoholism, drug abuse, or misuse of alcohol or taking of drugs, then that exclusion is replaced by the following:

- Alcoholism or drug addiction.

VII. CLAIMS

If the BENEFIT PAYMENTS provision in your Certificate and any riders indicates that there is a time limit on when we will make payment, then that statement is replaced by the following:

Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim.

VIII. CHILDREN'S CRITICAL ILLNESS RIDER

If your Certificate includes a Children's Critical Illness Rider, then in addition to any changes noted above, this rider is changed as follows:

If the rider includes a benefit for Congenital Birth Defects, then all references to "Congenital Birth Defects" are changed to: "Congenital Anomaly."

In the **DEFINITIONS** section:

If the definition of **Child** or **Children** includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The reference to an adopted child in the definition of **Child** or **Children** is changed to add the following:

"Placed" means physical placement in your care, except when physical placement is prevented due to the medical needs of the child, in which case 'placed' means the date you sign an agreement for adoption of the child and assume financial responsibility for the child.

If the definition of **Child** or **Children** includes a requirement that the child be eligible to be claimed by you or your Spouse for federal income tax purposes, then that requirement does not apply to your natural or adopted child.

If the definition of **Child** or **Children** includes any requirements for full-time students over a certain age, then these requirements do not apply.

If the rider contains a definition of **Congenital Birth Defects**, that definition is replaced by the following (if the rider contains no such definition, the following definition is added):

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body, and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

Examples includes, but are not limited to, the following:

- Heart defects.
- Lung defects.
- Spina Bifida.
- Cleft lip or palate.
- Limb malformations.

Congenital Anomaly includes being born blind without the recommendation of surgery. Congenital Anomaly does not include prematurity.

In the **GENERAL PROVISIONS** section:

If the ELIGIBILITY provision includes a time period following one parent's termination of Employee coverage during which the other parent may enroll for Child coverage, then this time period does not apply.

The following replaces any language in the EFFECTIVE DATE provision specific to a newborn Child (if there is no language specific to a newborn Child, then this is added):

If you have coverage on yourself, your eligible newborn Child is automatically covered for the first 60 days after birth. This includes an adopted newborn Child who is placed with you within 60 days of birth. The coverage amount(s) will be the same as for your other eligible Children. If you do not already have Children's coverage under this rider, then Child coverage beyond the 60th day is subject to the conditions regarding application and Active Employment.

If you pay any part of the cost of coverage under this rider, the Employer will notify you of the premium required for this rider and the date that either payroll deductions will begin or your first premium payment is due, which will not be less than 31 days following your receipt of the notification.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 60 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 60 days after birth, the "event" will be the date of placement. No additional premium is required.

In the **CRITICAL ILLNESS BENEFITS** section:

If the rider includes benefits for Additional Child Diseases, then this statement is added:

If any Additional Child Disease is also considered a Congenital Anomaly, only one benefit is payable.

In the **EXCLUSIONS** (or **EXCLUSIONS AND LIMITATIONS**) section, if any:

If the rider contains a PRE-EXISTING CONDITION EXCLUSION (or LIMITATION) provision, then the following statement is added to that provision:

A Congenital Anomaly is not considered a Pre-Existing Condition.

IX. ABSENCE FROM EMPLOYMENT PREMIUM WAIVER RIDER

If your Certificate includes an Absence from Employment Premium Waiver Rider, then this rider is changed as follows:

In the **DEFINITIONS** section:

If the rider includes a definition of **Waiting Period** and the time period in that definition is more than 30 days (or more than 1 month if shown in months), then this time period is limited to 30 days (or 1 month).

X. OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

See the next page for the Outline of Coverage for Idaho Residents.

XI. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

SPECIFIED DISEASE COVERAGE

THE CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER MEDICAL EXPENSES

OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the "Guide to Health Insurance for People With Medicare" available from the company.

This coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it.

Read Your Certificate Carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

The policy provides a lump-sum benefit if a covered person is diagnosed with any of the covered illnesses/conditions listed on the Schedule of Benefits. Commonly covered conditions include: **heart attack, cancer, stroke, major organ failure, coronary artery disease, and carcinoma in situ (CIS)**. Please consult your certificate and riders for specific information about the conditions covered, how terms are used, any requirements that describe qualifying for a particular loss, and the benefit amounts. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of benefits available under the Policy.

In order for a benefit to be payable, the specified disease must be diagnosed after the covered person's coverage effective date. **A pre-existing condition exclusion or limitation may apply to a specified disease diagnosed during the first year that coverage (or an increase in coverage) is in force. Coverage may reduce based on age.** Benefit payment is contingent on proof of loss which may require additional information be provided prior to claim determination. The Policyholder may choose to have an eligibility waiting period, during which time no coverage is in force.

The exclusions that apply to all provisions for specified disease coverage are provided in the "Exclusions" section of the certificate and any riders. The "Schedule of Benefits," the Benefits section(s) and the "Exclusions" section of the certificate and any riders provide specific information about the conditions for receiving benefits and any limitations. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of the exclusions and limitations under the policy.

The eligibility requirements for a spouse and children may include age limitations, as provided in the riders. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of any age limitations under the policy.

Your coverage will continue under the policy, while the policy remains in force, as long as you continue to meet the eligibility requirements and all premiums due are paid. You may have the option to continue your coverage by direct payment of premiums to ReliaStar Life Insurance Company after you no longer meet the eligibility requirements.

The Policyholder may change the terms of the policy at any time with ReliaStar Life Insurance Company's agreement. The Policyholder or ReliaStar Life Insurance Company may terminate the policy at any time. ReliaStar Life Insurance Company reserves the right to change premiums at any time according to the terms of the policy.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MAINE CERTIFICATE ENDORSEMENT

for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

The following are added after the TERMINATION OF COVERAGE provision:

If your coverage ends due to a lapse or default on your part, your coverage may be reinstated on the basis that you suffered from a cognitive impairment or functional incapacity at the time of cancellation. You or someone authorized to act on your behalf must submit a request for reinstatement to us within 90 days of cancellation along with medical proof, at your expense, that you suffered from a cognitive impairment or functional incapacity at the time of cancellation. Within 15 days of our request, all premiums due from the date of cancellation must also be received by us in order to consider your request for reinstatement. If we approve your request, your coverage will be reinstated at the same level as though the cancellation had not occurred.

THIRD PARTY NOTICE
You may designate an additional person to receive notice of any intent to terminate coverage. You may change this designation at any time. The form is available upon request from the Policyholder.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MASSACHUSETTS CERTIFICATE ENDORSEMENT

for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

The following statements are added to the TERMINATION OF COVERAGE provision:

> If your employment ends, your coverage will continue under the Policy for a period of 31 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.
>
> If your employment is terminated due to a plant closing or a partial closing (as defined in section 71A of Chapter 151A, Massachusetts Statutes), your coverage will continue under the Policy for a period of 90 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MINNESOTA CERTIFICATE ENDORSEMENT

for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

The POLICY TERMINATION provision is changed to add the following statement:

> If the Policy is terminated, we will make a good faith effort to notify all Insured Persons at least 30 days before the termination date. We will not notify Insured Persons if we have reasonable evidence that the Policy has been or will be replaced by a substantially similar group policy, plan or contract.

II. CHILDREN'S CRITICAL ILLNESS RIDER

If your Certificate includes a Children's Critical Illness Rider, the definition of **Child** or **Children** is changed as follows:

> If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.
>
> The definition includes a child for whom you or your Spouse are a legal guardian. The definition also includes your grandchild who is financially dependent on you and resides with you continuously from birth.
>
> If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.
>
> Any reference in the definition to "disability" means developmental disability, mental illness or disorder, or physical disability.

III. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MINNESOTA CONTINUATION CERTIFICATE ENDORSEMENT

for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

If any riders include an EXTENSION FOLLOWING DEATH and/or an EXTENSION FOLLOWING DEATH OR DIVORCE provision, then all references below to "Portability" mean Extension.

I. SPOUSE CRITICAL ILLNESS RIDER

If your Certificate includes a Spouse Critical Illness Rider, then the PORTABILITY FOLLOWING DEATH OR DIVORCE provision on that rider is replaced by the following:

MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse can elect to maintain Spouse coverage if certain conditions are met. Upon your Spouse's request, the Employer will provide your Spouse with information about the cost of maintaining coverage under this provision and how to elect continuation. Your Spouse must have been insured under this rider on the date of your death or divorce, and your Spouse must elect continuation and pay the first premium within 90 days of the date of your death or divorce.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time your Spouse becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your Spouse.

Coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the Spouse according to this rider's TERMINATION provision.
- The date your Spouse becomes covered under any group critical illness or specified disease policy as an employee, member or spouse.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

If your Spouse Critical Illness Rider does not include a PORTABILITY FOLLOWING DEATH OR DIVORCE provision, then the provision above is added to the rider.

Any references to Portability in the BENEFIT PAYMENTS provision on the Spouse Critical Illness Rider are replaced by the following:

For MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits unpaid at your Spouse's death will be paid to your Spouse's estate.

If your Spouse Critical Illness Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statement is added to the BENEFIT PAYMENTS provision on the rider.

II. CHILDREN'S CRITICAL ILLNESS RIDER

If your Certificate includes a Children's Critical Illness Rider, then the PORTABILITY FOLLOWING DEATH provision on that rider is replaced by the following:

MINNESOTA CONTINUATION FOLLOWING DEATH

If you die while this rider is in force, Children's coverage can be maintained if certain conditions are met. Your Children must have been insured under this rider on the date of your death. Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to your death.

If your Spouse has elected Minnesota continuation under the Spouse Critical Illness Rider, then your Spouse may also elect continuation of this Children's Critical Illness Rider at the same time. If you do not have an eligible Spouse insured under the Spouse Critical Illness Rider at the time of your death, then each eligible Child insured under the Children's Critical Illness Rider may elect Minnesota continuation and pay the first premium within 90 days of the date of your death.

Upon request of your Spouse, Child or the Child's legal guardian, the Employer will provide that person with information about the cost of maintaining coverage under this provision and how to elect this continuation.

Premiums will be billed directly to your Spouse, Child or Child's legal guardian as applicable. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time your Child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your Spouse, Child or Child's legal guardian as applicable.

If your Spouse or the Child's legal guardian dies while a Child's coverage is in force under this provision, then the Child or their new legal guardian must contact us within 31 days of the death for information about how to maintain the Child's coverage under this provision.

Each Child's coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the Child according to this rider's TERMINATION provision.
- The end of the period for which premium are paid for the Child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the Child becomes covered under any group critical illness or specified disease policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

If your Children's Critical Illness Rider does not include a PORTABILITY FOLLOWING DEATH provision, then the provision above is added to the rider.

The following provisions are also added to the Children's Critical Illness Rider:

MINNESOTA CONTINUATION FOLLOWING DIVORCE

If you divorce and your former spouse has elected Minnesota continuation under the Spouse Critical Illness Rider, then this Children's Critical Illness Rider can be maintained under your former spouse's coverage for each child whose coverage would otherwise terminate due to the divorce. Upon your former spouse's request, the Employer will provide your former spouse with information about the cost of maintaining coverage under this provision and how to elect continuation.

Premiums will be billed directly to your former spouse. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time the child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your former spouse.

If your former spouse dies while a child's coverage is in force under this provision, then the child or their legal guardian must contact us within 31 days of the death for information about how to maintain the child's coverage under this provision.

Each child's coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the child according to this rider's TERMINATION provision.
- The end of the period for which premiums are paid for the child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the child becomes covered under any group critical illness or specified disease policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD

If your Child's coverage under this rider would otherwise terminate because the child no longer meets the definition of Child in this rider, for a reason other than your death or divorce, then the child can elect to maintain Child coverage under this rider for a period of time. The child (or the child's legal guardian) must elect continuation and pay the first premium within 90 days of the date of loss of eligibility.

Upon request of the child or the child's legal guardian, the Employer will provide that person with information about the cost of maintaining coverage under this provision and how to elect this continuation.

Premiums will be billed directly to the child or child's legal guardian as applicable. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time the child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to the child or child's legal guardian as applicable.

If the child's legal guardian dies while the child's coverage is in force under this provision, then the child or their new legal guardian must contact us within 31 days of the death for information about how to maintain the child's coverage under this provision.

A child's coverage maintained under this provision will end on the earliest of the following:

- 36 months after the date continuation under this provision started.
- The date coverage would otherwise terminate for the child according to this rider's TERMINATION provision.
- The end of the period for which premiums are paid for the child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the child becomes covered under any group critical illness or specified disease policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

Any references to Portability in the BENEFIT PAYMENTS provision on the Children's Critical Illness Rider are replaced by the following:

> For MINNESOTA CONTINUATION FOLLOWING DIVORCE, benefits will be paid to your former spouse, and any accrued benefits unpaid at your former spouse's death will be paid to your former's spouse's estate. For MINNESOTA CONTINUATION FOLLOWING DEATH or MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD, benefits will be payable to the person responsible for premium payments for that child, and any accrued benefits unpaid at that person's death will be payable to that person's estate.

If your Children's Critical Illness Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statements are added to the BENEFIT PAYMENTS provision on the rider.

III. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900
Minneapolis, Minnesota 55401
(612) 372-5432

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or the health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South Seventh Street
Minneapolis, Minnesota 55402
Telephone: (612) 322-8713

The maximum amount the Guaranty Association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in the present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant’s lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association’s limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

NEW HAMPSHIRE CERTIFICATE ENDORSEMENT

for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

If your Certificate contains a definition of **Pre-Existing Condition**, and the time period in that definition is more than 6 months, then the time period in that definition for you and any Covered Person is limited to 6 months.
As it relates to your Children, congenital anomalies are not considered a Pre-Existing Condition.

II. EXCLUSIONS

If your Certificate and any riders contain a PRE-EXISTING CONDITION EXCLUSION, and the length of that exclusion is more than 6 months, then the length of that exclusion for you and any Covered Person is limited to 6 months.

III. CLAIMS

If the PROOF OF CLAIM provisions in your Certificate and any riders indicate that there is a one year limit for providing proof of claim, then this statement does not apply to you.

IV. CHILDREN'S CRITICAL ILLNESS RIDER

If your Certificate includes a Children's Critical Illness Rider, the definition of **Child** or **Children** is changed as follows:

> If the definition includes a maximum Child age of less than 26 years, then this maximum is changed to 26 years.
>
> If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

V. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

SPOUSE ENDORSEMENT FOR NEW HAMPSHIRE RESIDENTS

Your Certificate(s) and Spouse rider(s) have been changed as follows. Please keep this endorsement with your Certificate(s). This endorsement is subject to all other terms of the Policy.

If your Certificate contains definitions of "You and Your" and "We, Us and Our", then all references to "you" and "your" in this endorsement mean "You and Your" as defined in your Certificate, and all references to "we" and "us" and "our" in this endorsement mean "We, Us and Our" as defined in your Certificate.

I. CONTINUATION FOLLOWING DIVORCE OR LEGAL SEPARATION

If you divorce or legally separate, and the final decree of divorce or legal separation does not expressly prohibit continuation of coverage for your former Spouse, then your former Spouse can elect to continue Spouse coverage for a limited time. The former Spouse must have been insured under our Policy as your Spouse on the date before the date of divorce or legal separation. In order to continue coverage under this provision, the former Spouse has 30 days after the date of divorce or legal separation in which to make the election, pay the first premium, and provide us with the final decree of divorce or legal separation.

When we put the former Spouse on continuation under this provision, the former Spouse becomes the owner of that Spouse coverage under the Policy. All Spouse benefits are payable to the former Spouse. Premiums will be billed directly to the former Spouse. Continued premium payment is required to keep coverage in force. The benefits and premium rates for Spouse coverage continued under this provision will remain the same as though the former Spouse were still eligible as your lawful Spouse. Spouse coverage may not be increased.

Spouse coverage continued under this provision will end on the earliest of the following:

- The 3-year anniversary of the final decree of divorce or legal separation.
- The date of the former Spouse's remarriage.
- The date of your remarriage.
- The date the former Spouse dies.
- The date you die.
- The end date of coverage, if any, as provided by the final decree of divorce or legal separation.
- The end of the period for which the former Spouse paid premiums, if the former Spouse stops making a required premium contribution, subject to the grace period.
- The date the Policy terminates.

If all of the following are true:

- the former Spouse's coverage was being continued under a similar provision of the Employer's prior group policy that provided the same type of coverage as our Policy,
- your coverage under the prior policy is replaced by coverage under our Policy, and
- the former Spouse's coverage under the prior policy stops due to the prior policy's termination,

then the former Spouse can elect to continue the Spouse coverage for the remainder of the time period described above while our Policy is in force. The benefits, premium rates and all other terms for continued Spouse coverage are subject to the terms of our Policy. In order to continue Spouse coverage, the former Spouse has 30 days after your coverage effective date under our Policy in which to make the election, pay the first premium, and provide us with proof of their eligibility for continuation under the prior policy.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:
- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):
- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual Annuities
- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:
- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

(i) With respect to one life, regardless of the number of policies or contracts:

- $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability

income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or

- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each payee of a structured settlement annuity or beneficiary if the payee is deceased, $300,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any,

(iii) the association is not obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for health benefit plans, in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual or with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(iv) the limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(v) benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

TEXAS CERTIFICATE ENDORSEMENT

for Group Critical Illness Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

If your Certificate includes a Children's Critical Illness Rider, then the definition of **Child** or **Children** is changed as follows:

> If the definition includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.
>
> The definition includes your unmarried grandchild who is your dependent for federal income tax purposes on the date the grandchild is first eligible under this rider. The definition also includes a child for whom you must provide medical support under a court order.
>
> If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

Texas Residents: Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

ReliaStar Life Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Contact Center Manager at 1-800-955-7736

Toll-free: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Email: LifeClaims@voya.com

Mail: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puedo resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, pro su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tamblen debe presenter una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

ReliaStar Life Insurance Company

Para obtener informacion o para presenter una queja ante su compania de seguros:

Llame a: Customer Contact Center Manager at 1-800-955-7736

Telefono gratuito: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Correo electronico: LifeClaims@voya.com

Direccion postal: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada con los seguros o para presenter una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 for disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

To learn more about the above protections, please visit the Association's website at www.utlifega.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

Wisconsin Complaint Notice

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

ReliaStar Life Insurance Company
Customer Service
P.O. Box 20
Minneapolis, MN 55440-0020
1-877-236-7564

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103.

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 122
Minneapolis, Minnesota 55440-0122

Plan Name, Number and Name and Address of Plan Sponsor:
BMO U.S. Health and Welfare Benefit Plan
29316-4CCI2
BMO Financial Corp.
320 South Canal Street, Floor 8
Chicago, IL 60606

Name, Address, and Telephone Number of the Plan Administrator:
BMO Financial Corp.
Benefits Administration Committee
320 South Canal Street, Floor 8
Chicago, IL 60606
Human Resources Centre (HRC): 1-888-927-7700

Identification Numbers
IRS Employer Identification Number: 51-0275712
Plan Number: 507

Agent for Legal Process: Plan Administrator

Trustees: BNY Mellon Client Service Center, 500 Ross Street, 8th Floor, Pittsburgh, PA 15262-0001

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Premiums are 100% Employee paid.

Plan Year: January 1 through January 31

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR CRITICAL ILLNESS INSURANCE

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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YOUR HOSPITAL CONFINEMENT INDEMNITY INSURANCE PLAN

For Employees of
BMO Financial Corp.

D6028 (10/23)

GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE CERTIFICATE OF COVERAGE

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

Claims: 888-238-4840 Customer Service: 877-236-7564

POLICYHOLDER:	BMO Financial Corp.
GROUP POLICY NUMBER:	29316-4CHI2
POLICY EFFECTIVE DATE:	January 1, 2021
GOVERNING JURISDICTION:	Illinois

THIS IS LIMITED BENEFIT INDEMNITY COVERAGE

Benefits are paid for Hospital Confinements and other covered losses as defined in the Certificate. The Policy does not constitute comprehensive health insurance coverage (often referred to as "major medical insurance coverage"). In addition, the Policy does not satisfy the requirement of minimum essential coverage under the Affordable Care Act. Benefits are paid under the Policy for Hospital Confinement or other covered losses as indemnity insurance and are not intended to cover medical expenses.

ReliaStar Life Insurance Company certifies that we have issued the group Policy listed above to the Policyholder. The Policy is available for you to review if you contact the Policyholder for more information. **This is your Certificate as long as you are eligible for coverage and you become insured. Please read it carefully and keep it in a safe place.** This Certificate replaces any other Certificates we may have given you for the same level of coverage under the Policy.

This Certificate summarizes and explains the parts of the Policy which apply to you. The Certificate is part of the group Policy but by itself is not a policy. Your coverage may be changed under the terms and conditions of the Policy. The Policy is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the Policy, all days begin at 12:01 a.m. standard time at the Policyholder's address and end at 12:00 midnight standard time at the Policyholder's address. The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

In this Certificate, "you" and "your" refer to an Employee who is eligible for coverage under the Policy; "we", "us" and "our" refer to ReliaStar Life Insurance Company.

Exclusions may apply.

Signed for ReliaStar Life Insurance Company at its home office in Minneapolis, Minnesota on the Policy effective date.

William Bainbridge
President

Melissa A. O'Donnell
Secretary

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Arizona residents:
Notice: This Certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read this Certificate carefully.

California residents:
If you are age 65 or older on the effective date of any coverage under the Policy for which you are required to pay all or part of the premium, then you have 30 days from the date you receive your initial Certificate to cancel your coverage and have your full premium contribution and any policy or membership fee paid refunded, by returning the Certificate to the Policyholder by mail or other delivery method for cancellation without claim.

Florida residents:
The benefits of the Policy providing your coverage are governed primarily by the law of a state other than Florida.

Maryland residents:
Notice: This Certificate of insurance may not provide all benefits required for a policy issued and delivered in Maryland.

SCHEDULE OF BENEFITS

EMPLOYER: BMO Financial Corp.
GROUP POLICY NUMBER: 29316-4CHI2

ELIGIBLE CLASS(ES)
All Eligible Employees in Active Employment with the Employer in the United States.

You must be an Employee of the Employer and in an eligible class.
Temporary and seasonal workers are excluded from coverage.

MINIMUM HOURS REQUIREMENT
All Eligible Employees: 20 hours per week

ELIGIBILITY WAITING PERIOD
Persons in an eligible class on or before the Policy effective date and continuously employed thereafter: End of the month in which you complete a continuous period of 30 days of Active Employment.

Persons entering an eligible class after the Policy effective date and continuously employed thereafter: End of the month in which you complete a continuous period of 30 days of Active Employment.

Persons entering an eligible class after being rehired more than 30 days but less than 13 weeks after their termination date who enroll within 31 calendar days of their rehire date: First day of the month following your date of rehire.

Persons entering an eligible class after being rehired more than 13 weeks following their termination date, but before the annual enrollment for the next calendar year, who enroll within 31 calendar days of their rehire date: End of the month in which you complete a continuous period of 30 days of Active Employment.

REHIRE
If your employment with the Employer ends and you are rehired within 30 days, your previous Active Employment while in an eligible class will apply toward the Eligibility Waiting Period. All other Policy provisions apply.

WHO PAYS FOR THE COVERAGE
You pay the cost of your coverage.

BENEFIT AMOUNTS

DAILY CONFINEMENT AMOUNT(S)

Low Plan	High Plan
$100	$200

CONFINEMENT DAILY BENEFITS

Facility Confinement Benefits

Hospital Confinement	1 times the daily Confinement amount per day, up to a maximum of 10 days per Confinement
Critical Care Unit (CCU) Confinement	2 times the daily Confinement amount per day, up to a maximum of 10 days per Confinement
Rehabilitation Facility Confinement	1/2 of the daily Confinement amount per day, up to a maximum of 30 days per Confinement

Admission Benefits	Low Plan	High Plan
Hospital Admission	$1,000 for the first day of Hospital Confinement, once per Confinement	$1,500 for the first day of Hospital Confinement, once per Confinement
Critical Care Unit (CCU) Admission	$1,000 for the first day of CCU Confinement, once per Confinement	$1,500 for the first day of CCU Confinement, once per Confinement

Only one type of facility Confinement or admission benefit is payable per day. Each type of admission benefit is payable 8 times per calendar year.

Any combination of facility Confinement and admission benefits payable will not exceed a total of 52 days during a period of Confinement.

OBSERVATION UNIT DAILY BENEFIT

Observation unit benefit	$100 per day, up to a maximum of one day per calendar year.

An observation unit benefit is not payable for any day that a facility Confinement or admission benefit is payable.

DEFINITIONS

Accident or **Accidental** means an unforeseen event that results in a bodily Injury.

Active Employment means you are working for the Employer for earnings that are paid regularly and you are performing the material and substantial duties of your regular occupation. You must be working at least the minimum number of hours as described under the MINIMUM HOURS REQUIREMENT shown in the SCHEDULE OF BENEFITS.

Your work site must be one of the following:
- The Employer's usual place of business;
- An alternative work site at the direction of the Employer, including your home; or
- A location to which your job requires you to travel.

Normal vacation is considered Active Employment.
Temporary and seasonal workers are excluded from coverage.

Certificate means the document that explains the parts of the Policy which apply to eligible Insured Persons. It may include riders, endorsements or amendments.

Confined or **Confinement** means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or Critical Care Unit (CCU) or Rehabilitation Facility. There must be a charge for room and board, other than in any government, military or veterans' facility for which there is no charge for room and board.

Critical Care Unit means a specifically designated part of a Hospital commonly referred to as an intensive care unit which meets all of the following requirements:
- It provides the highest level of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care.
- It is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement.
- It is permanently equipped with special lifesaving equipment for the care of the critically ill or injured.
- It is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis.
- It is assigned a Doctor on a full-time basis.

Critical Care Unit does not include a sub-acute intensive care unit that provides a level of medical care below intensive care, but above a regular private or semi-private room or ward such as a step-down unit.

Doctor means a person other than you or any family member, who is licensed to practice medicine in the state in which treatment is received and providing treatment or advice in accordance with the license. State law may require consideration of professional services of a practitioner other than a medical doctor. If so, then this definition includes persons recognized as qualified to treat the condition for which claim is made by the state in which treatment is received.

Eligibility Waiting Period means the continuous period of time (shown in the SCHEDULE OF BENEFITS) that you must be in Active Employment in an eligible class before you are eligible for coverage under the Policy.

Employee means a person who is a citizen or legal resident of the United States in Active Employment with the Employer in the United States.

Employer means the Policyholder and includes any division, subsidiary or affiliated company named in the Policy.

Hospital means an institution that is run for the care and treatment of sick or injured persons as in-patients and which, on its premises or in facilities available to the Hospital on a pre-arranged basis, fully meets each of the following requirements:

- It is operated in accordance with the laws pertaining to hospitals in the jurisdiction in which it is located.
- It is under the supervision of a medical staff and has one or more Doctors available at all times.
- It provides 24 hours a day service by registered graduate nurses (RNs).
- It is not an institution or any part of an institution used as: a hospice unit, including any bed designated as a hospice or a swing bed; a convalescent home; a rest or nursing facility; a free-standing surgical center; an extended-care facility; a skilled nursing facility; or a facility primarily affording custodial, educational care or care for the aged.

Infection means bacterial infections, except infections which result from an Accident Injury, or infections which result from Accidental, involuntary or unintentional ingestion of a contaminated substance.

Injury means a bodily Injury that is the direct result of an Accident and not related to any disease or bodily infirmity. Injuries must be independent of Sickness, disease, and bodily infirmity.

Insured Person means an Employee who is eligible for coverage under the Policy, becomes covered according to the terms of the Policy, and whose coverage remains in effect according to the terms of the Policy.

Policy means the written group insurance contract between us and the Policyholder.

Policyholder means the Employer to which the Policy is issued and who sponsors the coverage for its Employees.

Rehabilitation Facility means a free-standing facility which meets the definition of Hospital but is specifically designated to provide coordinated multidisciplinary physical restorative services to inpatients. Services must be provided under the direction of a Doctor knowledgeable and experienced in the type of rehabilitative medicine being provided.

Rehabilitation Facility includes a unit of a Hospital with beds set up and staffed and specifically designated for rehabilitative medicine.

Sickness means illness, Infection, disease or any other abnormal physical condition that is not due to an Injury. Sickness includes pregnancy, Infection and any other abnormal physical condition that is not caused by an Accident.

GENERAL PROVISIONS

ELIGIBILITY

If you are working for the Employer in an eligible class (shown on the SCHEDULE OF BENEFITS), the date you are eligible for coverage is the later of the following:

- The Policy effective date.
- The day after you complete your Eligibility Waiting Period. **Exception:** If your Eligibility Waiting Period ends on the first day of the month, this eligibility date is the day you complete your Eligibility Waiting Period.

EFFECTIVE DATE OF COVERAGE

You will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date you are eligible for coverage, if you apply for coverage on or before that date.
- The date you apply for coverage.
- The date you return to Active Employment, if you are not in Active Employment when your coverage would otherwise become effective. **Exception**: Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your coverage begins, any increased or additional coverage will take effect on the latest of the following:

- The date of the increased or additional coverage, if you are in Active Employment and the increased or additional coverage does not require your election.
- The date you return to Active Employment, if you are not in Active Employment due to Injury or Sickness.

Any decrease in coverage will take effect immediately but will not affect a payable claim that occurs prior to the decrease.

TERMINATION OF COVERAGE

Your coverage under the Policy ends on the earliest of the following dates:

- The date the Policy terminates.
- The last day of the month during which you are no longer in an eligible class.
- The last day of the month during which your eligible class is no longer covered.
- The last day of the month during which you voluntarily cancel your coverage.
- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The end of the Policyholder's grace period, if the Policyholder does not remit premium to us by the end of such period.
- The last day of the month during which you are no longer in Active Employment.

We will provide coverage for a payable claim that occurs while you are covered under the Policy.

POLICY TERMINATION

The Policy can be terminated either by us or by the Policyholder.

We may terminate the Policy for any of the following reasons:

- The Policyholder does not promptly provide us with information that is reasonably required.
- Fewer than 25 persons are insured under the Policy.
- The premium is not paid in accordance with the provisions of the Policy.
- We determine that there is a significant change in the size, occupation or age of the eligible class(es) as a result of a corporate transaction such as a merger, divestiture, acquisition, sale or reorganization of the Policyholder and/or its persons.
- We stop providing the type of coverage under this Policy to all groups in the Policy issue state.

We reserve the right to review and terminate all class(es) covered under the Policy if any class(es) cease(s) to be covered.

If the Policyholder fails to pay the full premium due by the end of the grace period, the Policy will terminate according to the GRACE PERIOD provision.

If we terminate the Policy for reasons other than the Policyholder's failure to pay premiums, written notice will be mailed to the Policyholder at least 60 days prior to the termination date.

The Policyholder may terminate the Policy by written notice delivered to us at our home office prior to the termination date. When both the Policyholder and we agree, the Policy can be terminated on an earlier date.

If the Policyholder or we terminate the Policy, coverage will end at 12:00 midnight standard time at the Policyholder's address on the termination date.

If the Policy is terminated, the termination will not affect a payable claim.

PORTABILITY

Portability means you have the option to continue your coverage after it would otherwise terminate, if certain conditions are met.

To continue your coverage, you must apply for portability and pay the first premium within 31 days of the date your coverage would otherwise terminate due to any of the following:

- You retire or terminate employment with the Employer, if coverage remains in effect under the Policy for other Insured Persons.
- The Policyholder terminates coverage under the Policy for all Insured Persons, and does not replace it with a similar insurance plan.
- You are no longer eligible for coverage under the Policy.

You can decrease but not increase the ported coverage amount. Ported coverage is subject to all the terms of the Policy and this Certificate.

Premiums will be billed directly to you. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time you apply for portability. We may change the portability premium rates at any time upon 60 days written notice to you.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which you paid premiums, if you stop making a required premium contribution, subject to the grace period.
- The date you die.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

GRACE PERIOD

The Policyholder has a grace period of 60 days for the payment of any premium due except the first. During the grace period the Policy will remain in force. If full payment is not received by us by the end of the grace period, the Policy will automatically terminate at the end of the grace period. The Policyholder is required to pay a pro rata premium for any period the Policy was in force during the grace period. There is no grace period if the Policyholder gives us advance written notice of termination, or if we have given the Policyholder advance written notice of termination as described under the POLICY TERMINATION provision.

If you are on portability, you also have a grace period of 31 days for the payment of any premium due. During the grace period your coverage will remain in force. If full payment is not received by us by the end of the grace period, your coverage will automatically terminate at the end of the grace period. A pro rata premium payment is required for any period your coverage was in force during the grace period.

REPRESENTATIONS NOT WARRANTIES

We consider any statements the Policyholder and you make in an application to be representations and not warranties. No statements made by you will be used to reduce or deny any claim or to cancel your coverage unless both of the following are true:

- The statement is in writing and is signed by you.
- A copy of that statement is given to you or your personal representative.

INCONTESTABILITY

Except in the case of fraud, no statement made by you in an application or enrollment form relating to your insurability will be used to contest the insurance for which the statement was made after the coverage has been in force for two years during your lifetime.

CLERICAL ERROR

Clerical error or omission by us or by the Policyholder will not:

- Prevent you from receiving coverage, if you are entitled to coverage under the terms of the Policy.
- Cause coverage to begin or continue for you when the coverage would not otherwise be effective.

If the Policyholder gives us information about you that is incorrect, we will do both of the following:

- Use the facts to decide whether you are eligible for coverage under the Policy and in what amounts.
- Make a fair adjustment of the premium.

MISSTATEMENT OF AGE

If premiums are based on your age and you have misstated your age, we will make a fair adjustment of benefits to reflect the amount that the premium paid would have purchased at your true age. We may require satisfactory proof of your age before paying any claim.

ASSIGNMENT

No assignment of benefits under the Policy is valid, unless otherwise specified in the Policy.

AGENCY

For purposes of the Policy, the Policyholder acts on its own behalf or as your agent. Under no circumstances will the Policyholder be deemed our agent.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on the Policy effective date and each subsequent Policy anniversary date, conflicts with any law that applies in the jurisdiction where the Policy is issued, is automatically amended to conform to the minimum requirements of such law.

CHANGES TO POLICY OR CERTIFICATE

No agent, representative or employee of ours or of any other entity may change or waive the terms of the Policy, or of any Certificate or rider issued under it, except in writing signed by one of our executive officers and endorsed or attached to the Policy.

If there is a conflict between the terms of this Certificate or any attached rider and the Policy, the Policy controls.

BENEFITS

We will pay a benefit as shown on the SCHEDULE OF BENEFITS for an eligible Confinement or other covered loss that occurs on or after your coverage effective date, subject to the EXCLUSIONS of this Certificate.

CONFINEMENT DAILY BENEFITS

Only one type of facility Confinement benefit is payable per day. Confinement benefits are payable for each day you are Confined up to the maximums shown on the SCHEDULE OF BENEFITS.

Re-Confinements to a Hospital or Critical Care Unit (CCU) or Rehabilitation Facility that occur within 30 days after being discharged for the same or a related condition are considered to be part of the previous period of Confinement. A Confinement that begins more than 30 days after discharge for a previous period of Confinement is considered a new Confinement.

A Confinement benefit will not be payable for any day that an admission benefit is payable.

Admission: Only one type of admission benefit is payable per day. Admission benefits are payable upon admission to a Hospital or Critical Care Unit (CCU) or Rehabilitation Facility for Confinement as an inpatient due to treatment of an Injury or Sickness. The first day of Confinement must occur on or after your coverage effective date. The number of admission benefits payable during a period of Confinement are limited as shown on the SCHEDULE OF BENEFITS.

Hospital Confinement: Benefits are payable if you are Confined in a Hospital on an inpatient basis due to treatment of an Injury or Sickness.

Critical Care Unit (CCU) Confinement: Benefits are payable if you are Confined in a Critical Care Unit on an inpatient basis due to treatment of an Injury or Sickness. Once the CCU Confinement benefits have been paid for the maximum number of days in the SCHEDULE OF BENEFITS, any remaining days of Hospital Confinement during the same period of Confinement will be payable under the Hospital Confinement daily benefit, up to the maximum number of days in the SCHEDULE OF BENEFITS.

Rehabilitation Facility Confinement: Benefits are payable if you are Confined in a Rehabilitation Facility on an inpatient basis due to treatment of an Injury or Sickness.

OBSERVATION UNIT DAILY BENEFIT

Observation unit benefit: Benefits are payable if you are admitted to a Hospital observation unit for at least 4 consecutive hours other than as an inpatient. This benefit is not payable for any day that a facility Confinement or admission benefit is payable.

An observation unit is a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored following outpatient surgery or following treatment in the Emergency Room by a Doctor, and that fully meets each of the following requirements:

- It is under the direct supervision of a Doctor or registered nurse.
- It is staffed by nurses assigned specifically to that unit.
- It provides care seven days per week, 24 hours per day.

EXCLUSIONS

Benefits are not payable for any loss resulting from any of the following:

- Participation or attempt to participate in a felony or illegal occupation.
- Operation of a motorized vehicle while intoxicated. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (other than acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Misuse of alcohol or taking of drugs, other than under the direction of a Doctor. **Exception:** This exclusion does not apply to a Confinement in an eligible Hospital or Rehabilitation Facility for the purpose of treatment for alcoholism or drug addiction.
- Elective surgery, except when required for appropriate care as determined by a Doctor as a result of your Injury or Sickness.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require you to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while your claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid to the first survivor(s) who is/are living on the date of your death, in the following order:

1. Your spouse.
2. Your natural and adopted children, in equal shares.
3. Your grandchildren, in equal shares.
4. Your parents, in equal shares.
5. Your siblings, in equal shares.
6. Your estate.

If a survivor entitled to receive a payment dies before receiving it, we will make payment to that person’s estate.

If a survivor entitled to receive a payment has a special needs trust established, we will make payment to that person’s trust instead of to the person directly.

"Spouse" in this provision means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

CERTIFICATE ENDORSEMENT

For Group Hospital Confinement Indemnity Insurance

RELIASTAR LIFE INSURANCE COMPANY

250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CHI2

This endorsement is made a part of the Hospital Confinement Indemnity Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate. Except as expressly changed by this endorsement, the terms used in this endorsement have the same meaning as in the Certificate.

EFFECTIVE DATE

The endorsement effective date is the effective date of the Certificate.

ENDORSED PROVISIONS

Your Certificate has been changed. The following provision(s) are amended to read as follows:

Confined or **Confinement** means that on the advice of a Doctor, your assignment to a bed as a resident inpatient in a Hospital or Critical Care Unit (CCU) or Rehabilitation Facility. Confined or Confinement includes being admitted to a Hospital observation unit for 0 hours or more. An observation unit is a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored by a Doctor, and that fully meets each of the following requirements:

- It is under the direct supervision of a Doctor or registered nurse.
- It is staffed by nurses assigned specifically to that unit.
- It provides care seven days per week, 24 hours per day.

There must be a charge for room and board for the confinement, other than in any government, military or veterans' facility or Hospital observation unit for which there is no charge for room and board.

OBSERVATION UNIT DAILY BENEFIT

Observation unit benefit: Benefits are payable if you are admitted to a Hospital observation unit for at least 4 consecutive hours but less than 0 consecutive hours other than as an inpatient. This benefit is not payable for any day that a facility Confinement or admission benefit is payable.

An observation unit is a specified area within a Hospital, apart from the Emergency Room, where a patient can be monitored by a Doctor, and that fully meets each of the following requirements:

- It is under the direct supervision of a Doctor or registered nurse.
- It is staffed by nurses assigned specifically to that unit.
- It provides care seven days per week, 24 hours per day.

Executed at our home office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

SPOUSE HOSPITAL CONFINEMENT INDEMNITY RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CHI2

This rider is made a part of the Hospital Confinement Indemnity Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE
You pay the cost of coverage under this rider.

BENEFIT AMOUNTS
The benefit amounts for your Spouse are the same as the Employee BENEFIT AMOUNTS as shown in the SCHEDULE OF BENEFITS section of the Certificate.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Spouse.

Spouse means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then your Spouse is eligible under this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Hospital Confinement Indemnity coverage effective date.
- The date of your marriage.

If your Spouse is covered under the Policy as an Employee, then your Spouse is not eligible for coverage under this rider.

EFFECTIVE DATE

Your Spouse will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Spouse is eligible for coverage, if you apply for Spouse coverage on or before that date.
- The date you apply for Spouse coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Spouse's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical leave of absence and paid time off for nonmedical-related absences.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Spouse's coverage begins, any increased or additional coverage due to an increase in the Employee coverage amount will take effect on the same date as the Employee coverage increase.

Any decrease in coverage due to a decrease in the Employee coverage amount will take effect on the same date as the Employee coverage decrease, but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The last day of the month during which you voluntarily cancel this rider.
- The last day of the month during which your Spouse is no longer an eligible Spouse as defined by this rider. See the PORTABILITY FOLLOWING DEATH OR DIVORCE provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse can apply to continue Spouse coverage if certain conditions are met. Your Spouse must have been insured under this rider on the date of your death or divorce, and your Spouse must apply for portability and pay the first premium within 31 days of the date of your death or divorce.

If your Spouse is approved by us for portability, your Spouse will become the owner of the Spouse coverage that was previously provided under this rider. Your Spouse can decrease but not increase the ported coverage amount. Ported coverage is subject to all the terms of the Policy and Certificate.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

SPOUSE BENEFITS

The benefits for your Spouse are the same as your benefits as shown in the BENEFITS section of the Certificate, based on your Spouse's Confinement or other covered loss, and subject to the EXCLUSIONS of this rider.

EXCLUSIONS

Benefits are not payable for any loss resulting from any of the following:

- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while your Spouse is operating a motorized vehicle while intoxicated. Intoxication means your Spouse's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (other than acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Misuse of alcohol or taking of drugs, other than under the direction of a Doctor. **Exception:** This exclusion does not apply to a Confinement in an eligible Hospital or Rehabilitation Facility for the purpose of treatment for alcoholism or drug addiction.
- Elective surgery, except when required for appropriate care as determined by a Doctor as a result of your Spouse's Injury or Sickness.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Spouse's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Spouse to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require your Spouse to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your Spouse's coverage.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401

Robert L. Grubka
President

Melissa A. O'Donnell
Secretary

CHILDREN'S HOSPITAL CONFINEMENT INDEMNITY RIDER

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CHI2

This rider is made a part of the Hospital Confinement Indemnity Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE
You pay the cost of coverage under this rider.

BENEFIT AMOUNTS
The benefit amounts for your Children are the same as the Employee BENEFIT AMOUNTS as shown in the SCHEDULE OF BENEFITS section of the Certificate. **Exception(s):** The benefit amount for your newborn Child is described under the NEWBORN BENEFIT provision below.

NEWBORN BENEFIT

Your newborn Child's Confinement, if you have coverage under this rider on the date of your newborn Child's birth	The same as benefits for any other Child.
Your newborn Child's Confinement, if you do <u>not</u> have coverage under this rider on the date of your newborn Child's birth	$100 No admission benefit is payable.

DEFINITIONS

General terms defined in the DEFINITIONS section of the Certificate regarding medical conditions and eligibility apply to your Children.

Child or **Children** means a child from live birth but less than 26 years of age who is one of the following:

- Your natural or adopted child from the date of placement or pursuant to an interim court order of adoption, whichever comes first.
- Your stepchild.
- A child of your civil union partner who is recognized as equivalent to a spouse by Illinois law.
- A child of your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer.

- Your foster child or a child for whom you are a legal guardian.

The child must also meet all of the following conditions:

- Not be on full-time active duty in the armed forces of any country or subdivision thereof.
- Legally reside in the United States or its territories or possessions.
- Not be insured under the Policy as an Employee or Spouse.

This definition includes your Child age 26 or older who is incapable of self-sustaining employment due to physical or intellectual disability. Written proof of the Child's incapacity must be furnished to us at our home office within 31 days after the Child reaches the limiting age. We may require, at reasonable intervals, but not more than once a year after the two year period following attainment of the limiting age, evidence satisfactory to us that the incapacity is continuing. Coverage will continue while the Child remains incapable of self-sustaining employment due to physical or intellectual disability and continues to meet the definition of Child except for the age limit.

Spouse means your lawful spouse. It includes your civil union partner who is recognized as equivalent to a spouse by Illinois law which allows both same sex and different sex couples to enter into a civil union with all of the obligations, protections, and legal rights that Illinois provides to married heterosexual couples. It also includes your domestic partner as defined by the Employer if you have completed and signed an affidavit of domestic partnership on a form acceptable to the Employer. Any reference to marriage includes establishment of a domestic partnership or civil union. Any reference to divorce includes termination of a domestic partnership or civil union.

GENERAL PROVISIONS

ELIGIBILITY

If you are covered under the Policy, then your Children are eligible under this rider on the latest of the following:

- The Policy effective date.
- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Hospital Confinement Indemnity coverage effective date.
- The date you acquire a Child by marriage, birth or adoption.

If your Child is covered under the Policy as an Employee, then your Child is not eligible for coverage under this rider.

EFFECTIVE DATE

Your Children will be covered at 12:01 a.m. standard time at the Policyholder's address on the latest of the following:

- The date your Children are eligible for coverage, if you apply for Children's coverage on or before that date.
- The date you apply for Children's coverage.
- The date you return to Active Employment, if you are not in Active Employment when your Children's coverage would otherwise become effective. **Exception:** Coverage starts on a non-working day if you were in Active Employment on your last scheduled working day before the non-working day. Non-working days include time off for the following: vacations, personal holidays, weekends and holidays, approved nonmedical Leave of Absence and paid time off for nonmedical-related absences.

If you have Employee coverage but you do not have Children's coverage under this rider, and you acquire a new eligible Child due to birth, your eligible newborn Child is automatically covered under the terms of this rider for the NEWBORN BENEFIT as shown on the SCHEDULE OF BENEFITS. This includes an adopted newborn Child who is placed with you within 30 days after birth. The effective date of any coverage you apply for after birth is subject to the conditions above including Active Employment.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 30 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 30 days after birth, the "event" will be the date of placement. No additional premium is required.

EFFECTIVE DATE OF CHANGES TO COVERAGE

Once your Children's coverage begins, any increased or additional coverage due to an increase in the Employee coverage amount will take effect on the same date as the Employee coverage increase.

Any decrease in coverage due to a decrease in the Employee coverage amount will take effect on the same date as the Employee coverage decrease, but will not affect a payable claim that occurs prior to the decrease.

TERMINATION

Coverage for each Child ends on the earliest of the following:

- The date this rider terminates.
- The last day of the month during which the Child is no longer an eligible Child as defined by this rider. Eligibility of a Child who is incapable of self-sustaining employment due to physical or intellectual disability ends when there is no longer evidence satisfactory to us that the incapacity is continuing.

This rider terminates on the earliest of the following:

- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- The date you voluntarily cancel this rider.
- The date you no longer have any eligible Children covered under this rider. See the PORTABILITY FOLLOWING DEATH provision below.
- The end of the period for which premiums are paid, if the next required premium contribution is not paid, subject to the grace period.

PORTABILITY

If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider can also be continued during portability.

PORTABILITY FOLLOWING DEATH

If you die and your Spouse is approved by us for portability under the Spouse Hospital Confinement Indemnity Rider, then this rider can be continued under your Spouse's coverage. Following portability of this rider, Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to the death of the Employee.

Premiums will be billed directly to your Spouse. Continued premium payment is required to keep coverage in force. The initial premium will be based on the portability premium rates in effect at the time your Spouse applies for portability. We may change the portability premium rates at any time upon 60 days written notice to your Spouse.

Coverage continued under this provision will end on the earliest of the following:

- The end of the period for which your Spouse paid premiums, if your Spouse stops making a required premium contribution, subject to the grace period.
- The date your Spouse dies.
- The date there are no longer any eligible Children covered under this rider.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

CHILDREN BENEFITS

Benefits are payable for each covered Child. The benefits for your Children are the same as your Employee benefits as shown in the BENEFITS section of the Certificate, based on your Child's Confinement or other covered loss.
Exception(s): Benefits for your newborn Child are described under the NEWBORN BENEFIT provisions on this rider.

NEWBORN BENEFIT

If you have coverage under this rider on the date of your newborn Child's birth, then the benefits for the newborn Child under this rider are the same as for any other Child.
If you have Employee coverage but you do <u>not</u> have coverage under this rider on the date of your newborn Child's birth, and your newborn Child is Confined due to birth, then this rider provides a one-time benefit for your newborn Child as shown on the SCHEDULE OF BENEFITS. All other benefits under this rider are subject to the conditions regarding application, effective date and Active Employment.

EXCLUSIONS

Benefits are not payable for any loss resulting from any of the following:

- Participation or attempt to participate in a felony or illegal occupation.
- An Accident while your Child is operating a motorized vehicle while intoxicated. Intoxication means your Child's blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the Accident occurred.
- Suicide, attempted suicide or any intentionally self-inflicted Injury, while sane or insane.
- War or any act of war, whether declared or undeclared (other than acts of terrorism).
- Loss sustained while on active duty as a member of the armed forces of any nation. We will refund, upon written notice of such service, any premium which has been accepted for any period not covered as a result of this exclusion.
- Misuse of alcohol or taking of drugs, other than under the direction of a Doctor.
- Elective surgery, except when required for appropriate care as determined by a Doctor as a result of your Child's Injury or Sickness.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Operating, or training to operate, or service as a crew member of, or jumping, parachuting or falling from, any aircraft or hot air balloon, including those which are not motor-driven. Flying as a fare-paying passenger is not excluded.
- Engaging in hang-gliding, bungee jumping, parachuting, sailgliding, parasailing, parakiting, kitesurfing or any similar activities.
- Practicing for, or participating in, any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received.

CLAIMS

NOTICE OF CLAIM

Written notice of your claim should be given to us within 30 days after the date of loss. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and your Child's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of loss. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

PHYSICAL EXAMINATION

We may require your Child to be examined by one or more Doctors or other medical practitioners of our choice. We will pay for this examination. We can require an examination as often as it is reasonable to do so while the claim is pending. We may also require you to be interviewed by our authorized representative. Failure to comply with this request may result in denial or termination of benefits.

BENEFIT PAYMENTS

Benefits under this rider are payable to you. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum or in a method comparable to one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401

William Bainbridge
President

Melissa A. O'Donnell
Secretary

CONTINUATION OF INSURANCE RIDER

RELIASTAR LIFE INSURANCE COMPANY
20 Washington Avenue South, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CHI2

This rider is made a part of the Hospital Confinement Indemnity Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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DEFINITIONS

Covered Person means:
- You, if you are covered for Hospital Confinement Indemnity insurance under the Policy.
- Your Spouse who is covered under your Spouse Hospital Confinement Indemnity Rider.
- Your Children who are covered under your Children's Hospital Confinement Indemnity Rider.

Leave of Absence means you are absent from Active Employment for a period of time under a leave granted in writing by the Employer that is in accordance with the Employer's formal leave policies. Your normal vacation time is not considered a Leave of Absence.

GENERAL PROVISIONS

ELIGIBILITY
If you are covered under the Policy, then you are eligible for this rider on the latest of the following:
- The Policy effective date.
- The date this rider is available to the eligible class of Employees to which you belong.
- Your Hospital Confinement Indemnity coverage effective date.

EFFECTIVE DATE
You will be covered at 12:01 a.m. standard time at the Policyholder's address on the date you are eligible for this rider.

TERMINATION
This rider terminates on the earliest of the following:
- The date your Hospital Confinement Indemnity insurance terminates.
- The date this rider is terminated for all Employees under the Policy.
- The date this rider is terminated for the eligible class of Employees to which you belong.

CONTINUATION OF INSURANCE

If you stop Active Employment due to:

- Employer-approved Leave of Absence

then insurance coverage may be continued under the Policy beyond the date you are no longer in Active Employment, limited to the time period(s) described below.

During this continued coverage period, the amount of continued insurance equals the amount in effect the day prior to the continuation period. That amount will reduce or stop according to the Certificate and riders in effect the day prior to the continuation period.

Premiums are due during the continuation period on the same basis as on the day prior to the continuation period. Contact the Employer for more information.

If an eligible claim occurs while coverage is being continued under this rider, then benefits will be paid as described in the Certificate and riders.

EMPLOYER-APPROVED LEAVE(S) OF ABSENCE

Family and Medical Leave

If you are on a Leave of Absence as described under the Family and Medical Leave Act of 1993 and any amendments ("FMLA") or any applicable state family and medical leave law ("State FML"), and the Employer's human resource policy provides for continuation of insurance during an FMLA or State FML Leave of Absence, then insurance coverage for all Covered Persons may be continued until the end of the later of:

- The leave period permitted by FMLA.
- The leave period permitted by state FML.

This continuation of coverage includes all riders that were in effect on the date before the FMLA or State FML Leave of Absence began.

Sickness or Injury

If you are on a Leave of Absence due to your sickness or injury, then insurance coverage for all Covered Persons may be continued during the Leave of Absence. This continuation period will not be less than 1 week while the Policy is in force for Employees.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

Military Leave

If you are on a Leave of Absence for active military service as described under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”) and any applicable state law, then insurance coverage for all Covered Persons may be continued during the Leave of Absence. This continuation period will not be less than 1 week while the Policy is in force for Employees.

This continuation of coverage includes all riders that were in effect on the date before the Leave of Absence began.

CONCURRENT LEAVES OF ABSENCE

If you would be eligible for more than one type of continuation under this rider during any one period that you are not in Active Employment, we will consider such periods to be concurrent for the purpose of determining how long your coverage may continue under the Policy.

TERMINATION OF CONTINUATION

Coverage continued under this rider will end on the earliest of the following:

- The end of the continuation period as indicated above.
- The end of the period for which premiums are paid if the next premium is not paid by its due date, subject to the grace period.
- The date you are eligible under the Policy due to Active Employment.

- The date of your death.
- The date you become covered under another group hospital confinement indemnity insurance policy as an employee or member.
- The date the Policy terminates.
- The date coverage for all Employees under the Policy terminates.

In no event will coverage for any Covered Person be continued beyond the date coverage would otherwise end according to the termination provision(s) of the Certificate and riders.

When this continuation ends, insurance under the Policy will stay in force only if all of the following conditions are met:
- Hospital Confinement Indemnity insurance is in force for Employees under the Policy; and
- You are in an eligible class for coverage under the Policy; and
- Your premium payments are resumed.

The amount of insurance will be subject to the Certificate and riders in effect on the date your premium payments are resumed.

RETURN TO ACTIVE EMPLOYMENT

If coverage is not continued during any period that is eligible for continuation under the Policy, and you return to Active Employment while coverage is in force for Employees under the Policy, then the terms of the Certificate and riders will apply.

Executed at our Home Office:
20 Washington Avenue South
Minneapolis, MN 55401



William Bainbridge
President



Melissa A. O'Donnell
Secretary

WELLNESS BENEFIT RIDER

RELIASTAR LIFE INSURANCE COMPANY
250 Marquette Avenue, Suite 900, Minneapolis, Minnesota 55401

POLICYHOLDER: BMO Financial Corp.

GROUP POLICY NUMBER: 29316-4CHI2

This rider is made a part of the Hospital Confinement Indemnity Insurance Certificate and is subject to all of the provisions, limitations and exclusions of the Policy and Certificate, unless changed by this rider. Unless expressly changed by this rider, the terms used in this rider have the same meaning as in the Certificate.

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SCHEDULE OF BENEFITS

WHO PAYS FOR THE COVERAGE
The cost of coverage under this rider is automatically included in the cost of your coverage and the cost of your Spouse's coverage and the cost of your Children's coverage.

WELLNESS BENEFIT

You:	$50 per day
Your Spouse:	$50 per day
Your Children:	100% of your wellness benefit amount, per day, per Child

The wellness benefit is payable up to a maximum of one day per Covered Person per calendar year.

DEFINITIONS
General terms are defined in the DEFINITIONS section of the Certificate and riders.

Covered Person means:
- You, if you are covered for Hospital Confinement indemnity insurance under the Policy.
- Your Spouse who is covered under your Spouse Hospital Confinement Indemnity Rider.
- Your Children who are covered under your Children's Hospital Confinement Indemnity Rider.

GENERAL PROVISIONS

ELIGIBILITY
If you are working for the Employer in an eligible class (shown in the Certificate's SCHEDULE OF BENEFITS), you are eligible for this rider on the latest of the following dates:
- The Policy effective date.

- The date this rider is available to the eligible class of Insured Persons to which you belong.
- Your Hospital Confinement indemnity coverage effective date.

Your Spouse is eligible for coverage under this rider on the later of the date above or the date your Spouse is eligible for coverage under the Spouse Hospital Confinement Indemnity Rider.

Your Children are eligible for coverage under this rider on the later of the date above or the date each Child is eligible for coverage under the Children's Hospital Confinement Indemnity Rider.

EFFECTIVE DATE
Each Covered Person will be covered at 12:01 a.m. standard time at the Policyholder's address on the date the Covered Person is eligible for coverage under this rider.

TERMINATION
This rider will terminate on the earliest of the following:
- The date your Certificate terminates.
- The date this rider is terminated for all Insured Persons under the Policy.
- For your Spouse's coverage, the date the Spouse Hospital Confinement Indemnity Rider terminates.
- For each Child's coverage, the date your Child's coverage under the Children's Hospital Confinement Indemnity Rider terminates.

PORTABILITY
If you are approved by us to continue your coverage under the Certificate's PORTABILITY provision, then this rider will also be continued during portability.

PORTABILITY FOLLOWING DEATH OR DIVORCE
If you die or divorce and your Spouse is approved by us for portability under the Spouse Hospital Confinement Indemnity Rider, then this rider can also be continued under your Spouse's coverage.

BENEFITS
We will pay you a wellness benefit for each day that a Covered Person has one or more eligible health screening tests, on or after the Covered Person's coverage effective date. This benefit is payable up to a maximum of one day per Covered Person per calendar year. The amounts are shown on the SCHEDULE OF BENEFITS.

Eligible health screening tests include, but are not limited to:

– Blood test for triglycerides
– Pap smear or thin prep pap test
– Flexible sigmoidoscopy
– CEA (blood test for colon cancer)
– Bone marrow testing
– Serum cholesterol test for HDL & LDL levels
– Hemoccult stool analysis
– Serum Protein Electrophoresis (myeloma)
– Breast ultrasound, sonogram, MRI
– Chest x-ray
– Mammography
– Colonoscopy
– CA 15-3 (breast cancer)
– Stress test on bicycle or treadmill
– Fasting blood glucose test
– Thermography
– PSA (prostate cancer)
– Biometric screenings
– Electrocardiogram (EKG)
– Routine eye exam
– Routine dental exam
– Well child/preventive exams for ages 1 through 18

EXCLUSIONS
The EXCLUSIONS section of the Certificate and riders does not apply to this rider.

CLAIMS

The PHYSICAL EXAMINATION provision does not apply to this rider.

NOTICE OF CLAIM

Written notice of your claim must be given to us during the same Policy year the health screening test occurs or within 30 days of the end of the Policy year, whichever is later. The notice may be given to us at our home office or to our authorized agent or administrator. Failure to give notice within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such notice within that time and the notice was given as soon as reasonably possible.

CLAIM FORM

The claim form is available from the Employer or you can request a claim form from us. If you do not receive the form from us within 15 days of your request, you may send us written proof of claim without waiting for the form. If such written proof of claim covers the occurrence, character and extent of the loss within the time period below for proof of claim, you will be deemed to have complied with the requirements for providing proof of claim.

FILING A CLAIM

The claim form(s) may require completion by you and the Employer and the Covered Person's attending Doctor. The completed form(s) and any attachments indicated on the form(s) as required should be sent directly to us at the address indicated on the form.

PROOF OF CLAIM

You must send us written proof of your claim within 90 days after the date of the health screening test. Failure to give such proof within this timeframe will not invalidate or reduce any payable claim if it can be shown that it was not reasonably possible to give such proof within that time, and the proof was given as soon as reasonably possible. However, in any event, you must provide proof of claim no later than one year after the time proof is otherwise required, except in the absence of legal capacity.

BENEFIT PAYMENTS

Benefits under this rider are payable to you unless otherwise specified. Once a claim has been approved, we will make payment as soon as possible but no more than 30 days after receipt of proof of claim. Any accrued benefits that are payable at your death will be paid according to the BENEFIT PAYMENTS provision in the Certificate. For PORTABILITY FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits that are payable at the time of your Spouse's death will be paid to your Spouse's estate.

Any payment we make in good faith will discharge our liability as to the extent of such payment. We will pay the benefits in one sum.

If an approved claim is not paid within 30 days of our receipt of the proof of claim, we will pay interest on the late payment at 9% per year accruing from the 30th day after receipt of the proof of claim until the date of payment.

LEGAL ACTION

You can start legal action regarding a claim no earlier than 60 days after written proof of claim has been given to us, and no later than three years from the time proof of claim is required, unless otherwise provided under federal law. Nothing in this provision waives, extends or tolls any applicable statute of limitations governing any claim relating in any way to your coverage.

Executed at our Home Office:
250 Marquette Avenue, Suite 900
Minneapolis, MN 55401



Robert L. Grubka
President



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

ALASKA CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

ALASKA LAW GOVERNS WITH RESPECT TO CERTIFICATES COVERING ALASKA RESIDENTS UNDER GROUP POLICIES ISSUED IN A STATE OTHER THAN ALASKA.

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

The definition of "Doctor" is changed to add the following statement to the end of the definition:

> In Alaska this includes: a state licensed physician, physician assistant, dentist, osteopath, optometrist, chiropractor, nurse midwife, advance nurse practitioner, naturopath, physical therapist, occupational therapist, marital and family therapist, psychologist, psychological associate, licensed clinical social worker, licensed professional counselor, or certified direct-entry midwife.

II. GENERAL PROVISIONS

If your Certificate or any riders include a PORTABILITY provision, and the time period for us to change portability premium rates with written notice is less than 45 days, then this time period is changed to be 45 days.

III. EXCLUSIONS

If your Certificate or any riders have an exclusion related to an aircraft or hot air balloon, then the following statement is added:

> Jumping or falling from an aircraft or hot air balloon in an emergency while a fare-paying passenger is not excluded.

If your Certificate or any riders have an exclusion related to recreational activities, then that exclusion only applies to the activities listed and not to "any similar activities."

IV. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

Consumer Notice for Arkansas Residents

The nearest servicing office is the Minneapolis, Minnesota office of Voya Employee Benefits, a division of ReliaStar Life Insurance Company and ReliaStar Life Insurance Company of New York.
The mailing address is:

PO Box 20
Minneapolis, Minnesota 55440-0122
Telephone: (800) 537-5024

You have the right to file a complaint with the Arkansas Insurance Department (AID). A complaint can be filed online at the AID website https://insurance.arkansas.gov.

You may also contact AID to request a complaint form be mailed to you by calling AID at (800) 852-5494 or (501) 371-2640.

You may also request in writing for a complaint form to be mailed to you. Mail your request to:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

This consumer notice is for information only and does not become a part or condition of this certificate or policy. Please insert this notice in your certificate or policy.

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

NOTICE TO CALIFORNIA POLICYHOLDERS/CERTIFICATEHOLDERS KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

If you have a question about your policy, if you need assistance with a problem, or if you have questions about a claim, you may write to us at the above address or call 1-800-955-7736.

You will need to provide your policy number with any communication.

If you do not reach a satisfactory resolution after having discussions with us, or our agent or representative, or both, you may contact the following unit within the Department of Insurance that deals with consumer affairs:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, California 90013

Outside Los Angeles: 1-800-927-HELP (1-800-927-4357)
Los Angeles: (213) 897-8921

Web Site: www.insurance.ca.gov/01-consumers/101-help

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual
- Employer and association plans, to the extent they are self-funded or uninsured
- A policy or contract providing any health care benefits under Medicare Part C or Part D
- An annuity issued by an organization that is only licensed to issue charitable gift annuities
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract
- Any policy of reinsurance unless an assumption certificate was issued
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

IDAHO CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. CERTIFICATE COVER

The following statements are added to the cover page of your Certificate:

Notice to Buyer: This is a hospital confinement indemnity certificate. This certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

RENEWABILITY

The coverage under the Policy is conditionally renewable according to the terms and provisions of the Policy.

II. SCHEDULE OF BENEFITS

If any facility Confinement benefit in your Certificate or any riders is less than $40 per day, then this benefit is increased to $40 per day.

If your Certificate or any riders include a BENEFIT REDUCTIONS provision or reductions due to age, these reductions will not decrease the daily facility Confinement benefit for any Covered Person below $40.

If any facility Confinement benefit in your Certificate is for less than 31 days, then this benefit is increased to 31 days.

III. DEFINITIONS

If the definition of **Hospital** in your Certificate excludes a hospice unit, including any bed designated as a hospice or swing bed, then that exclusion does not apply.

If your Certificate and any riders contain a definition of **Pre-Existing Condition**, and the time period in that definition is more than 6 months, then the time period in that definition is limited to 6 months.

IV. GENERAL PROVISIONS

The following provision is added to your Certificate:

CONSUMER NOTICE

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer, you may contact the Department of Insurance:

Idaho Department of Insurance
Consumer Affairs
700 W. State Street, 3rd Floor
P.O. Box 83720
Boise, Idaho 83720-0043

(800) 721-3272
www.DOI.Idaho.gov

V. BENEFITS (or HOSPITAL CONFINEMENT INDEMNITY BENEFITS)

If the references to re-Confinements in your Certificate indicate time periods of less than 90 days, then this time period is changed to 90 days.

VI. EXCLUSIONS

If your Certificate and any riders contain an exclusion for felony or illegal activity, then that exclusion is replaced by the following:

- Participation in a felony.

If your Certificate and any riders contain an exclusion for intoxication while operating a motor vehicle, then that exclusion does not apply.

If your Certificate and any riders contain an exclusion for misuse of alcohol or taking of drugs, then that exclusion is replaced by the following:

- Alcoholism or drug addiction.

If this exclusion in your Certificate or any riders contains an **Exception**, that Exception is unchanged.

If your Certificate and any riders contain an exclusion for elective surgery, then the reference to "elective" is changed to "cosmetic" and the following is added to that bullet:

> "Cosmetic surgery" will not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; reconstructive surgery because of congenital disease or anomaly of a covered dependent child; or involuntary complications or complications related to a cosmetic procedure.

If your Certificate and any riders contain exclusions for racing, aircraft or hot-air balloons, recreational activities or competitive athletic contests, then those exclusions do not apply.

The following exclusion is added below the bulleted list of EXCLUSIONS in your Certificate and any riders:

> In addition, benefits are not payable due to illness, treatment or medical condition arising out of professional aviation for wage or profit.

If your Certificate includes a Children's Hospital Confinement Indemnity Rider with a PRE-EXISTING CONDITION EXCLUSION, then the following statement is added to that provision:

> Congenital Anomalies are not considered a Pre-Existing Condition.

VII. CLAIMS

If the BENEFIT PAYMENTS provision in your Certificate and any riders indicates that there is a time limit on when we will make payment, then that statement is replaced by the following:

> Once a claim has been approved, we will make payment immediately upon receipt of due written proof of claim.

VIII. CHILDREN'S HOSPITAL CONFINEMENT INDEMNITY RIDER

If your Certificate includes a Children's Hospital Confinement Indemnity Rider, then in addition to any changes noted above, this rider is changed as follows:

In the **SCHEDULE OF BENEFITS:**

If the BENEFIT AMOUNTS provision contains an **Exception** regarding admission benefits payable for a newborn Child, then that **Exception** does not apply.

If there is a NEWBORN BENEFIT provision, that provision does not apply. The benefit amounts payable for an eligible newborn Child are the same as the benefit amounts payable for any other eligible Child. If there is a benefit for a stillborn Child, that benefit is unchanged.

In the **DEFINITIONS** section:

If the definition of **Child** or **Children** includes a maximum Child age of less than 25 years, then this maximum is changed to 25 years.

The reference to an adopted child in the definition of **Child** or **Children** is changed to add the following:

"Placed" means physical placement in your care, except when physical placement is prevented due to the medical needs of the child, in which case 'placed' means the date you sign an agreement for adoption of the child and assume financial responsibility for the child.

If the definition of **Child** or **Children** includes a requirement that the child be eligible to be claimed by you or your Spouse for federal income tax purposes, then that requirement does not apply to your natural or adopted child.

If the definition of **Child** or **Children** includes any requirements for full-time students over a certain age, then these requirements do not apply.

The following definition is added:

Congenital Anomaly means a condition existing at or from birth that is a significant deviation from the common form or function of the body, whether caused by a hereditary or developmental defect or disease. The term significant deviation is defined to be a deviation which impairs the function of the body, and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be congenital anomalies.

In the **GENERAL PROVISIONS** section:

If the EFFECTIVE DATE provision includes a time period following the date you become eligible for Children's coverage during which you must apply or elect coverage, then this time period does not apply.

The following replaces any language in the EFFECTIVE DATE provision specific to a newborn Child, other than for a stillborn Child (if there is no language specific to a newborn Child, then this is added):

If you have Employee coverage but you do not have Children's coverage under this rider, and you acquire a new eligible Child due to birth, your eligible newborn Child is automatically covered under the terms of this rider for the first 60***** days after birth. This includes an adopted newborn Child who is placed with you within 60 days after birth. The effective date of any coverage you apply for after birth is subject to the conditions above including Active Employment. Coverage beyond the 60th***** day is subject to the conditions above regarding application and Active Employment.

If you pay any part of the cost of coverage under this rider, the Employer will notify you of the premium required for this rider and the date that either payroll deductions will begin or your first premium payment is due, which will not be less than 31 days following your receipt of the notification.

If you have coverage under this rider and you acquire a new eligible Child due to birth, marriage or adoption, then the newly eligible Child will be covered automatically from the date of the event. If an adopted newborn Child is placed with you within 60 days of birth, the "event" will be the date of birth. If an adopted Child is placed with you more than 60 days after birth, the "event" will be the date of placement. No additional premium is required.

*****If your rider indicates a longer period, then the longer period will apply.

In the TERMINATION provision, if any reference to termination of coverage for your newborn Child has a time period of less than 60 days, then this time period is changed to 60 days. If there is no reference to termination of coverage for a newborn Child, then the following is added to the list:

- For your newborn Child, the 60th day after the newborn Child's birth, if Children's coverage under this rider is not otherwise effective on that date according to the EFFECTIVE DATE provision.

In the **CHILDREN BENEFITS** section:

If the first paragraph contains an **Exception** regarding admission benefits payable for a newborn Child, then that **Exception** does not apply.

If your rider has a NEWBORN BENEFIT provision, that provision does not apply. The benefit amounts payable for an eligible newborn Child are the same as the benefit amounts payable for any other eligible Child. If your rider contains a benefit for a stillborn Child, that benefit is unchanged.

IX. OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

See the next page for the Outline of Coverage for Idaho Residents.

X. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THE CERTIFICATE PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE FOR IDAHO RESIDENTS

Read Your Certificate Carefully – This outline of coverage provides a very brief description of the important features of coverage. This outline is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the Certificate. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefits described in the Certificate and riders.

The Policy pays a fixed benefit amount for each day that a covered person is confined in a hospital, to a maximum number of days per confinement. At the Policyholder's option, there may also be a daily benefit payable for confinement in a critical care unit (CCU), a CCU step-down unit, and/or a rehabilitation facility. The Certificate and riders will contain information about the daily benefit amounts, types of facilities, and duration of benefits. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of benefits available under the Policy.

Hospital confinement indemnity coverage is subject to exclusions which may prevent benefits from being paid. Also, benefit payment is contingent on proof of loss which may require additional information be provided prior to claim determination. At the Policyholder's option, there may also be an eligibility waiting period, during which time no coverage is in force. **There may be benefit reductions or termination provisions based on age.** There may also be benefit reductions during the initial 1, 3, 6, 9 or 12 months of a covered person's coverage.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of benefits are provided in the Certificate and any riders. The exclusions that apply to all provisions for hospital confinement indemnity coverage are provided in the "Exclusions" section of the Certificate and any riders. The "Schedule of Benefits," the Benefits section(s) and the "Exclusions" section of the Certificate and any riders provide specific information about the conditions for receiving benefits and any limitations. If you pay all or part of the cost of coverage, then the enrollment materials you received also contain a description of the exclusions and limitations under the Policy.

Your coverage will continue under the Policy, while the Policy remains in force, as long as you continue to meet the eligibility requirements and all premiums due are paid. You may have the option to continue your coverage by direct payment of premiums to ReliaStar Life Insurance Company after you no longer meet the eligibility requirements.

The Policyholder may change the terms of the Policy at any time with ReliaStar Life Insurance Company's agreement. The Policyholder or ReliaStar Life Insurance Company may terminate the Policy at any time. ReliaStar Life Insurance Company reserves the right to change premiums at any time according to the terms of the Policy.

The Policy may provide additional benefits under optional riders. The Certificate and riders will contain a description of all benefits included under the Policy.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the "Guide to Health Insurance for People With Medicare" available from the company.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MAINE CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

The following are added after the TERMINATION OF COVERAGE provision:

If your coverage ends due to a lapse or default on your part, your coverage may be reinstated on the basis that you suffered from a cognitive impairment or functional incapacity at the time of cancellation. You or someone authorized to act on your behalf must submit a request for reinstatement to us within 90 days of cancellation along with medical proof, at your expense, that you suffered from a cognitive impairment or functional incapacity at the time of cancellation. Within 15 days of our request, all premiums due from the date of cancellation must also be received by us in order to consider your request for reinstatement. If we approve your request, your coverage will be reinstated at the same level as though the cancellation had not occurred.

THIRD PARTY NOTICE
You may designate an additional person to receive notice of any intent to terminate coverage. You may change this designation at any time. The form is available upon request from the Policyholder.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MASSACHUSETTS CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. GENERAL PROVISIONS

The following statements are added to the TERMINATION OF COVERAGE provision:

> If your employment ends, your coverage will continue under the Policy for a period of 31 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.
>
> If your employment is terminated due to a plant closing or a partial closing (as defined in section 71A of Chapter 151A, Massachusetts Statutes), your coverage will continue under the Policy for a period of 90 days unless during that period you are otherwise entitled to similar benefits. Premium payment is required.

Massachusetts law requires the following disclosure to be provided to Massachusetts residents:

> **As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).**
>
> This plan is not intended to provide comprehensive health care coverage and **does not meet Minimum Creditable Coverage standards,** even if it does include services that are not available in your other health plans.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MINNESOTA CONTINUATION CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

If any riders include an EXTENSION FOLLOWING DEATH and/or an EXTENSION FOLLOWING DEATH OR DIVORCE provision, then all references below to "Portability" mean Extension.

I. SPOUSE HOSPITAL CONFINEMENT INDEMNITY RIDER

If your Certificate includes a Spouse Hospital Confinement Indemnity Rider, then the PORTABILITY FOLLOWING DEATH OR DIVORCE provision on that rider is replaced by the following:

MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE

If you die or divorce, your Spouse can elect to maintain Spouse coverage if certain conditions are met. Upon your Spouse's request, the Employer will provide your Spouse with information about the cost of maintaining coverage under this provision and how to elect continuation. Your Spouse must have been insured under this rider on the date of your death or divorce, and your Spouse must elect continuation and pay the first premium within 90 days of the date of your death or divorce.

Premiums will be billed directly to your Spouse. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time your Spouse becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your Spouse.

Coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the Spouse according to this rider's TERMINATION provision.
- The date your Spouse becomes covered under any group hospital confinement or other fixed indemnity policy as an employee, member or spouse.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

If your Spouse Hospital Confinement Indemnity Rider does not include a PORTABILITY FOLLOWING DEATH OR DIVORCE provision, then the provision above is added to the rider.

Any references to Portability in the BENEFIT PAYMENTS provision on the Spouse Hospital Confinement Indemnity Rider are replaced by the following:

For MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE, benefits are payable to your Spouse, and any accrued benefits unpaid at your Spouse's death will be paid to your Spouse's estate.

If your Spouse Hospital Confinement Indemnity Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statement is added to the BENEFIT PAYMENTS provision on the rider.

II. CHILDREN'S HOSPITAL CONFINEMENT INDEMNITY RIDER

If your Certificate includes a Children's Hospital Confinement Indemnity Rider, then the PORTABILITY FOLLOWING DEATH provision on that rider is replaced by the following:

MINNESOTA CONTINUATION FOLLOWING DEATH

If you die while this rider is in force, Children's coverage can be maintained if certain conditions are met. Your Children must have been insured under this rider on the date of your death. Children may be covered only if they would have been eligible for coverage under the eligibility rules in force prior to your death.

If your Spouse has elected Minnesota continuation under the Spouse Hospital Confinement Indemnity Rider, then your Spouse may also elect continuation of this Children's Hospital Confinement Indemnity Rider at the same time. If you do not have an eligible Spouse insured under the Spouse Hospital Confinement Indemnity Rider at the time of your death, then each eligible Child insured under the Children's Hospital Confinement Indemnity Rider may elect Minnesota continuation and pay the first premium within 90 days of the date of your death.

Upon request of your Spouse, Child or the Child's legal guardian, the Employer will provide that person with information about the cost of maintaining coverage under this provision and how to elect this continuation.

Premiums will be billed directly to your Spouse, Child or Child's legal guardian as applicable. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time your Child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your Spouse, Child or Child's legal guardian as applicable.

If your Spouse or the Child's legal guardian dies while a Child's coverage is in force under this provision, then the Child or their new legal guardian must contact us within 31 days of the death for information about how to maintain the Child's coverage under this provision.

Each Child's coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the Child according to this rider's TERMINATION provision.
- The end of the period for which premium are paid for the Child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the Child becomes covered under any group hospital confinement or other fixed indemnity policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

If your Children's Hospital Confinement Indemnity Rider does not include a PORTABILITY FOLLOWING DEATH provision, then the provision above is added to the rider.

The following provisions are also added to the Children's Hospital Confinement Indemnity Rider:

MINNESOTA CONTINUATION FOLLOWING DIVORCE

If you divorce and your former spouse has elected Minnesota continuation under the Spouse Hospital Confinement Indemnity Rider, then this Children's Hospital Confinement Indemnity Rider can be maintained under your former spouse's coverage for each child whose coverage would otherwise terminate due to the divorce. Upon your former spouse's request, the Employer will provide your former spouse with information about the cost of maintaining coverage under this provision and how to elect continuation.

Premiums will be billed directly to your former spouse. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time the child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to your former spouse.

If your former spouse dies while a child's coverage is in force under this provision, then the child or their legal guardian must contact us within 31 days of the death for information about how to maintain the child's coverage under this provision.

Each child's coverage maintained under this provision will end on the earliest of the following:

- The date coverage would otherwise terminate for the child according to this rider's TERMINATION provision.
- The end of the period for which premiums are paid for the child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the child becomes covered under any group hospital confinement or other fixed indemnity policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD

If your Child's coverage under this rider would otherwise terminate because the child no longer meets the definition of Child in this rider, for a reason other than your death or divorce, then the child can elect to maintain Child coverage under this rider for a period of time. The child (or the child's legal guardian) must elect continuation and pay the first premium within 90 days of the date of loss of eligibility.

Upon request of the child or the child's legal guardian, the Employer will provide that person with information about the cost of maintaining coverage under this provision and how to elect this continuation.

Premiums will be billed directly to the child or child's legal guardian as applicable. Ongoing premium payment is required to keep coverage in force. The initial premium will be based on the premium rates in effect at the time the child becomes eligible for this continuation. We may change the premium rates at any time upon 60 days written notice to the child or child's legal guardian as applicable.

If the child's legal guardian dies while the child's coverage is in force under this provision, then the child or their new legal guardian must contact us within 31 days of the death for information about how to maintain the child's coverage under this provision.

A child's coverage maintained under this provision will end on the earliest of the following:

- 36 months after the date continuation under this provision started.
- The date coverage would otherwise terminate for the child according to this rider's TERMINATION provision.
- The end of the period for which premiums are paid for the child, if the next required premium contribution is not paid, subject to the GRACE PERIOD provision in the Certificate.
- The date the child becomes covered under any group hospital confinement or other fixed indemnity policy as an employee, member, spouse or child.
- The date the Policy terminates and coverage for all Insured Persons under the Policy terminates, upon 60 days written notice of termination.

Any references to Portability in the BENEFIT PAYMENTS provision on the Children's Hospital Confinement Indemnity Rider are replaced by the following:

> For MINNESOTA CONTINUATION FOLLOWING DIVORCE, benefits will be paid to your former spouse, and any accrued benefits unpaid at your former spouse's death will be paid to your former's spouse's estate. For MINNESOTA CONTINUATION FOLLOWING DEATH or MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD, benefits will be payable to the person responsible for premium payments for that child, and any accrued benefits unpaid at that person's death will be payable to that person's estate.

If your Children's Hospital Confinement Indemnity Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statements are added to the BENEFIT PAYMENTS provision on the rider.

III. ACCIDENT BENEFIT RIDER

If your Certificate includes an Accident Benefit Rider, then the PORTABILITY FOLLOWING DEATH OR DIVORCE provision on that rider is replaced by the following:

> **MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE**
> If you die or divorce and your Spouse's or Child's coverage is being maintained under the Spouse Hospital Confinement Indemnity Rider or Children's Hospital Confinement Indemnity Rider, then this rider can also be maintained under that person's coverage.

If your Accident Benefit Rider does not include a PORTABILITY FOLLOWING DEATH OR DIVORCE provision, then the provision above is added to the rider.

The following provision is added to the rider:

> **MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD**
> If your child's coverage is being maintained under the Children's Hospital Confinement Indemnity Rider due to no longer meeting the definition of Child, then this rider can also be maintained under your child's coverage.

Any references to Portability in the BENEFIT PAYMENTS provision on the Accident Benefit Rider are replaced by the following:

> For MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE or MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD, benefits are payable according to the BENEFIT PAYMENTS provisions in the Spouse Hospital Confinement Indemnity Rider and Children's Hospital Confinement Indemnity Rider.

If your Accident Benefit Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statements are added to the BENEFIT PAYMENTS provision on the rider.

IV. CRITICAL ILLNESS RIDER

If your Certificate includes a Critical Illness Rider, then the PORTABILITY FOLLOWING DEATH OR DIVORCE provision on that rider is replaced by the following:

> **MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE**
> If you die or divorce and your Spouse's or Child's coverage is being maintained under the Spouse Hospital Confinement Indemnity Rider or Children's Hospital Confinement Indemnity Rider, then this rider can also be maintained under that person's coverage.

If your Critical Illness Rider does not include a PORTABILITY FOLLOWING DEATH OR DIVORCE provision, then the provision above is added to the rider.

The following provision is added to the rider:

> **MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD**
> If your child's coverage is being maintained under the Children's Hospital Confinement Indemnity Rider due to no longer meeting the definition of Child, then this rider can also be maintained under your child's coverage.

Any references to Portability in the BENEFIT PAYMENTS provision on the Critical Illness Rider are replaced by the following:

> For MINNESOTA CONTINUATION FOLLOWING DEATH OR DIVORCE or MINNESOTA CONTINUATION WHEN YOUR CHILD NO LONGER MEETS THE DEFINITION OF CHILD, benefits are payable according to the BENEFIT PAYMENTS provisions in the Spouse Hospital Confinement Indemnity Rider and Children's Hospital Confinement Indemnity Rider.

If your Critical Illness Rider does not include references to Portability in the BENEFIT PAYMENTS provision, then the above statements are added to the BENEFIT PAYMENTS provision on the rider.

V. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

ReliaStar Life Insurance Company
250 Marquette Avenue, Suite 900
Minneapolis, Minnesota 55401
(612) 372-5432

NOTICE CONCERNING POLICYHOLDER RIGHTS IN AN INSOLVENCY UNDER THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

If the insurer or health maintenance organization that issued your life, annuity or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy or contract from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or the health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance, or health maintenance coverage from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

For purposes of this notice, the terms “insurance company” and “insurer” include health maintenance organizations.

Minnesota Life and Health Insurance Guaranty Association
3300 Wells Fargo Center
90 South Seventh Street
Minneapolis, Minnesota 55402
Telephone: (612) 322-8713

The maximum amount the Guaranty Association will pay for all policies or contracts issued on one life by the same insurer or health maintenance organization is limited to $500,000. Subject to this $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance, health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in the present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant’s lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association’s limits you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, HEALTH INSURANCE, OR HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY IMPAIRED OR INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, HEALTH INSURANCE, AND HEALTH MAINTENANCE ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

MONTANA CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. DEFINITIONS

If your Certificate and any riders contain a definition of **Pre-Existing Condition**, and the time period in that definition is more than 6 months, then the time period in that definition for you and any Covered Person is limited to 6 months. Pregnancy is not considered a Pre-Existing Condition.

II. NEWBORN BENEFIT

If you are covered under the Policy, your eligible newborn Child is automatically covered for the first 31 days after birth. The benefit amount is the same amount indicated on the Children's Hospital Confinement Indemnity Rider for all eligible Children.

No benefit reductions apply to your eligible newborn Child.

III. GENERAL PROVISIONS

If your Certificate and any riders include a PORTABILITY provision, and the time period for us to change portability premium rates with written notice is less than 60 days, then this time period is changed to be 60 days.

IV. BENEFITS

If your Certificate includes a child care benefit, and the maximum child age within that child care benefit is less than 25, then the maximum child age for this benefit is changed to 25.

V. EXCLUSIONS

If the EXCLUSIONS section of your Certificate and any riders contains an exclusion that refers to operation of a motor vehicle while intoxicated, then this exclusion does not apply.

VI. CHILDREN'S HOSPITAL CONFINEMENT INDEMNITY RIDER

If your Certificate includes a Children's Hospital Confinement Indemnity Rider, the definition of **Child** or **Children** is changed as follows:

If the definition includes a maximum Child age of less than 25, then this maximum is changed to 25.

If the definition includes any requirements that the child reside with you, or be supported by you financially, or be eligible to be claimed by you or your Spouse for federal income tax purposes, then these requirements do not apply.

If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

VII. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

SPOUSE ENDORSEMENT FOR NEW HAMPSHIRE RESIDENTS

Your Certificate(s) and Spouse rider(s) have been changed as follows. Please keep this endorsement with your Certificate(s). This endorsement is subject to all other terms of the Policy.

If your Certificate contains definitions of "You and Your" and "We, Us and Our", then all references to "you" and "your" in this endorsement mean "You and Your" as defined in your Certificate, and all references to "we" and "us" and "our" in this endorsement mean "We, Us and Our" as defined in your Certificate.

I. CONTINUATION FOLLOWING DIVORCE OR LEGAL SEPARATION

If you divorce or legally separate, and the final decree of divorce or legal separation does not expressly prohibit continuation of coverage for your former Spouse, then your former Spouse can elect to continue Spouse coverage for a limited time. The former Spouse must have been insured under our Policy as your Spouse on the date before the date of divorce or legal separation. In order to continue coverage under this provision, the former Spouse has 30 days after the date of divorce or legal separation in which to make the election, pay the first premium, and provide us with the final decree of divorce or legal separation.

When we put the former Spouse on continuation under this provision, the former Spouse becomes the owner of that Spouse coverage under the Policy. All Spouse benefits are payable to the former Spouse. Premiums will be billed directly to the former Spouse. Continued premium payment is required to keep coverage in force. The benefits and premium rates for Spouse coverage continued under this provision will remain the same as though the former Spouse were still eligible as your lawful Spouse. Spouse coverage may not be increased.

Spouse coverage continued under this provision will end on the earliest of the following:

- The 3-year anniversary of the final decree of divorce or legal separation.
- The date of the former Spouse's remarriage.
- The date of your remarriage.
- The date the former Spouse dies.
- The date you die.
- The end date of coverage, if any, as provided by the final decree of divorce or legal separation.
- The end of the period for which the former Spouse paid premiums, if the former Spouse stops making a required premium contribution, subject to the grace period.
- The date the Policy terminates.

If all of the following are true:

- the former Spouse's coverage was being continued under a similar provision of the Employer's prior group policy that provided the same type of coverage as our Policy,
- your coverage under the prior policy is replaced by coverage under our Policy, and
- the former Spouse's coverage under the prior policy stops due to the prior policy's termination,

then the former Spouse can elect to continue the Spouse coverage for the remainder of the time period described above while our Policy is in force. The benefits, premium rates and all other terms for continued Spouse coverage are subject to the terms of our Policy. In order to continue Spouse coverage, the former Spouse has 30 days after your coverage effective date under our Policy in which to make the election, pay the first premium, and provide us with proof of their eligibility for continuation under the prior policy.

II. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

NOTICE OF PROTECTION PROVIDED BY
PENNSYLVANIA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** regarding the protections provided to the policyholders by the Pennsylvania Life and Health Insurance Guaranty Association ("the Association"). This protection was created under Pennsylvania law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, or health insurance company, RANLI PPO, hospital plan corporation, professional health services plan corporation or health maintenance organization (member insurer) becomes financially unable to meet its obligations. If this should happen, the Association will typically arrange to provide coverage, pay claims, or otherwise provide protection in accordance with Pennsylvania law. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting companies that are well managed and financially stable.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

Persons Covered

Generally, individuals will be protected by the Association if the member insurer was a member of the Association and the individual lives in Pennsylvania at the time the member insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees of such individuals.

Amounts of Coverage

The basic coverage protections provided by the Association per insured in each insolvency are limited in the aggregate to $300,000 (or $500,000 in the case of health benefit plans), including specific limits for the following types of coverage but not in excess of the contractual obligations of the member insurer;

Life insurance:
- Up to $300,000 in death benefits including up to $100,000 in net cash surrender or withdrawal value.

Accident, accident and health, or health insurance (including HMOs):
- Up to $500,000 for health benefit plans, with some exceptions.
- Up to $300,000 for disability income benefits.
- Up to $300,000 for long-term care insurance benefits.
- Up to $100,000 for all other types of health insurance.

Individual Annuities
- Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.

LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association also does not provide coverage for:
- any policy or contract or portion of a policy or contract which is not guaranteed by the member insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

- claims based on marketing materials or other documents which are not approved policy or contract forms, claims based on misrepresentations of policy or contract benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields or increases based on an index that exceed an average rate specified by statute;
- dividends, experience rating credits, or credits given in connection with the administration of a policy or contract by a group contract holder;
- employers' plans that are self-funded (that is, not insured by member insurer, even if member insurer administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals) other than in limited circumstances and amounts;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the member insurer; or
- policies providing health care benefits for Medicare Parts C or D coverage, for Medicaid or under the Pennsylvania program for Comprehensive Health Care for Uninsured Children.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in Pennsylvania when it issued the policy or contract.
- If the person is provided coverage by the guaranty association of another state.
- A policy issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

NOTICES

Member insurers or their agents are required by law to give or send you this notice, and are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance or other coverage. Policyholders with additional questions should first contact their member insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.palifega.org. You can obtain additional information from the Association by contacting it at the address below. You may also contact the Pennsylvania Insurance Department to file a complaint with the Pennsylvania Insurance Commissioner to allege a violation of any provisions of Pennsylvania laws and regulations relating to insurance including the law establishing the Association:

Pennsylvania Life and Health Insurance
Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

Pennsylvania Insurance Department
1209 Strawberry Square
Harrisburg, PA 17120
1-877-881-6388
www.insurance.pa.gov

The summary provided by this notice and on the Association's website do not limit or alter the more comprehensive and detailed provisions of the law and are subject to change without notice. The statements made herein are for information purposes only. The Association has not reviewed any specific policy, or verified the information provided regarding residency or other relevant factors. Moreover, whether coverage will be provided to any specific policyholder can only be determined by reference to the statute in effect, at the earliest, at the time that the member insurer is declared insolvent. No final determination of coverage can be made until a member insurer is declared insolvent and the specific factual and legal circumstances can be reviewed. Nothing contained herein is intended to guarantee coverage for any insured, or to bind the Association in any way. Finally, this summary and the Association's website are for general information purposes and should not be relied upon as legal advice.

Summary of the South Carolina Life and Accident and Health Insurance Guaranty Association Act and Notice Concerning Coverage Limitations and Exclusions

Residents of South Carolina who hold life insurance, annuities, or health insurance policies should know that the insurance companies and health maintenance organizations (HMOs) licensed in this state to write these types of insurance are required by law to be members of the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA). The purpose of SCLAHIGA is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this happens, SCLAHIGA will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through SCLAHIGA is limited. Consumers should shop around for insurance coverage and exercise care and diligence when selecting insurance coverage.

Disclaimer

Under South Carolina law, the South Carolina Life and Accident and Health Insurance Guaranty Association (SCLAHIGA) may provide coverage of certain direct life insurance policies, accident and health insurance policies, annuity contracts and contracts supplemental to life, accident and health insurance policies and annuity contract claims (covered claims) if the insurer becomes impaired or insolvent. South Carolina law does not require the SCLAHIGA to provide coverage for every policy. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.**

Coverage is generally conditioned upon residence in this state. Other conditions that may preclude or exclude coverage are described in this notice. Even if coverage is provided, there are significant limits and exclusions. Please read the entire notice for further details on limitations and exclusions.

Insurance companies and insurance agents are prohibited by law from using the existence of the SCLAHIGA or its coverage to sell you an insurance policy. You should not rely on the availability of coverage under SCLAHIGA when selecting an insurer. The South Carolina Life and Accident and Health Insurance Guaranty Association or the Department of Insurance will respond to any questions you may have which are not answered by this document.

If you think the law has been violated, you may file a written complaint with the SCLAHIGA or the South Carolina Department of Insurance at the addresses listed below:

South Carolina Life and Accident and Health Insurance Guaranty Association Attention: Executive Director P.O. Box 8625 Columbia, SC 29202	**South Carolina Department of Insurance** Attention: Office of Consumer Services 1201 Main Street, Suite 1000 Columbia, SC 29201 Electronic complaint submission via www.doi.sc.gov/complaint

Please attach copies of all pertinent documentation. You may submit a written complaint or a complaint electronically to the Department through submission of the electronic form on the Department's website at www.doi.sc.gov/complaint. You should receive a response to your complaint within 10 days.

This safety-net coverage is provided for in the South Carolina Life and Accident and Health Insurance Guaranty Association Act (the Act). The following summary of the Act's coverages, exclusions and limits does not cover all provisions of the Act; nor does it in any way change any person's rights or obligations under the Act or the rights or obligations of the SCLAHIGA.

COVERAGE

Generally, individuals will be protected by the SCLAHIGA if they live in this state and hold a covered life, accident, health or annuity policy, plan or contract issued by an insurer (including a health maintenance organization) authorized to conduct business in South Carolina. The beneficiaries, payees or assignees of insured persons may also be protected if they live in another state unless circumstances described under the Act exclude coverage.

EXCLUSIONS FROM COVERAGE

Persons who hold a covered life, accident, health or annuity policy, plan or contract are not protected by SCLAHIGA if:

- They are eligible for protection under the laws of another state (This may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state.);
- The insurer was not authorized to do business in this state; or
- They acquired rights to receive payments through a structured settlement factoring agreement.

SCLAHIGA also does not provide coverage for:

- A portion of a policy or contract or part thereof not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;
- A policy or contract of reinsurance, unless assumption certificates have been issued;
- Interest rate or crediting rate yields or similar factors employed in calculating value changes that exceed an average rate;
- Any policy or contract issued by assessment mutuals, fraternals, and nonprofit hospital and medical service plans;
- Benefits payable by an employer, association or other person under: (a) a multiple employer welfare arrangement; (b) a minimum premium group insurance plan; (c) a stop-loss group insurance plan; or (d) an administrative services contract;
- A portion of a policy or contract to the extent that it provides for (a) dividends or experience rating credits; (b) voting rights; or (c) payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;
- A portion of a policy or contract to the extent that the assessments required by Section 38-29-80 with respect to the policy or contract are preempted by federal or state law;
- An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation: (a) Claims based on marketing materials; (b) Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements; (c) Misrepresentations of or regarding policy or contract benefits; (d) Extra-contractual claims; or (e) A claim for penalties or consequential or incidental damages;
- An unallocated annuity contract;
- A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Medicare Part C or D or Medicaid; or
- Interest or other changes in value to be determined by the use of an index or other external references but which have not been credited to the policy or contract or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes impaired or insolvent insurer, whichever is earlier.

LIMITS ON AMOUNTS OF COVERAGE

The South Carolina Life and Accident and Health Insurance Guaranty Association Act also limits the amount that SCLAHIGA is obligated to pay for covered claims. The benefits for which SCLAHIGA may become liable shall in no event exceed the lesser of the following:

(i) With respect to one life, regardless of the number of policies or contracts:

- $300,000 in life insurance death benefits, or not more than $300,000 in net cash surrender and net cash withdrawal values for life insurance;
- For health insurance benefits: (a) $300,000 for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values; (b) $300,000 for disability

income insurance; (c) $300,000 for long-term care insurance; (d) $500,000 for health benefit plans; or

- $300,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values;

(ii) with respect to each payee of a structured settlement annuity or beneficiary if the payee is deceased, $300,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any,

(iii) the association is not obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for health benefit plans, in which case the aggregate liability of the association shall not exceed $500,000 with respect to any one individual or with respect to one owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation, or other person, and whether the persons insured are officers, managers, employees, or other persons, more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner;

(iv) the limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(v) benefits provided by a long-term care rider to a life insurance policy or annuity contract are considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

TEXAS CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. BENEFITS

If your Certificate includes a child care benefit, and the maximum child age within that child care benefit is less than 25, then the maximum child age for this benefit is changed to 25. "Child or children" for this benefit includes your unmarried grandchild who is your dependent for federal income tax purposes on the date you are eligible for coverage. It also includes a child for whom you must provide medical support under a court order.

II. CHILDREN'S HOSPITAL CONFINEMENT INDEMNITY RIDER

If your Certificate includes a Children's Hospital Confinement Indemnity Rider, then the definition of **Child** or **Children** on the rider is changed as follows:

If the definition includes a maximum Child age of less than 25, then this maximum is changed to 25.

The definition includes your unmarried grandchild who is your dependent for federal income tax purposes on the date the grandchild is first eligible under this rider. The definition also includes a child for whom you must provide medical support under a court order.

If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

III. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

Texas Residents: Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

ReliaStar Life Insurance Company

To get information or file a complaint with your insurance company:

Call: Customer Contact Center Manager at 1-800-955-7736

Toll-free: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Email: LifeClaims@voya.com

Mail: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puedo resolver el problema, es possible que el Departamento de Seguros de Texas (Texas Department of Insurance, pro su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tamblen debe presenter una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

ReliaStar Life Insurance Company

Para obtener informacion o para presenter una queja ante su compania de seguros:

Llame a: Customer Contact Center Manager at 1-800-955-7736

Telefono gratuito: 1-888-238-4840 for Life Insurance and 1-877-236-7564 for Supplemental Benefits Insurance

Correo electronico: LifeClaims@voya.com

Direccion postal: 250 Marquette Avenue, Suite 900, Minneapolis, MN 55401

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacion ada con los seguros o para presenter una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, P.O. Box 12030, Austin, TX 78711-2030

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

UTAH CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. RIGHT TO EXAMINE CERTIFICATE

If you contribute to the cost of your coverage, you may cancel your coverage for any reason within 30 days after your receipt of your initial Certificate of coverage under the Policy, provided no benefits have been paid. Contact the Policyholder to cancel your coverage and receive any premium refund.

II. SCHEDULE OF BENEFITS

If any facility Confinement benefit in your Certificate is less than $50 per day, then this benefit is increased to be $50 per day. If your Certificate or any riders include a BENEFIT REDUCTIONS provision, these reductions will not decrease the daily facility Confinement benefit for any Covered Person below $50.

If any facility Confinement benefit maximum in your Certificate is for less than 31 days, then this maximum is increased to 31 days. The maximum of all Confinement benefits payable will not be less than 31 days during a period of Confinement.

III. BENEFITS

If the PORTABILITY provision in your Certificate has any requirements that you are under a certain age or that you have been continuously covered for a specified period of months in order to apply for portability, then those requirements do not apply. Portability is not restricted by age, duration of coverage, class or coverage level.

If the time period for us to change portability premium rates under the PORTABILITY provision in your Certificate is less than 45 days, then that time period is changed to 45 days.

If your Certificate includes a child care benefit, and the maximum child age within that child care benefit is less than 26, then the maximum child age for this benefit is changed to 26.

IV. SPOUSE HOSPITAL CONFINEMENT INDEMNITY RIDER

If your Certificate includes a Spouse Hospital Confinement Indemnity Rider, then the PORTABILITY FOLLOWING DEATH OR DIVORCE provision on that rider is changed as follows:

If there is any requirement that your Spouse is under a certain age in order to apply for portability, then that requirement does not apply. Portability is not restricted by age, class or coverage level.

“Divorce” includes a valid decree of legal separation or annulment.

If the time period for us to change portability premium rates is less than 45 days, then that time period is changed to 45 days.

If there is a condition that coverage continued under this provision will end when your Spouse reaches a specified age, then that condition does not apply.

V. CHILDREN'S HOSPITAL CONFINEMENT INDEMNITY RIDER

If your Certificate includes a Children's Hospital Confinement Indemnity Rider, then this rider is changed as follows:

In the SCHEDULE OF BENEFITS:

If there is a NEWBORN BENEFIT provision which limits any newborn's Confinement benefit to a maximum of less than 31 days, then that maximum is changed to 31 days.

In the DEFINITIONS section:

The definition of **Child** or **Children** includes a child for whom you are required to provide hospital confinement indemnity coverage under a court or administrative order.

If the definition includes a maximum Child age of 26 years or less, then this maximum is changed to the end of the month in which the Child reaches 26 years of age.

If the definition includes any requirements for full-time students over a certain age, then these requirements do not apply.

In the PORTABILITY FOLLOWING DEATH provision:

Portability is not restricted by class or coverage level.

If the time period for us to change portability premium rates is less than 45 days, then that time period is changed to 45 days.

VI. ACCIDENT BENEFIT RIDER

If your Certificate includes an Accident Benefit Rider, then the definition of Dislocation is changed to remove the word "completely."

VII. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.



Melissa A. O'Donnell
Secretary

Notice of Protection Provided by
Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (Association) and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its insurance department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies. (For the purposes of this notice, the terms “insurance company and “insurer” include health maintenance organizations (HMOs) and limited health plans.)

The basic protections provided by the Association are:

- Life Insurance
  - o $500,000 in death benefits
  - o $200,000 in cash surrender or withdrawal values
- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $500,000 in long-term care insurance benefits
  - o $500,000 for disability income insurance benefits
  - o $500,000 in other types of health insurance benefits
- Annuities
  - o $250,000 in the present value of annuity benefits in aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical, and surgical insurance benefits.

NOTE: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Utah law.

To learn more about the above protections, please visit the Association's website at www.utlifega.org, or contact:

Utah Life and Health Insurance Guaranty Assoc.
32 West 200 South #150
Salt Lake City, UT 84101
(801)320-9955

Utah Insurance Department
State Office Bldg., Rm. 3110
Salt Lake City, UT 84114
(801) 538-3800

RELIASTAR LIFE INSURANCE COMPANY
Minneapolis, Minnesota

WASHINGTON CERTIFICATE ENDORSEMENT

for Group Hospital Confinement Indemnity Insurance

Your Certificate has been changed as follows. Please keep this endorsement with your Certificate. This endorsement is subject to all other terms of the Policy.

I. EXCLUSIONS

If your Certificate or any riders contain exclusions for intoxication, misuse of alcohol or taking of drugs, then these exclusions do not apply.

II. ACCIDENT BENEFIT RIDER

If your Certificate includes an Accident Benefit Rider, then that rider is changed as follows:

The time period in the **Burns** provisions between the Covered Accident and treatment is changed to one year.

The time period in the **Chip Fractures** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Concussion** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Dislocations** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Emergency dental work** provision between the Covered Accident and treatment is changed to one year.

The time period in the **Fractures** provision between the Covered Accident and diagnosis is changed to one year.

The time period in the **Laceration** provision between the Covered Accident and treatment is changed to one year.

The time period in the **Ruptured Disk** provision between the Covered Accident and treatment is changed to one year. The time period between the Covered Accident and surgical repair is also one year.

The time period in the **Tendon/ligament/rotator cuff** provision between the Covered Accident and surgical repair is changed to one year.

The time period in the **Torn knee cartilage** provision between the Covered Accident and treatment is changed to one year. The time period between the Covered Accident and surgical repair is also changed to one year.

III. EFFECTIVE DATE

This endorsement is effective for you on or after the later of the following dates:

- The Policy effective date.
- The effective date of your insurance.

Melissa A. O'Donnell
Secretary

RL-HI2-END-WA

Wisconsin Complaint Notice

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? – If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

ReliaStar Life Insurance Company
Customer Service
P.O. Box 20
Minneapolis, MN 55440-0020
1-877-236-7564

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can file a complaint electronically with the **OFFICE OF THE COMMISSIONER OF INSURANCE** at its website at http://oci.wi.gov/, or by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517
608-266-0103.

The Summary Plan Description on the following pages is provided to you at the request of the Policyholder. It is not part of the insurance certificate.

SUMMARY PLAN DESCRIPTION

For a Plan of Insurance Underwritten by
ReliaStar Life Insurance Company
P.O. Box 122
Minneapolis, Minnesota 55440-0122

Plan Name, Number and Name and Address of Plan Sponsor:
BMO U.S. Health and Welfare Benefit Plan
29316-4CHI2
BMO Financial Corp.
320 South Canal Street, Floor 8
Chicago, IL 60606

Name, Address, and Telephone Number of the Plan Administrator:
BMO Financial Corp.
Benefits Administration Committee
320 South Canal Street, Floor 8
Chicago, IL 60606
Human Resources Centre (HRC): 1-888-927-7700

Identification Numbers
IRS Employer Identification Number: 51-0275712
Plan Number: 507

Agent for Legal Process: Plan Administrator

Trustees: BNY Mellon Client Service Center, 500 Ross Street, 8th Floor, Pittsburgh, PA 15262-0001

Collective Bargaining or Multiple-Employer Agreements under which Plan is Established: None

Type of Administration: Records maintained by Policyholder.

Premium Payments: Premiums are 100% Employee paid.

Plan Year: January 1 through December 31

Claim Procedures: Please refer to CLAIM PROCEDURES section(s).

Statement of ERISA Rights: Please refer to STATEMENT OF ERISA RIGHTS section.

Eligibility and Circumstances Limiting Eligibility: As described in the Certificate of insurance.

Type of Plan: As described in the Certificate of insurance.

Benefits in Plan: As described in the Certificate of insurance.

Amendment or Termination of Plan: The Plan Sponsor makes no promise to continue these benefits in the future and rights to future benefits will never vest. The Plan Sponsor reserves the right to amend, modify, revoke or terminate the plan, in whole or part, at any time. ReliaStar Life Insurance Company's policy may be amended or terminated as set forth in the Policy.

Benefits, Rights, and Obligations after Termination: As described in the Certificate of insurance.

SUMMARY PLAN DESCRIPTION

CLAIM PROCEDURES FOR HOSPITAL CONFINEMENT INDEMNITY INSURANCE

1) Information regarding claim submission may be obtained from the Plan Administrator or Human Resource Department.
2) ReliaStar Life Insurance Company (ReliaStar Life) will process the claim and make payment or issue a denial notice.
3) Written notice of denial of a claim will be furnished to the claimant within 90 days after receipt of the claim. An extension of 90 days will be allowed for processing the claim if special circumstances are involved. The claimant will be given notice of any such extension. The notice will state the special circumstances involved and the date a decision is expected.
4) The notice of denial will be written in an understandable manner and include the following:
   a. The specific reason(s) for the denial.
   b. Specific reference to the provision which forms the basis of the denial.
   c. A description of additional information, if any, which would enable a claimant to receive the benefits sought and an explanation of why it is needed.
   d. An explanation of the claim review procedure, including the time limits applicable to such procedures and notice of the claimant's right to bring a civil action pursuant to Section 502(a) of ERISA following an adverse decision on appeal.
5) The claimant may request an appeal at any time during the 60-day period following receipt of the notice of denial of the claim.
6) ReliaStar Life will consider requests for an appeal of a denied claim upon written application of the claimant or his or her duly authorized representative. As part of the appeal, the claimant has the right, upon request and free of charge, to access or obtain copies of all documents, records and other information that is relevant to the claim for benefits. The claimant may, in the course of this appeal, submit to ReliaStar Life written comments, documents, records, and other information relating to the claim. ReliaStar Life will provide a full and fair review that takes into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was submitted or considered in the initial benefit determination. Review of claim denials and final decisions on appeal are the responsibility of ReliaStar Life.
7) ReliaStar Life will provide the claimant with a written decision of the final determination of the claim. This decision will be written in an understandable way, state the specific reason(s) for the decision, and make specific reference to the provision(s) on which the decision is based. This decision will be issued as soon as practicable from the date of appeal, but not longer than 60 days unless an extension is needed. An extension of 60 days will be allowed for making this decision if special circumstances are present. The claimant will be given notice if this extension is necessary. If the decision on review is not received within these time limits, the claim may be considered denied. If the claimant receives an adverse benefit determination, the claimant will then have the right to bring a civil action pursuant to Section 502(a) of ERISA.
8) ReliaStar Life has final discretionary authority to determine all questions of eligibility and status, to interpret and construe the terms of this policy(ies) of insurance, and to make claim determinations.

SUMMARY PLAN DESCRIPTION

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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AIG Insurance Company of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
www.aig.ca

Group Business Travel Accident & Medical Policy



This policy is a contract between the Policyholder and the **Company**, AIG Insurance Company of Canada.

The **Company** agrees to provide the insurance cover set out in this policy under the sections (and subsections) of cover that are shown as being included in the Group Business Travel Accident **Policy Schedule**. This policy, the **Policy Schedule** and all attached memoranda and endorsements detail the entire cover provided and the terms and conditions applying to it.

The **Company** will only provide cover for those people who are shown as being insured on the **Policy Schedule** and/or any attached memoranda or endorsements as long as the required premium has been paid and the **Company** has accepted it.

The Policyholder should read this policy and **Policy Schedule** to make sure that they understand the cover provided and the limitations applying. If any elements of the cover require clarification or do not meet the needs of the Policyholder, the Policyholder should in the first instance raise these with the **Company**, where applicable.

This group policy and the booklet contain a provision removing or restricting the right of the insured and the group person insured to designate persons to whom or for whose benefit insurance money is to be payable.

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Section 1 : Definitions

There are certain words and expressions used in this group policy which have a specific meaning, and those meanings are unique to this policy. These words are defined below and each time one of them is used in this group policy and Policy Schedule (and any endorsements, riders or memoranda attached to thereto), it is with Initial Capital Letters and bold. Plural forms of the words defined have the same meaning as the singular form. However, when these same words are shown as beginning in lower case letters, the meaning is not specific to this policy.

Please read each section of the policy for additional definitions applicable to those sections and subsections.

***Activities of Daily Living*:** The following six activities:

1. Maintaining continence: ability to control urination and bowel movements, including the use of ostomy supplies or other devices such as catheters if required;
2. Transferring: ability to move in and out of a bed, between a bed and a chair, or a bed and a wheelchair;
3. Dressing: putting on and taking off all necessary items of clothing including braces, artificial limbs or other surgical appliances;
4. Toileting: use of a lavatory including getting to and from and getting on and off, to manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Eating: ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils; and
6. Bathing: washing in either a tub or shower, including the task of getting in or out of the tub or shower or washing satisfactorily by other means.

Air Transportation: Any land, water or air conveyance required in connection with the transport of the **Insured Person** by air.

Aircraft: A vehicle used for aerial navigation which has a valid certificate of airworthiness and is being flown by a pilot with a valid license to operate the **Aircraft**.

Annual Earnings: The **Insured Employee's** annual salary from employment with the Policyholder or the **Employer** immediately prior to the date of loss, exclusive of overtime, bonus, incentive payments, profit sharing or commission.

Assistance Company: The company listed on the **Policy Schedule Declarations** which provides emergency travel assistance under Section 7 of the policy.

Brain Death: Irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Business Travel While on a Trip: If applicable to an Eligible Class, means any activity of the **Insured Person** while an **Insured Employee** is on assignment by or at the direction of the Policyholder for the purpose of furthering the business of the Policyholder, which takes place during a **Trip** and excludes every day travel to and from work and bonafide leaves of absence or vacations. **Sojourn or Personal Deviation** is covered for a maximum number of days as listed under Sojourn or Personal Deviation Maximum in the **Policy Schedule Declarations**.

Carjacking: Taking unlawful possession of a **Private Passenger Type Automobile** by means of force or threats against the **Insured Person(s)** then rightfully occupying such **Private Passenger Type Automobile**.

Change in Treatment: Includes any new **Treatment** or medication, stopped **Treatment** or medication, increase or decrease in **Treatment** or medication but does not include transition between generic and brand-name versions of drugs with the same active ingredient and dosage or the routine adjustment of dosage within prescribed parameters when taking insulin or oral diabetes medication.

Charter Flight: Air travel that is chartered for a specific trip, or part of a trip, and the air travel is not part of an airline's regularly scheduled flight.

Company: AIG Insurance Company of Canada.

Complications of Pregnancy: Conditions requiring **Hospital** stays (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. These conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. **Complications of Pregnancy** also include non-elective caesarean section, ectopic pregnancy, which is terminated and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, **Physician**-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

Covered Expenses: Those **Reasonable and Customary** expenses, up to the maximum specified, for transportation, medical services and medical supplies which are **Medically Necessary** and incurred in connection with the **Air Transportation** of the **Insured Person**. All transportation arrangements made for transporting the **Insured Person** must be by the most direct and economical route. Expenses for **Special Transportation** must be recommended by the attending **Physician** or surgeon or required by the standard regulations of the conveyance transporting the **Insured Person**. Expenses for medical supplies and services must be recommended by the attending **Physician**.

Declarations: The **Declarations** relating to this policy as set out in the **Policy Schedule**.

Departure Date: The date upon which an **Insured Person** leaves their province of residence on a **Trip**, which date must occur while this policy is in effect.

Dependent Child(ren): A person who is either the natural child, adopted child or step-child of the **Insured Employee,** or an infant to which the **Insured Employee** is "*in loco parentis*", and who is:

(a) under 23 years of age, unmarried and dependent upon the **Insured Employee** for maintenance and support and who is not engaged in gainful employment more than 25 hours per week at the time of **Loss**;

(b) under 26 years of age and unmarried and in attendance at an **Institution of Higher Learning** and dependent upon the **Insured Employee** for maintenance and support and who is not engaged in gainful employment more than 25 hours per week at the time of **Loss**; or

(c) by reason of mental or physical infirmity, incapable of self-sustaining employment and who is considered a dependent child of the **Insured Employee** within the terms of the Income Tax Act (Canada).

Dependent Parent: The **Insured Person's** parents, parents-in-law, grandparents, grandparents-in-law, great-grandparents or great-grandparents-in-law that are dependent upon the **Insured Person** for support, maintenance and care.

Effective Date: The date stipulated within the **Policy Schedule Declarations** as the date from which coverage begins under this policy.

Employer: The Policyholder or an affiliate or subsidiary thereof which employs the Eligible set out within the **Policy Schedule Declarations**.

Expiration Date: The date stipulated within the **Policy Schedule Declarations** as the date from which coverage ends under this policy.

GHIP: The Government Health Insurance Plan that provides health insurance coverage that Canadian provincial or territorial governments provide for their residents.

Hospital: An establishment which:

(a) holds a licence as a hospital (if licencing is required in the jurisdiction);

(b) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients;

(c) provides 24 hour a day nursing service by registered or graduate nurses;

(d) has a staff of one or more licenced **Physicians** available at all times;

(e) provides organized facilities for diagnosis, and major medical surgical facilities;

(f) is not primarily a clinic, nursing, rest or convalescent home or similar establishment; and

(g) is not, other than incidentally, a place for the treatment of alcohol or drug addiction.

Immediate Family: A person who is related to the **Insured Person** in any of the following ways a **Spouse**, parent (includes stepparent), father-in-law, mother-in-law, a child (including legally adopted or stepchild), son-in-law, daughter-in-law, brother or sister (includes stepbrother or stepsister), brother-in-law, sister-in-law, grandparent, grandchildren, aunt, uncle, niece, nephew or first cousin

Injury: Bodily injury which is sustained by an **Insured Person** as a direct result of an unintended unanticipated accident, provided such accident is external to the body and occurs while the **Insured Person's** insurance under this policy is in force.

Institution of Higher Learning: A school that provides a post-secondary program of education which includes, but is not limited to, any university, private post-secondary college or trade school, and any College of General and Vocational Education/ Collège d'enseignement général et professionnel (CÉGEP).

Insured Employee: An individual who belongs to an Eligible Class as specified in the **Policy Schedule Declarations** provided such individual's name is on file with the Policyholder as being insured under this policy.

Insured Person: An **Insured Employee** and any additional **Insured Persons** as described in the Eligible Classes in the Policy Schedule Declarations.

Leased Aircraft: An aircraft owned by a person other than the **Insured Employee's Employer** that is used by the Policyholder or such **Employer** under the terms of a fixed agreement for a specified duration of time.

Loss when used with reference to:

(a) ***Quadriplegia***, ***Paraplegia***, and ***Hemiplegia*** means the complete and irreversible **Paralysis** of such limbs;

(b) ***Hand or Foot*** means the complete and irrecoverable severance through or above the wrist or ankle joint, but below the elbow or knee joint;

(c) ***Arm or Leg*** means the complete and irrecoverable severance through or above the elbow or knee joint;

(d) ***Thumb and Index Finger*** means the complete and irrecoverable severance through or above the first phalange;

(e) ***Fingers*** means the complete and irrecoverable severance through or above the first phalange of all four **Fingers** of one **Hand**;

(f) ***Toes*** means the complete and irrecoverable severance of both phalanges of all the toes of one foot;

(g) ***The Entire Sight of One Eye*** means the total and irrecoverable loss of sight such that corrected visual acuity must be 20/200 or less in such eye;

(h) ***The Entire Sight of Both Eyes*** means the total and irrecoverable loss of sight in both eyes such that corrected visual acuity must be 20/200 or less and the field of vision must be less than 20 degrees in both eyes. A **Physician** certified in ophthalmology must clinically confirm the diagnosis in writing;

(i) ***Hearing in One Ear*** means the diagnosis of permanent loss of **Hearing in one Ear**, with an auditory threshold of more than 90 decibels. A **Physician** certified in otolaryngology must confirm the diagnosis in writing;

(j) ***Hearing*** means the diagnosis of permanent loss of **Hearing** in both ears, with an auditory threshold of more than 90 decibels in each ear. A **Physician** certified in otolaryngology must confirm the diagnosis in writing;

(k) ***Speech*** means complete and irrecoverable loss of the ability to utter intelligible sounds; and

(l) ***Loss of Use*** means the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent.

Loss when used herein may also include ***Loss of Life.***

Medical Emergency: A condition caused by an **Injury** or **Sickness** which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the **Insured Person's** condition or place their life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while the policy is in force.

Medically Necessary: Services or supplies provided by a **Hospital** or **Physician**, licenced dentist or other licenced provider that are required to identify or treat an **Insured Person's Sickness** or **Injury** and that are defined as follows:

- Consistent with the symptom or diagnosis and **Treatment** of the **Insured Person's Sickness** or **Injury**;
- Appropriate with regard to standards of good medical practices;
- Not solely for the convenience of the **Insured Person** or a **Physician** or other licenced provider; and
- When applied to the care of a **Hospital** in-patient, it further means that the **Insured Person's** medical symptoms or conditions require that the services cannot be safely provided as a **Hospital** outpatient.

Minor Ailment: Any **Injury** or **Sickness** which does not require:

(a) the use of medication for a period of greater than 15 days;

(b) more than one follow-up visit to a **Physician**;

(c) hospitalization or surgical intervention;

(d) referral to a specialist; and

which ends at least 30 consecutive dates prior to the **Insured Person's Departure Date** of a **Trip**. A chronic condition or any complication of a chronic condition is not considered a minor ailment.

Owned Aircraft: An Aircraft to which the Policyholder or the **Employer** (or a related company, subsidiary, affiliate, parent company, principal, officer or employee or family member of an officer or employee of the Policyholder, the **Employer** or such entity) holds legal or equitable title such that the Policyholder, **Employer** or such entity or person can use, alter or sell the Aircraft as they wish.

Paralysis: Complete and irreversible paralysis of such limbs, provided such loss of function is continuous for 12 months and such loss of function is thereafter determined to be permanent.

Permanent and Total Disability: **Injury** which prevents an **Insured Employee** from performing at least two of the six **Activities of Daily Living**, without assistance from another person and the **Insured Employee** has been determined on evidence satisfactory to the **Company**, to be and remain, as of 12 months after the date of the **Injury**, incapable of performing at least two of the six **Activities of Daily Living** without assistance from another for the remainder of their life. The disability must be determined to be total, permanent, and irreversible and certified to be such by a **Physician** acceptable to the **Company**. The **Insured Employee's** inability to obtain employment is not a criteria to qualify for the **Permanent and Total Disability** benefit.

Physician: A medical doctor, who is licenced to administer medical treatment and prescribe drugs in the place where they provide medical services. The following are not considered to be **Physicians**: naturopath, herbalist and homeopath.

Policy Schedule: The Group Business Travel Accident **Policy Schedule** listing policy **Declarations**, Premium Rates, **Principal Sums** and the Schedule of Benefits, which should be read with this policy.

Pre-Existing Condition: Any medical or physical condition, symptom, illness or disease for which **Treatment** was received or for which an ordinarily prudent person would have sought **Treatment** within the number of days as specified in the Pre-Existing Condition Period in the Policy Schedule Declarations, immediately prior to the **Insured Person's Departure Date** unless such condition was **Stable and Controlled**.

Principal Sum: That amount specified in the **Policy Schedule Declarations** as the **Principal Sum** for an **Insured Person** based on the Eligible Class to which an **Insured Person** belongs.

Private Passenger Type Automobile: Any means of transportation not operated for commercial purposes, designed to carry passengers and that is pulled, propelled or fuelled in any way, including cars, trucks, motorcycles, mopeds, snowmobiles or boats.

Reasonable and Customary: The amount usually charged for **Treatment**, services or supplies to provide an appropriate level of care given the severity of the **Sickness** or **Injury** being treated, in the geographical location where the **Treatment**, services or supplies are being provided.

Sickness: Any disease, illness, or infection of an **Insured Person** that begins while coverage under the benefit provision is in force as to the **Insured Person**.

Sojourn or Personal Deviation: Non-business travel or activities undertaken while an **Insured Employee** is engaged in **Business Travel While on a Trip** or **While on the Business of the Policyholder**, but such travel or activities are unrelated to furthering the business of the Policyholder.

Special Transportation: Includes, but is not limited to, air ambulances, land ambulances, commercial airlines and private motor vehicles.

Spouse: A person who is either:

(a) legally married to the **Insured Employee**, or if there is no such person;

(b) a person who, although not legally married to the **Insured Employee**, is cohabitating with the **Insured Employee** and is publicly represented as the **Insured Employee's** domestic partner in the community in which they reside.

Stable and Controlled: Any medical condition (whether or not the diagnosis has been determined), other than a **Minor Ailment**, for which there has been:

(a) no hospitalization; and

(b) no new diagnosis, **Treatment** or prescribed medication; and

(c) no **Change in Treatment**; and

(d) no new, more frequent or more severe symptoms; and

(e) no new test results showing deterioration; and

(f) no referral to a specialist (made or recommended) and the **Insured Person** is not awaiting surgery of results of further investigations performed by a **Physician**.

Supplemental Restraint System: An air bag which inflates for added protection to the head and chest areas.

Table of Losses: The table set out in the **Policy Schedule**.

Travel Companion: The person with whom an Insured Person is sharing travel arrangements and prepaid accommodations on a Trip.

Treatment: Any medical, therapeutic or diagnostic procedure, service or supply that is prescribed, performed or recommended by a **Physician**, including but not limited to prescribed medication, investigative testing and surgery.

Trip: A trip taken by an **Insured Person** which begins when the **Insured Employee** leaves their residence or place of regular employment for the purpose of going on the trip (whichever occurs last) and is deemed to end when the **Insured Employee** returns from the trip to their residence or place of regular employment (whichever occurs first). To be considered a trip, one or more of the following conditions must be met:

(a) at least one overnight stay in a hotel; or

(b) the travel is scheduled by an aircraft; or

(c) the destination is more than 150 kilometres from the **Insured Employee's** place of regular employment.

Twenty-Four (24) Hour Coverage: If applicable, to an Eligible Class, means coverage hereunder occurring at any time, regardless of whether the accident occurs: (1) during **Business Travel While on a Trip**; or (2) **While on the Business of the Policyholder**.

While on the Business of the Policyholder: If applicable, to an Eligible Class, means any activity of the **Insured Person** while the **Insured Employee** is on assignment by or at the direction of the **Policyholder** for the purpose of furthering the business of the **Policyholder**, which takes place outside the **Insured Employee's** residence or place of regular employment, excluding every day travel to and from work and bonafide leaves of absence or vacations. **Sojourn or Personal Deviation** is covered up to the number of

days as listed under Sojourn or Personal Deviation Maximum in the Policy Schedule Declarations directly before or after a **Trip** which occurs **While on the Business of the Policyholder**.

Section 2 : Term of Coverage

2.1 Term Of Policy

This policy commences on the **Effective Date** and continues until the **Expiration Date** stated within the **Policy Schedule Declarations** and, unless otherwise terminated or cancelled in accordance with the terms of this policy, it shall continue in effect until the last day of the period for which premium has been paid.

2.2 Termination Of Policy

(a) The Policyholder may terminate this policy by giving at least 31 days advance written notice to the **Company** which termination shall be effective at 12:01 am at the Policyholder's address on the date set out in such notice. In the event that this policy is terminated by the Policyholder, the **Company** shall refund the amount of unearned premium, if any, on a pro rata basis, subject to a 10% reduction.

(b) The **Company** may terminate this policy effective at any time by providing at least 31 days advance written notice of termination to the Policyholder which termination shall be effective at 12:01 am at the Policyholder's address on the date set out in such notice. A notice of termination given to the Policyholder by the **Company** shall be binding on each **Insured Person** as if such notice had been sent directly to each **Insured Person**. The **Company** shall refund the amount of unearned premium, if any, on a pro rata basis. The **Company** may terminate this policy if premiums are unpaid as outlined in Section 3 (c).

2.3 Effective Date of Individual Insurance Coverage

The insurance of an individual shall take effect on the later of:

(a) the date such person satisfies the definition of **Insured Person**;

(b) the date requested by the Policyholder; and

(c) the **Effective Date** of this policy.

If a person enters an Eligible Class as specified in the **Policy Schedule Declarations**, or changes from one such class to another, any consequential change in coverage hereunder shall take effect on the effective date of the change, except that if the person changes from one Eligible Class to another and is absent from active full-time work on the effective date of such change for employment purposes, any consequential change in coverage hereunder shall only become effective upon the date the person returns to active full-time work.

2.4 Termination of Individual Insurance Coverage

The insurance of an **Insured Person** shall immediately end on the date the Termination of Coverage is met as set out in the **Policy Schedule**.

Termination of coverage will not affect a claim for a covered **Loss** that occurred while the **Insured Person's** coverage was in force under this policy.

2.5 Automatic Extension of Coverage After Termination (Applicable to Emergency Travel Benefits under Section 7 only)

(a) Notwithstanding the provisions of Section 2.4, if an **Insured Person** is confined to **Hospital** as a result of a **Medical Emergency**, at the time that this contract would normally terminate for them, as determined under Section 2.4, and is prevented from returning to their province of residence, this contract will remain in force for such **Insured Person** for the period of their confinement to **Hospital** but in no event for more than 12 consecutive months after such **Insured Person's Departure Date**.

(b) Notwithstanding the provisions of Section 2.4, if an **Insured Person's** return from a **Trip** to their province of residence is delayed due to the delay of a common carrier in which such **Insured Person** is scheduled to travel, this contract shall remain in force for such **Insured person** for the delay period to a maximum of 72 hours.

Section 3 : Premium

(a) If the Premium Frequency stated in the **Policy Schedule Declarations** is monthly in arrears, all required premium shall be paid by the Policyholder in arrears and by no later than the 15th day of each month commencing with the month following the month in which the **Effective Date** occurs.

(b) If the Premium Frequency stated in the **Policy Schedule Declarations** is annually, all required premium shall be paid by the Policyholder on or before the 60th day after the **Effective Date**. In the event of a change in coverage any additional premium must be paid on or before the 60th day after the effective date of such change.

(c) If all the required premium is not paid during the applicable period set out in Section 3(b) this policy and the coverage hereunder does not come into effect. If all the premium is not paid as required under Section 3(a) this policy terminates at the end of the period permitted under such Section for the payment of premium and the Policyholder shall owe and shall pay to the **Company** all the premiums accruing up to the date of termination of this policy.

(d) The **Company** may, by notifying the Policyholder, alter the rate stipulated in the Policy Schedule Declarations at which premiums shall be computed. The **Company** shall provide the Policyholder with at least 60 days advance written notice of any such change in rates.

Section 4 : Policyholder's Obligations

4.1 Information to be Provided to Insured Employees

The Policyholder shall inform **Insured Employees** regarding the coverage which is provided under this policy and regarding the limitations of and exclusions from such coverage. This shall be done in a document, whether in written or electronic form, which shall be provided by the Policyholder to each **Insured Employee**. In the event of an amendment to the terms of this policy the Policyholder shall also deliver to **Insured Employees** an additional or amended document pertaining to such change. The **Insured Employee** and any claimant may request a copy of the group policy (other than confidential commercial information or other information exempted from disclosure by applicable law).

4.2 Information to be Furnished About Insured Employees

The Policyholder must provide the **Company**, upon request, with all the information the **Company** requires to properly administer the coverage provided under this policy including but not limited to:

(a) an accurate list of the names, home and work addresses of **Insured Employees** and the information required to determine an **Insured Employee's Principal Sum**, the amount of any benefit payable hereunder and the applicable premium for each **Insured Employee**; and

(b) the names of any **Insured Employees** who have left the employment of the **Employer** and the date of their departure.

4.3 Access to Records

On reasonable advance written notice, provided by the **Company** to the Policyholder, the Policyholder shall grant the **Company** access to salary records and other files which pertain to and which would allow the **Company** to verify eligibility, an **Insured Employee's Principal Sum**, the amount of any benefit payable hereunder and the premium to be paid hereunder.

4.4 Obligation of Policyholder to Ensure Accuracy and Consistency with Collective Agreement

The Policyholder is obliged to accurately determine if a person is eligible for coverage under this policy and to submit the applicable premium for each **Insured Person**. The incorrect or erroneous submission of premium by the Policyholder does not have the effect of in any way altering the coverage otherwise available to any person under this policy nor does it have the effect of in any way affording coverage to any person under this policy if such person is not eligible. Further, the Policyholder shall ensure that if any collective agreement shall pertain or does pertain to the benefits afforded by this policy, that such collective agreement is consistent with and does not afford any lesser benefits or rights to **Insured Persons** than is provided hereunder.

Section 5 : Primary Accidental Death & Dismemberment Benefits

5.1 Accidental Death and Dismemberment Benefit

The **Company** shall pay the amount specified in the **Table of Losses** in the **Policy Schedule**, if an **Insured Person** sustains a **Loss** stated therein resulting from **Injury**, provided that:

(a) such **Loss** occurs within 365 days after the date of accident causing such **Loss**;

(b) the amount of the benefit payable for any such **Loss** shall be the amount set out in the **Table of Losses** in the **Policy Schedule**, for that specific **Loss**; and

(c) if more than one **Loss** is sustained as the result of any accident, only one benefit shall be payable, the largest; and

(d) if the **Insured Person** belongs to an Eligible Class which provides coverage:

(i) for **Business Travel While on a Trip**, the accident causing **Injury** and **Loss** must occur while the **Insured Employee** was engaged in **Business Travel While on a Trip**; or

(ii) **While on the Business of the Policyholder**, the accident causing **Injury** and **Loss** to the **Insured Person** must occur **While on the Business of the Policyholder**; or

(iii) on a **Twenty-Four (24) Hour Coverage** basis, the accident causing **Injury** and **Loss** to the **Insured Person** may occur at any time, without limitation to **Business Travel While on a Trip** or **While on the Business of the Policyholder**.

5.2 Disappearance and Exposure

If the body of an **Insured Person** has not been found within one year, the **Insured Person** will be deemed to have suffered **Loss of Life** only if their disappearance involved the forced landing, stranding, sinking or wrecking of a conveyance.

If by reason of an accident covered by this policy an **Insured Person** is unavoidably exposed to the elements and as the result of such exposure suffers a **Loss**, such **Loss** will be covered under the terms of this policy.

Section 6 : Additional Accidental Death & Dismemberment Benefits

These sections of the policy only apply if selected by the Policyholder and the appropriate premium paid.

Subject to the conditions applicable to each of the additional benefits set out below, the **Company** shall pay additional benefits, up to the maximum amount specified for each such benefit, if an **Insured Person** suffers an **Injury**.

6.1 Permanent and Total Disability

If an **Insured Employee** suffers **Injury** causing **Permanent and Total Disability**, the **Company** shall pay the amount which listed in the **Policy Schedule's** Schedule of Benefits section for the **Insured Employee** less any amounts under the **Table of Losses** which have been paid or which are payable by the **Company** for **Losses** of the **Insured Employee**.

6.2 Rehabilitation Benefit

If an **Insured Employee** suffers **Injury** resulting in a **Loss** (other than **Loss of Life**) for which the **Company** has paid a benefit set out in the **Table of Losses**, the **Company** shall pay the reasonable and necessary expenses actually incurred for the occupational training of the **Insured Employee**, provided that:

(a) such training is required because of such **Injury** and in order for the **Insured Employee** to be qualified to engage in an occupation in which they would not have been engaged except for having suffered such **Injury**;

(b) the training expenses are incurred within three years from the date of the accident causing such **Injury**; and

(c) no payment shall be made for ordinary living, travelling or clothing expenses.

The Maximum Amount Payable per **Insured Employee** for this benefit for all **Injuries** resulting from any one accident is listed on the **Policy Schedule's** Schedule of Benefits section.

6.3 Home Alteration and Vehicle Modification

If an **Insured Person** suffers **Injury** resulting in a **Loss** (other than **Loss of Life**) for which the **Company** has paid a benefit set out in the **Table of Losses** and which **Loss** results in and necessitates the use of a wheelchair in order for the **Insured Person** to be ambulatory, the **Company** shall pay the reasonable and necessary expenses actually incurred for:

(a) the one-time cost of alterations to the injured **Insured Person's** residence to make the residence wheel-chair accessible and habitable; and

(b) the lesser of:

(i) the one-time cost of modifications necessary to a motor vehicle, owned by the injured **Insured Person**, to make the vehicle accessible or drivable for the **Insured Person**; and

(ii) the one-time cost to purchase a wheelchair accessible specially modified vehicle, with the prior approval of the **Company**.

This benefit is payable only if:

(a) home alterations are made on behalf of the **Insured Person** and carried out by an experienced individual in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and

(b) vehicle modifications are made on behalf of the **Insured Person** and carried out by an experienced individual in such matters and modifications are approved by the provincial vehicle licencing authorities in the **Insured Person's** province of residence.

The Maximum Amount Payable per **Insured Person** for this benefit for all **Injuries** resulting from any one accident is listed on **the Policy Schedule's** Schedule of Benefits section.

6.4 Workplace Modification and Accommodation

If an **Insured Employee** suffers **Injury** resulting in a **Loss** (other than **Loss of Life**) for which the **Company** has paid a benefit set out in the **Table of Losses** and which **Loss** results in and necessitates the use of special adaptive equipment and/or workplace modification in order to reasonably accommodate the **Insured Employee's** return to active full-time work with their **Employer**, the **Company** shall pay to the **Insured Employee's Employer**, upon the **Insured Employee's** return to active full-time work with the **Employer**, the reasonable and necessary expenses actually incurred by the **Employer** for such adaptive equipment and/or workplace modification provided:

(a) the **Employer** agrees in writing with the **Company** to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to the needs of such **Insured Employee**;

(b) the **Employer** acknowledges in writing to the **Company** that the performance of the essential duties of such **Insured Employee's** job may be altered; and

(c) the proposed special adaptive equipment and/or workplace modification have been approved in advance of an expense being incurred by the **Employer** for such equipment or modification.

The **Company** shall be afforded the opportunity to examine the **Insured Employee** to evaluate the appropriateness of the proposed modifications.

This benefit is payable only once in connection with **Injuries** and **Losses** suffered by any one **Insured Employee**, regardless of the number of policies, providing coverage for a workplace modification and accommodation benefit, that may be issued by the **Company** to the Policyholder or the **Employer**.

The Maximum Amount Payable per **Insured Employee** for this benefit for all Injuries resulting from any one accident is listed on the **Policy Schedule's** Schedule of Benefits section.

6.5 Psychological Therapy

If an **Insured Person** sustains **Injury** which results in a **Loss** payable under the **Table of Losses** other than **Loss of Life**, and subsequently as a result of such **Injury** and **Loss**, the **Insured Person** requires, within two years from the date of such **Injury**, **Psychological Therapy** as prescribed by a **Physician**, the **Company** will pay the reasonable and customary expenses for **Psychological Therapy**.

"**Reasonable and Customary**" means the lesser of:

(a) the usual charge made by **Physicians** or other health care providers for a given service or supply; or

(b) the charge determined to be the prevailing charge made by **Physicians** or other health care providers for a given service or supply in the geographical area where it is furnished; or

(c) the amount negotiated by the **Company** and the health care provider.

"**Psychological Therapy**" means treatment or counselling by a therapist or counsellor, who is licenced, registered, or certified to provide such treatment, whether such treatment is on an out-patient basis or provided while a patient at a medical facility licenced to provide such treatment.

The Maximum Amount Payable per **Insured Person** for this benefit for all Injuries resulting from any one accident is listed on the **Policy Schedule's** Schedule of Benefits section.

6.6 In-Hospital Benefit

If an **Insured Person** suffers **Injury** resulting in a **Loss** (other than **Loss of Life**) for which the **Company** has paid a benefit set out in the **Table of Losses**, and as a consequence of such **Loss** the **Insured Person** is, pursuant to the instructions of a **Physician**, confined to a **Hospital** for more than five consecutive overnight stays, the **Company** will pay:

(a) for a period of confinement in **Hospital** of more than 30 consecutive overnight stays, 1% of the **Insured Person's Principal Sum**; or

(b) for a period of confinement of 30 consecutive overnight stays or less, 1/30 of the amount determined in accordance with Section 6.6(a) for each overnight stay in **Hospital**.

The **Company** will pay this benefit monthly, retroactive to the first overnight stay of confinement in **Hospital**.

The Maximum Amount Payable per **Insured Person** for this benefit for all **Injuries** resulting from any one accident is listed on the **Policy Schedule's** Schedule of Benefits section.

Benefits are not payable for more than a total of 12 months of confinement for any one accident causing **Injury**.

Successive periods of confinement to **Hospital** for **Injury** resulting from the same accident, if separated by a period of less than three months, are considered one period of confinement to **Hospital** for the purposes of calculating this benefit.

6.7 Family Transportation

If an **Insured Person** suffers **Injury** resulting in a **Loss** (other than **Loss of Life**) set out in the **Table of Losses** and if such **Loss** requires that the **Insured Person** be confined to a **Hospital** located more than 100 kilometres from their permanent place of residence, the **Company** shall pay the reasonable and necessary expenses actually incurred for the transportation of one **Immediate Family** member to such **Hospital**. This benefit is only payable if:

(a) confinement to **Hospital** occurs within 365 days of the accident causing Injury; and

(b) reimbursement of expenses are limited to the cost of one economy class return airfare via the most direct route, or the equivalent amount toward another type of common carrier transportation for such **Immediate Family** member.

The Maximum Amount Payable per **Insured Person** for this benefit for all **Injuries** resulting from any one accident is listed on the **Policy Schedule's** Schedule of Benefits section.

6.8 Repatriation Benefit

If an **Insured Person** suffers Injury causing **Loss of Life** and for which a benefit is paid or payable hereunder and:

(a) such **Loss of Life** occurs more than 50 kilometres from their permanent city of residence; and

(b) such **Loss of Life** occurs within 365 days of the date of the accident causing the **Injury**,

the **Company** shall pay the actual expenses incurred for preparing the deceased **Insured Person** for burial or cremation and shipment of the body to the city of residence of the deceased **Insured Person**.

The Maximum Amount Payable per **Insured Person** for this benefit for all **Injuries** resulting from any one accident is listed on the **Policy Schedule's** Schedule of Benefits section.

6.9 Identification Benefit

If an **Insured Person** suffers **Injury** causing **Loss of Life** for which a benefit is paid or payable hereunder and the **Insured Person's** body requires identification, the **Company** will pay to one **Immediate Family** member of the **Insured Person**, the reasonable and necessary expenses actually incurred by such **Immediate Family** member for:

(a) commercial lodging and board while en route and/or during the stay in the city or town where the body is located (not to exceed a maximum duration of three consecutive nights); and

(b) transportation by the most direct route to such location.

This benefit is payable by the **Company** only if the body of the **Insured Person** is located more than 150 kilometres from the said **Immediate Family** member's normal place of residence and the identification of the body is requested by the police or a similar law enforcement agency having authority over such matters.

Payment will not be made for ordinary living, travelling or clothing expenses, other than as specifically stated above. If transportation occurs in a vehicle or device other than one operated under the licence for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.40 per kilometre travelled.

This benefit is payable only once in connection with **Injuries** and **Losses** suffered by any one **Insured Person**, regardless of the number of policies providing coverage for this benefit for such **Insured Person**, that may be issued by the **Company**.

The Maximum Amount Payable per **Insured Person** for this benefit is listed on the **Policy Schedule's** Schedule of Benefits section.

6.10 Day Care Benefit

If an **Insured Person** suffers **Injury** resulting in **Loss of Life** for which the **Company** has paid the benefit set out in the **Table of Losses**, the **Company** will pay to the legal guardian of any surviving **Dependent Child** of the **Insured Person**, an amount equal to the lesser of the following:

(a) the actual annual cost charged by a commercial and licenced day care centre; or

(b) 5% of the **Insured Person's Principal Sum**; or

(c) the Maximum Amount Payable listed on the Policy Schedule's Schedule of Benefits section per year.

This benefit is payable annually for a maximum of four consecutive payments per **Dependent Child**:

(a) only for such **Dependent Child** who at the date of the **Insured Person's Loss of Life** is under age 13;

(b) provided such **Dependent Child** is enrolled in a commercial and licenced day care centre no later than 90 days following the **Insured Person's Loss of Life**; and

(c) provided that the **Dependent Child** continues their enrollment in a commercial and licenced day care centre.

6.11 Dependent Child Educational Benefit

If an **Insured Person** suffers **Injury** resulting in **Loss of Life**, for which the **Company** has paid the benefit set out in the **Table of Losses**, the **Company** will reimburse the annual tuition, not including room and board, charged by an **Institution of Higher Learning** per school year for each **Dependent Child** of such **Insured Person** up to the lesser of the following amounts:

(a) the Maximum Amount Payable listed on the **Policy Schedule's** Schedule of Benefits section per school year; or

(b) 5% of such **Insured Person's Principal Sum**.

This benefit is payable annually up to a maximum of four consecutive payments per **Dependent Child**:

(a) only for such Dependent **Child** who is, at the time of such **Insured Person's Loss of Life**, enrolled as a full-time student in an **Institution of Higher Learning** beyond the 12th grade level; and

(b) only while such **Dependent Child** continues their continuous enrollment in an **Institution of Higher Learning**.

The Company will reimburse the person who has incurred the actual tuition expenses.

6.12 Spousal Educational Benefit

If an **Insured Employee** suffers **Injury** resulting in **Loss of Life**, for which the **Company** has paid the benefit set out in the **Table of Losses**, the **Company** will pay to the **Insured Employee's Spouse** the actual cost incurred for a professional or trades training program in which such **Spouse** enrols for the purpose of obtaining an independent source of support and maintenance provided such cost is incurred not later than 36 months after the **Insured Employee's Loss of Life**.

The Maximum Amount Payable for this benefit per **Insured Employee** is listed on the **Policy Schedule's** Schedule of Benefits section.

6.13 Funeral Expense

If an **Insured Person** suffers **Injury** resulting in **Loss of Life**, for which the **Company** has paid the benefit set out in the **Table of Losses**, the **Company** will reimburse the reasonable and usual expenses incurred with a mortician, crematory or a funeral home, for the services or supplies related to the burial or cremation. The **Company** shall also reimburse the usual expenses relative to the purchase of a cemetery plot, grave or mausoleum, including a plaque, tombstone or monument. This benefit is payable to the person who has incurred the actual expenses pertaining to the cremation, burial or funeral expenses of the **Insured Person**.

The Maximum Amount Payable for this benefit per **Insured Person** is listed on the **Policy Schedule's** Schedule of Benefits section.

6.14 Bereavement Benefit

If an **Insured Person** suffers **Injury** which results in **Loss of Life** for which the **Company** has paid the benefit set out in the **Table of Losses**, the **Company** will pay the reasonable and necessary expenses actually incurred for grief counselling provided that:

(a) the counselling is for the **Spouse** and/or **Dependent Children**;

(b) such expenses are incurred within 365 days of the date of the **Loss of Life**; and

(c) such grief counselling is provided by a therapist or councellor who is licenced, registered or certified to provide such treatment.

The **Company** will pay the person who has incurred the actual expense.

The Maximum Amount Payable for this benefit is listed on the **Policy Schedule's** Schedule of Benefits section.

6.15 Seat Belt and Air Bag Benefit

If an **Insured Person** suffers **Injury** resulting in a **Loss** for which the **Company** has paid a benefit set out in the **Table of Losses**, the **Company** shall pay an additional amount if **Injury** causing the **Loss** results while they are a passenger or driver of a **Private Passenger Type Automobile** and their seat belt is properly fastened.

The **Company** will pay an additional benefit if a Seat Belt Benefit is payable and if the **Insured Person** is positioned in a seat protected by a properly functioning, original, factory-installed **Supplemental Restraint System** that inflates on impact.

Verification of the actual use of the seat belt, at the time of the accident, must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s). Verification that the **Supplemental Restraint System** inflated properly must be provided by the person submitting the claim.

The Maximum Amount Payable for this benefit per **Insured Person** is listed on the **Policy Schedule's** Schedule of Benefits section.

6.16 Disability Fitness Benefit

If an **Insured Employee** suffers **Injury** resulting in a **Loss** (other than **Loss of Life**) for which the **Company** has paid a benefit set out in the **Table of Losses**, the **Company** will pay the reasonable and necessary expenses actually incurred for the purchase of any specially designed fitness training or athletic equipment for disabled persons, which would not have been required except for such **Injury**.

The Maximum Amount Payable for this benefit per **Insured Person** is listed on the **Policy Schedule's** Schedule of Benefits section. In addition, the **Company** shall not issue payment for any expense incurred more than two years after the date of the accident.

If the above benefit is available in other policies issued by the **Company** to the Policyholder, only one benefit shall be payable, the largest, under the policies issued by the **Company** and shall not duplicate benefits payable under any other insurance.

6.17 Parental Care Benefit

If an **Injury**, for which a benefit is paid or payable hereunder, sustained by an **Insured Person** results in a Loss of Life within 365 days of the date of Injury, the **Company** will pay a Parental Care Benefit for an eligible **Dependent Parent**.

A **Dependent Parent** is eligible if, at the time of the accident:

1. They are a resident in a licensed nursing care facility; or
2. They are enrolled in a home health care program; or
3. They are living in the **Insured Person's** residence; or
4. They are receiving support and care provided by the **Insured Person** as evidenced by:
   (a) Cancelled cheques;
   (b) Income tax returns showing the **Dependent Parent** as a dependent; or
   (c) Other similar forms of proof as deemed acceptable by the **Company**.

The amount of the Parental Care Benefit will be an additional 10% of the **Insured Person's Principal Sum** to any **Dependent Parents**. The Maximum Amount Payable for this benefit per **Insured Person** is listed on the **Policy Schedule's** Schedule of Benefits section.

The Parental Care Benefit will be payable in equal shares to the **Dependent Parents**. Only one Dependent Care Benefit will be payable regardless of the number of **Dependent Parents**.

6.18 Carjacking Benefit

If an **Insured Person** suffers **Injury** resulting in **Loss** for which the **Company** has paid a benefit set out in the **Table of Losses**, the **Company** shall pay an additional amount equal to 10% of the **Insured Person's Principal Sum** if **Injury** causing the **Loss** is as a result of a **Carjacking** of a **Private Passenger Type Automobile** while the **Insured Person** is operating, or riding as a passenger in, (including getting in or out of) such **Private Passenger Type Automobile**.

Verification of the **Carjacking** must be a part of an official report of the **Carjacking** or be certified, in writing, by the investigating officer(s).

The Maximum Amount Payable for this benefit is listed on the **Policy Schedule's** Schedule of Benefits section. Only one benefit is payable under this policy for all **Losses** as a result of the same **Carjacking**.

6.19 Criminal Assault Benefit

If an **Insured Person** suffers **Injury** resulting in **Loss** for which the **Company** has paid a benefit set out in the **Table of Losses**, the **Company** will pay an additional benefit equal to 10% of the **Insured Person's Principal Sum** if such **Injury** and the resulting **Loss** are caused by the deliberate act of another person, where such deliberate act:

(a) constitutes a felony, attempted felony, indictable offence, attempted indictable offence, misdemeanour, attempted misdemeanour, summary conviction offence, riot or attempted riot;

(b) is not a moving violation as defined under the applicable province/state motor vehicle laws;

(c) is directed at a group of **Insured Employees** engaged in the usual course of business or at the property or assets of the **Insured Employee's Employer**, or at the **Insured Employee** as a representative of the group; and

(d) is not the act of a fellow employee or a member of the **Insured Person's** family or household.

The words act, felony, indictable offence, misdemeanour, summary conviction offence and riot, include, but are not limited to, robbery, theft, bombing, kidnapping, hijacking, larceny, sniping, murder, rioting or inciting a riot. In this Section 6.19, the laws of the jurisdiction where the **Injury** occurs will govern as to whether an act constitutes a felony, attempted felony, indictable offence, attempted indictable offence, misdemeanour, attempted misdemeanour, summary conviction offence, attempted summary conviction offence, riot or attempted riot.

The amount of the benefit is determined by multiplying the Body Classification (A) by the actual percentage of the **Insured Person's** Body Part that is burned and then multiplying the resulting percentage [not to exceed the Maximum Percentage for that Body Part (B)] by the **Principal Sum** for such **Insured Person**.

The Maximum Amount Payable per **Insured Person** for this benefit for all **Injuries** resulting from any one accident is listed on the **Policy Schedule's** Schedule of Benefits section.

6.20 Fracture Benefit

If an **Insured Person** sustains **Injury** resulting in a fracture or dislocation listed in the following Fracture Table, the **Company** shall pay this benefit, provided that such fracture or dislocation occurs within thirty (30) days after the date of accident causing it.

The amount payable per **Insured Person** per accident for this benefit is the Percentage of the Fracture Benefit Payable listed in the Fracture Table for each scheduled fracture and dislocation multiplied by the Maximum Amount Payable per **Insured Person** per accident listed in the **Policy Schedule**. The Maximum Amount Payable per **Insured Person** for this benefit for all Injuries resulting from any one accident is listed on the **Policy Schedule**.

FRACTURE TABLE	
For complete fracture (including Greenstick type fracture) of:	**% of Fracture Benefit Payable**

FRACTURE TABLE	
The Cranium (depressed fracture), or The spine (two or more vertebrae)	100%
The Cranium (other compound), or The spine (one vertebrae)	40%
The upper jaw (maxilla), or The thigh (femur), or The pelvis	33%
The kneecap (patella)	27%
The leg (tibia or fibula), or The shoulder blade (scapula), or The ankle (Pott's fracture), or The wrist (Colles fracture)	25%
The forearm (compound or comminute)	23%
The spine (compression fracture)	20%
The sacrum or coccyx, or The sternum, or The Arm, between elbow and shoulder	17%
The forearm (not compound), or The collarbone (Clavicle), or The nose	12%
Two or more ribs	10%
The lower jaw (mandible), or One Hand (one or more metacarpal), or The Foot (one or more metacarpal), or Facial bones	8%
One rib	5%
Any bone not specified above	3%
For complete dislocation of the:	**% of Fracture Benefit Payable**
Hip	42%
Knee (with open primary repair)	33%
Shoulder (with open reduction)	25%
Wrist, or Ankle	17%
Elbow	12%
Bones of the Foot, other than Toes	8%

"Cranium" means the vault of the skull consisting of the following bones: frontal, parietals, occipital, temporals, sphenoid and ethmoid.

Section 7 : Emergency Travel Benefits

This section of the policy only apply if selected by the Policyholder and the appropriate premium paid.

The **Company** will pay for **Reasonable and Customary** medical expenses actually incurred by an **Insured Person** for those services described below and required by them outside their province/country of residence, up to the Maximum Trip Duration listed in the **Policy Schedule's** Schedule of Benefits, as a result of a **Medical Emergency** that occurs on a **Trip** provided such **Medical Emergency** occurs while this policy is in effect for such person.

The Total Maximum Benefit Amount Payable for this benefit per **Insured Person** is listed on the **Policy Schedule's** Schedule of Benefits.

For purposes of the Emergency Travel Benefits, any references to "**Injury**" are deemed to mean Injuries that occur outside an Insured Person's province/country of residence.

Emergency Travel Benefit Limitations: The maximum amount payable for Emergency Travel Benefits related to **Complications of Pregnancy** or a **Pre-Existing Condition** is listed on the **Policy Schedule's** Schedule of Benefits.

It is understood and agreed that the following exclusions in Section 10.3 Exclusions (d), (f), and (i) are not in effect for expenses incurred under the Emergency Travel Benefits provision

7.1 Co-Ordination of Benefits and Coverage Type

IMPORTANT NOTICE – COVERAGE TYPE
Please refer to the Policy Schedule to determine the Coverage Type.

Primary Coverage: If Primary Coverage has been selected by the Policyholder, the Emergency Travel Medical Expense Benefit does not require an **Insured Person** to have coverage under a separate employee benefit plan. The **Company** will seek recoveries from the applicable **GHIP** and will coordinate benefits with all other benefit plans according to the guidelines established by the Canadian Life and Health Insurance Association.

Supplemental Coverage: If Supplemental Coverage has been selected by the Policyholder, the Emergency Travel Medical Expense Benefit is intended to fill the gaps in coverage that may exist under a separate employee benefit plan that provides benefits for covered medical expenses. The **Company** will seek recoveries from the applicable **GHIP** and will coordinate benefits with all other benefit plans according to the guidelines established by the Canadian Life and Health Insurance Association.

Excess Coverage: If Excess Coverage has been selected by the Policyholder, the Emergency Travel Medical Expense Benefit is intended to fill the gaps in coverage that may exist under a separate employee benefit plan that provides benefits for covered medical expenses. **Insured Persons** must have coverage under such a plan. The **Company** is the last payer to all other benefit plans.

7.2 Emergency Hospital Confinement

The **Company** will pay benefits hereunder in the event of a **Medical Emergency** to an **Insured Person** which results in emergency confinement as a resident in-patient in a **Hospital** outside their province/country of residence. The **Company** shall cover only **Reasonable and Customary** charges made by the **Hospital** for services and supplies provided to the **Insured Person** to the extent that such are **Medically Necessary**, including semi-private accommodation and only if such expenses are incurred while this **Policy** is in effect for such person.

7.3 Emergency Medical and Therapeutic Services

The **Company** will pay benefits hereunder in the event an **Insured Person** requires emergency medical or therapeutic services outside their province/country of residence to treat a **Medical Emergency** to the extent that such are **Medically Necessary** and only if such expenses are incurred while this policy is in effect for such person. Benefits are payable to reimburse **Reasonable and Customary** expenses for:

(a) the services of a **Physician** or legally qualified surgeon,

(b) laboratory tests and X-ray examinations (not including MRI) ordered by a **Physician** or legally qualified surgeon for the purpose of diagnosis,

(c) MRI, for diagnostic purposes when **Medically Necessary**,

(d) the services of a registered graduate nurse,

(e) rental of crutches or a hospital type bed, or the cost of splints, canes, slings, trusses, braces or other prosthetic appliances approved by the **Company**,

(f) the services of a **Physician** who is an anaesthetist,

(g) drugs or medicines that require a **Physician**, nurse practitioner or legally qualified surgeon's written prescription,

(h) services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist up to the Maximum Amount Payable listed in the **Policy Schedule's** Schedule of Benefits,

(i) expenses for accidental **Injury** to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which requires the care of a legally qualified dentist or dental surgeon within 30 days from the date of the accident, Maximum Amount Payable listed in the **Policy Schedule's** Schedule of Benefits, and

(j) out-patient services provided by a **Hospital**.

7.4 Ground Transportation Benefit

If a **Medical Emergency** during a **Trip** results in a **Medically Necessary** transportation of an **Insured Person** by a licenced ground ambulance, the **Company** will pay the expenses actually incurred for such transportation.

The Maximum Amount Payable per **Insured Person** for this benefit is listed on the **Policy Schedule's Schedule of Benefits**.

7.5 Emergency Air Transportation Benefit

(a) If a **Medical Emergency** during a **Trip** results in a **Medically Necessary Air Transportation** of an **Insured Person**, the **Company** will pay benefits for **Covered Expenses** up to the Maximum Amount Payable per **Insured Person** listed in the **Policy Schedule** for such **Air Transportation**. Any **Air Transportation** must first be approved by the **Company** and it must be ordered by a **Physician** or licenced surgeon who certifies that the severity of the **Insured Person's Medical Emergency** warrants the **Air Transportation** of the **Insured Person** and that such is **Medically Necessary**.

(b) If due to the geographical area at the onset of the **Medical Emergency** an air ambulance is deemed necessary, the **Company** will pay the cost of a licenced air ambulance to transport the **Insured Person** to the nearest **Hospital** or medical facility where appropriate medical **Treatment** can be obtained.

An **Air Transportation** is **Medically Necessary** if:

(a) the **Insured Person's** medical condition warrants immediate transportation from the place where the **Insured Person** suffers from a **Medical Emergency** to the nearest **Hospital** where appropriate medical **Treatment** can be obtained; or

(b) after being treated at a local **Hospital**, the **Insured Person's** medical condition warrants transportation to the place where they reside (provided such residence is located in Canada) to obtain further medical **Treatment** or to recover; or

(c) both (a) and (b) above.

Emergency Medical Assistance

The **Company** provides worldwide emergency assistance for **Insured Persons** while on a **Trip** except where local conditions render such assistance not feasible. In the event of a **Medical Emergency** covered by this policy requiring hospitalization, the **Company** must be notified within 48 hours from the time of incident or expense claims may be denied or only partially covered. In the event of a **Medical Emergency**, **Insured Persons** or an individual acting on their behalf must call the **Assistance Company** listed in the Policy Schedule Declarations.

Refer to the **Assistance Company** for further details regarding the emergency assistance services available to travelling **Insured Persons**.

Availability and Quality of Care and Services

The **Company** is not responsible for, and incurs no liability for:

(a) the quality of any medical **Treatment** or services, or any facility that provides such **Treatment** or services;

(b) the availability of medical **Treatment**, services or any facility to provide such **Treatment** or services; and

(c) the failure or inability of any **Insured Person** to obtain or seek medical **Treatment**.

Section 8 : War Risk Coverage

War Risk Coverage shall not be afforded nor shall it come into effect unless the Policyholder has paid the deposit premium. Further, War Risk Coverage shall not be maintained unless the Policyholder provides an exposure report that conforms to the Reporting Requirements.

Notwithstanding the Section 10.3(c) of the policy, the **Company** will afford to certain **Insured Persons** who qualify for coverage under this policy for **Injury** or **Loss** caused by or resulting from an act of declared or undeclared war within the geographical limits or territorial waters of, or airspace above the geographic limits or territorial waters of, a **Designated War Risk Territory(ies)** (but not such an act in which the **Insured Person** is an active participant).

The maximum amount payable for **Injury** or **Loss** caused by or resulting from an act of declared or undeclared war is the lesser of:

(a) the **Principal Sum** specified in the **Policy Schedule**; and

(b) the Maximum Amount Payable per **Insured Person** per accident listed in the Policy Schedule's Schedule of Benefits section.

Changes in Premium: The **Company** may change the premium rate for the inclusion of War Risk Coverage under this policy at any time if:

(a) war risk conditions change in the **Designated War Risk Territory(ies)**;

(b) there is a change in which area(s) is (are) defined to be the **Designated War Risk Territory(ies)**; or

(c) the Policyholder's exposure to war risk in the **Designated War Risk Territory(ies)** changes in any way.

The **Company** will give the Policyholder written notice of any change in the premium rate for the inclusion of War Risk Coverage at least 30 days in advance of the effective date of the change.

Termination Date: War Risk Coverage ceases to apply with respect to this policy on the earliest of:

(a) the date the policy terminates;

(b) the date the **Company** receives written notice from the Policyholder of the Policyholder's intent to terminate the applicability of the War Risk Coverage (or on the date specified in the written notice, if later); or

(c) the date specified in the **Company's** written notice to the Policyholder of the **Company's** intent to terminate the applicability of War Risk Coverage (but in no event shall coverage terminate in less than 10 days after such noticed is mailed or delivered).

If the applicability of War Risk Coverage terminates prior to the end of a period for which premium has been paid, any unearned premium attributable to the War Risk Coverage will be returned.

Termination of the applicability of the War Risk Coverage will not affect a claim for a covered loss that occurred while the War Risk Coverage was still applicable.

Notwithstanding any other provision of this contract:

1. the War Risk Coverage shall automatically terminate upon the occurrence of war among the major powers of Europe or Asia; and
2. the **Company** will not be liable to provide any coverage or make any payment hereunder if to do so would be in violation of any sanctions law or regulation which would expose the insurer, its

parent company or its ultimate controlling entity to any penalty under any sanctions law or regulation.

War Risk Coverage Additional Definitions

In addition to the general policy definitions, words with a special meaning in this section are listed below and are shown with Initial Capital Letters and bold.

Designated War Risk Territory(ies): as used in Section 8, means named country(ies) or part(s) of country(ies) included on the war risk country listing maintained by the **Company**. A **Designated War Risk Territory** does not include Canada or the United States of America or the **Insured Person's** country of permanent residence.

Reporting Requirements: The Policyholder agrees to report, in writing, exposure of **Insured Persons** in the **Designated War Risk Territory(ies)** annually. For select **Designated War Risk Territory(ies)** as identified on the war risk listing, pre-approval by the **Company** is required and monthly reporting may be required until further notice. The report must include the name and occupation of each **Insured Person**, reason for travel, their specific itinerary and destination(s) in the **Designated War Risk Territory(ies)** including the exact location to which the **Insured Person** intends to travel, the effective and termination dates of their exposure, and their **Principal Sum** with respect to War Risk Coverage during the period of exposure.

Section 9 : Beneficiary Designation

The **Insured Employee** may designate a beneficiary to receive the amount payable hereunder for their **Loss of Life**.

In the absence of such a beneficiary designation, the beneficiary to receive the benefit payable hereunder for **Loss of Life** of the **Insured Employee** is the person(s) who is or are on file with the **Insured Employee's Employer** as the beneficiary for the basic group life insurance policy to receive the death benefit under such policy. In the absence of any such beneficiary designation validly made for the purposes of the Employer's current basic life insurance policy the beneficiary shall be the estate of the **Insured Employee**.

The amount payable hereunder for the **Loss of Life** of an **Insured Person**, other than the **Insured Employee**, is payable to the **Insured Employee**.

Section 10 : Exclusions and Limitations

10.1 Limitations

The maximum amount payable per **Insured Person** under this policy for **Losses** sustained by any one **Insured Person** as the result of any one accident is the **Principal Sum**, except where a **Loss** is **Quadriplegia, Paraplegia** or **Hemiplegia**, in which case the maximum amount payable per **Insured Person** is the amount indicated for such **Loss** in the **Table of Losses**. This limitation does not apply to the additional benefits set out in Section 6 and 7 which are subject to their own specific limits.

10.2 Aggregate Limit per Accident

The maximum amount payable by the **Company** under this policy for two or more **Insured Persons** who suffer an Injury in any one accident is the amount which is the Aggregate Limit per Accident set out in the Policy Schedule Declarations.

If the total of the benefits which would be paid by the **Company** would exceed the Aggregate Limit per Accident, the **Company** shall not be liable to any one **Insured Person** for any amount in excess of the Aggregate Limit per Accident. Each injured **Insured Person's** benefits shall be a portion of the benefits to which they otherwise would have been entitled hereunder. That portion shall be the proportion of what the **Company** would have paid hereunder to the **Insured Person** relative to what the **Company** would have paid hereunder to all **Insured Persons** who suffered an **Injury** in such accident but for the Aggregate Limit per Accident.

10.3 Exclusions

No coverage shall be provided under this policy and no payment shall be made for any **Loss** or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the Loss or claim is an accidental **Injury**:

(a) suicide or any attempt thereat by the **Insured Person**;

(b) self-inflicted Injury or any attempt thereat by the **Insured Person**;

(c) declared or undeclared war or any act thereof;

(d) sickness, disease, or bodily infirmity whether the **Loss** or claim results directly or indirectly from any of these;

(e) sustained while the **Insured Person** is undergoing the medical or surgical treatment of sickness, disease, or bodily or mental infirmity;

(f) stroke or cerebrovascular accident or event, cardiovascular accident or event, myocardial infarction or heart attack, coronary thrombosis, aneurysm;

(g) travel or flight in or on (including getting in or out of, or on or off of) any **Aircraft**, if **the Insured Person** is:

  (i) riding as a passenger in any **Aircraft** not intended or licenced for the transportation of passengers; or

  (ii) performing, learning to perform or instructing others to perform as a pilot or crew member of any **Aircraft**; or

  (iii) riding as a passenger in an **Owned Aircraft, Leased Aircraft** or on a **Charter Flight**.

(h) travel or flight in or on (including getting in or out of, or on or off of) any **Aircraft** or any craft designed to fly or glide above the Earth's surface:

  (i) except as a passenger on a regularly scheduled commercial airline; or

  (ii) being used for crop dusting, spraying or seeding, firefighting, traffic patrol, air ambulance, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or

  (iii) operating to or from offshore landing sites; or

  (iv) used in any operation that requires a special permit from the Civil Aviation Branch of Transport Canada, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).

(i) infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes;

(j) any services or supplies provided by an **Insured Person** or an **Immediate Family** member of the **Insured Person** including an **Insured Person** or **Immediate Family** member that is a **Physician**;

(k) **Injury** or **Loss** sustained while the **Insured Person** is on full-time active duty in the armed forces or organized reserve corps of any country or international authority. (Unearned premium for any period for which the **Insured Person** is on full-time active duty shall, upon application to the **Company** by the Policyholder, be refunded);

(l) **Injury** or **Loss** sustained while the **Insured Person** is under the influence of alcohol and operating any vehicle or means of transportation or conveyance while their blood alcohol is over eighty (80) milligrams in one hundred (100) millilitres of blood;

(m) **Injury** or **Loss** sustained while the **Insured Person** is under the influence of a drug or substance which is controlled as specified under the Controlled Drugs and Substances Act (Canada) or the Cannabis Act unless taken pursuant to the advice of and in strict accordance with the instructions of a duly licenced **Physician**;

(n) the committing of or the attempt to commit an assault or criminal offence

(o) an act, attempted act or omission taken or made by the **Insured Person**, or an act, attempted act or omission taken or made with the **Insured Person's** consent, for the purposes of interrupting the blood flow to the **Insured Person's** brain or to cause asphyxiation to the **Insured Person** whether with intent to cause harm or not; and

(p) death by natural causes.

10.4 Emergency Travel Benefits Exclusions

Exclusions in Section 10.3 (d), (f) and (i) are not in effect for expenses incurred under the Emergency Travel Benefit. In addition to the remaining exclusions in Section 10.3 Exclusions, Emergency Travel Benefits are not payable for, any expense for or resulting from:

(a) a child born during a **Trip** covered under this policy;

(b) **Sickness** or **Injury** where the **Trip** is undertaken for the purpose of securing medical **Treatment** or advice for such **Sickness** or **Injury**;

(c) **Sickness** or **Injury** due to participation in any professional sport;

(d) repair or replacement of the following except for the purpose of modifying the item because the **Injury** or **Sickness** has caused further impairment in the underlying bodily condition:

(i) existing artificial limbs, artificial eyes or other prosthetic appliances or rental of existing durable medical equipment;

(ii) new, or repair or replacement of, dentures, bridges, dental implants, dental bands or braces or other dental appliances, crowns, caps, inlays or onlays, fillings or any other treatment of the teeth or gums, except for repair or replacement of sound natural teeth damaged or lost;

(iii) new eye glasses or contact lenses or eye examinations related to the correction of vision or related to the fitting of glasses or contact lenses;

(iv) new hearing aids or hearing examinations;

(v) rental of durable medical equipment where the total rental expense exceeds the usual purchase expense for similar equipment in the locality where the expense is incurred (but if, in the **Company's** sole judgment, Emergency Medical and Therapeutic Services for rental of durable medical equipment are expected to exceed the usual purchase expense for similar equipment in the locality where the expense is incurred, the **Company** may, but is not required to, choose to consider such purchase expense as a **Reasonable and Customary** charge in lieu of such rental expense)

(e) Personal comfort or convenience items, such as but not limited to **Hospital** telephone charges, television rental, or **Hospital** guest meals;

(f) **Treatment** or services when reimbursement or coverage by the **Company** would contravene any **GHIP** in Canada;

(g) expenses incurred on an elective (non-emergency) basis;

(h) any **Treatment**, investigation or surgery for a specific condition, or a related condition, which had caused the **Insured Person's Physician** to advise such person not to travel;

(i) any services or supplies provided by an **Insured Person** or an **Immediate Family** member of the **Insured Person**;

(j) a **Sickness** or **Injury** that, at the time of departure, might reasonably be expected to require an **Insured Person** to undergo **Treatment**, investigation, surgery or hospitalization;

(k) any service, **Treatment**, surgery or stay in **Hospital** not required for the immediate relief of acute pain or suffering or which is not **Medically Necessary**;

(l) any **Treatment** or surgery which reasonably could be delayed until the **Insured Person** returns to their province/country of residence;

(m) anticipated medical **Treatments** required on an ongoing basis or for continued stabilization of a medical condition known to the **Insured Person** prior to departure from their province/country of residence;

(n) any sickness, injury or medical condition that is a **Pre-Existing Condition** within the number of days as specified in the Pre-Existing Condition Period in the **Policy Schedule's** Schedule of Benefits, except as provided herein;

(o) that portion, if any, of any expenses for **Treatment**, advice or hospitalization which are not **Reasonable and Customary**;

(p) Any condition for which the **Insured Person** is entitled to benefits under any Workers' Compensation Act or similar law;

(q) For non-Canadian residents **Treatment** or services within the **Insured Person's** country of residence after the person has returned or being evacuated back to their country of residence;

(i) AIG Insurance Company of Canada, in consultation with the attending **Physician**, reserves the right to return the patient to their country of residence. If any **Insured Person** is (on medical evidence) able to return to their country of residence following the diagnosis of, or the emergency treatment for, a medical condition which requires continuing medical services, **Treatment** or surgery, and the **Insured Person** selects to have such **Treatment** or services rendered or surgery performed outside their country of residence, the expense of such continuing medical services, **Treatment** or surgery will not be covered by the plan;

(ii) If the **Insured Person** declines to be transferred, or to return to their country of residence when declared medically fit to travel by the medical director, any continuing expense for such **Sickness** or **Injury** shall not be covered.

10.5 Additional Exclusion for Insured Persons belonging to an Eligible Class covered for Business Travel While on a Trip Only Coverage

If the **Insured Person** belongs to an Eligible Class for which there is **Business Travel While on a Trip** coverage only, no coverage shall be provided under this policy and no payment shall be made for any **Loss** or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any accident causing **Injury** or **Loss** which does not occur during **Business Travel While on a Trip** or during the portion of the **Trip** that is considered **Sojourn or Personal Deviation**.

10.6 Additional Exclusion for Insured Persons belonging to an Eligible Class covered for While on Business of the Policyholder Only Coverage

If the **Insured Person** belongs to an Eligible Class for which there is coverage only **While on Business of the Policyholder**, no coverage shall be provided under this policy and no payment shall be made for any **Loss** or claim resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any accident causing **Injury** or **Loss** to an **Insured Person** which does not occur **While on the Business of the Policyholder** or during the portion of a **Trip** that is considered **Sojourn or Personal Deviation**.

Section 11 : General Provisions

These General Provisions are applicable to this policy as a whole. Please read each section to see further additional conditions and provisions relating to that section.

11.1 The Policy

The policy between the Policyholder and the **Company** consists of:

(a) this document,

(b) the **Policy Schedule**; and

(c) any written amendment(s) to this document issued by the **Company**.

The policy can be changed or amended without the consent of any **Insured Person**.

11.2 Amendments

Only the President and CEO of the **Company** or their authorized representative has authority to waive or agree to amend any part of this policy on behalf of the **Company**.

11.3 Waiver

The **Company** shall be deemed not to have waived any condition of this policy, either in whole or in part, unless the waiver is clearly expressed in writing and signed by the **Company**.

11.4 Right To Return Policy

The Policyholder may return this policy for any reason within the later of: (1) 15 days after receiving it; or (2) 15 days after the policy becomes effective. It may be returned by e-mail or in person to the **Company**. Any premium paid will be refunded and this policy will be treated as if it were never issued.

11.5 Notice

Any notice required or permitted to be given to or by the Policyholder or the **Company** pursuant to this policy shall be in writing and shall be deemed to be properly given if sent to the applicable party at the address indicated on the **Policy Schedule**.

11.6 Notice and Proof of Claim

The Policyholder or its agent, the **Insured Person** or an **Insured Person's** beneficiary entitled to make a claim or their agent:

(a) shall give written notice of claim to the **Company** by delivery thereof, or by sending it by mail or email not later than 30 days from the date of the accident;

(b) within 90 days from the date of the accident or the Injury, furnish to the **Company** such proof of claim as is reasonably possible in the circumstances of the happening of the accident or **Injury** occasioned thereby; and

(c) if so required by the **Company**, furnish a certificate as to the cause and nature of the accident or Injury caused thereby, for which the claim is made and as to the duration of the **Injury** or **Loss**, from a legally qualified medical practitioner.

11.7 Failure to Give Notice or Proof

Failure to give notice of claim or furnish proof of claim within the time prescribed in Section 11.6 will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and in no event later than one year from the date of the accident or the **Injury** and if it is shown that it was not reasonably possible to give notice or furnish proof within the time as prescribed.

11.8 Right of Examination

As a condition precedent to recovery of insurance money under the policy, any **Insured Employee** making a claim must give the **Company** an opportunity to examine them when and as often as it reasonably requires while the claim hereunder is pending, and in the case of **Loss of Life** of an **Insured Employee**, the **Company** may require an autopsy, subject to any law of the applicable jurisdiction relating to autopsies.

11.9 When Moneys Payable

All money payable under the contract must be paid by the **Company** within 60 days after it has received proof of claim.

11.10 Limitation of Actions

Actions or proceedings against an insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the *Insurance Act* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed

by the laws of Saskatchewan), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the *Quebec Civil Code*.

11.11 Payment of Claims

The benefit payable for **Loss of Life** for an **Insured Employee** will be payable in accordance with Section 9.

Unless otherwise specified herein:

(a) any accrued other benefits payable but unpaid at the **Insured Person's** death will be paid to the **Insured Person's** estate; and

(b) all other benefits are payable to the **Insured Employee**, whether for a **Loss** incurred by the **Insured Employee** or another **Insured Person**.

For Emergency Travel Benefit all amounts payable shall be reimbursed to the individual who has paid the expense or shall be paid directly to the provider.

Section 12 : Additional Provisions

12.1 Currency

All moneys payable under this policy are payable in the lawful money of Canada unless otherwise stated.

12.2 Assignment

The Policyholder cannot assign this policy without the consent of the **Company**.

Neither the insurance provided hereunder nor benefits payable hereunder may be assigned.

12.3 Non-Participating

Neither the Policyholder nor any **Insured Employee** is entitled to share in the profits or surplus of the **Company**.

12.4 Governing Law

The relationship between the **Company** and the Policyholder shall be governed by and interpreted in accordance with the laws of the Policyholder's Canadian province or territory.

The relationship between the **Company** and any **Insured Employee** shall be subject to the laws of the **Insured Employee's** Canadian province or territory of residence at the time their insurance coverage hereunder comes into effect.

12.5 Conformity with Applicable Law

Any provision of this Policy, which is in conflict with any federal, provincial, territorial or other applicable law of an **Insured Employee's** place of residence, is hereby amended to conform to the minimum requirements of that law.

The **Company** will not be liable to provide any coverage or make any payment hereunder if to do so would be in violation of any sanctions law or regulation which would expose the **Company**, its parent company or its ultimate controlling entity to any penalty under any sanctions law or regulation.

This policy will not cover any loss, injury, damage or legal liability arising directly or indirectly from planned or actual travel in, to, or through Iran, Syria, Sudan, North Korea or the Crimea region.

12.6 Not In Lieu of Workers' Compensation

This policy is not in lieu of and does not affect any requirement for coverage under workers' compensation legislation or similar law.

12.7 Collective Agreement and this Policy

This policy shall take precedence in the event of an inconsistency between this policy and any collective agreement which applies to the **Insured Employee** and to which the Policyholder or the **Employer** is a party.

12.8 Clerical Error

Clerical error on the part of the **Company** or the Policyholder in the keeping of records for furnishing of information shall not void any **Insured Person's** insurance otherwise validly in force, provided the proper premium remittance is made, nor shall it continue any Insured Person's insurance otherwise validly terminated under the terms of the policy.

By signing below, the President and Chief Executive Officer of the Company agrees on behalf of the **Company** to all the terms of this Policy.



President and Chief Executive Officer
AIG Insurance Company of Canada

This Policy shall not be valid unless signed at the time of issuance by the President and CEO of the **Company**.

AIG Insurance Company of Canada
120 Bremner Boulevard, Suite 2200
Toronto, ON M5J 0A8
www.aig.ca

Group Business Travel Accident & Medical Policy Schedule



POLICY TERMS & CONDITIONS	This Group Business Travel Accident **Policy Schedule** is valid from **04.30.2025** and it overrides all previous **Policy Schedules** issued for this Group Business Travel Accident policy
SCOPE OF COVER **INCLUDED BENEFIT**	This Group Business Travel Accident policy provides coverage for those perils listed in this **Policy Schedule**, up to the sum insured stated. The Group Business Travel Accident policy, this **Policy Schedule** and all attached memoranda and endorsements detail the entire cover provided and the terms and conditions applying to it.

In consideration of the payment of premiums by the Policyholder, the **Company** agrees to provide the insurance cover set out in this policy to persons within the Eligible(es) Class, subject at all times to the terms, provisions, exclusions and limitations of this Group Business Travel Accident policy.

_____

Authorized Representative

Issue Date: June 4, 2025/SD Revised

Declarations

DECLARATIONS	
INSURER	AIG Insurance Company of Canada (the Company)
ASSISTANCE COMPANY	Travel Guard • U.S. and Canada toll free: 1 877 204-2017 • Outside U.S. and Canada (collect): +1 715 295-9967
POLICY NUMBER	BTA 9427924
POLICYHOLDER	Bank of Montreal
ADDRESS OF THE POLICYHOLDER	100 King Street West, Toronto on M5X 1A1
ISSUE DATE	April 24, 2025
EFFECTIVE DATE	12:01 a.m. local time at the Policyholder's address on the 30th day of April 2025.
EXPIRATION DATE	12:01 a.m. local time at the Policyholder's address on the 30th day of April 2026.
PLAN	GROUP BUSINESS TRAVEL ACCIDENT
ELIGIBLE CLASSES	**Insured members:** • Canadian and non-Canadian domiciled individuals; • employed by the Policyholder or an affiliate thereof on a permanent, full-time and part-time basis or are a board member of the Policyholder; and • who are a member of one of the following classes **Class I:** Executives of the Policyholder **Class II:** International Executives of the Policyholder **Class III:** All other Canadian permanent employees of the Policyholder **Class IV:** All other International permanent employees of the Policyholder **Class V:** All Canadian temporary employees of the Policyholder **Class VI:** All International temporary employees of the Policyholder **Class VII:** All non-employee directors of the Policyholder **Class VIII:** Spouse while on business travel of the Policyholder **Class IX:** Dependent Children while on business travel of the Policyholder **Class X:** Guests of the Policyholder

DECLARATIONS	
TERMINATION OF COVERAGE	Insured Member: The earlier of: • Retirement or age 70; • The date they no longer belong to an Eligible Class; or • The date they no longer meet the definition of **Insured Member**; or • 12:01 am the date following the **Maximum Trip Duration** days listed in the **Policy Schedule Declarations** from the **Departure Date** (for Emergency Travel Benefits only); or • the date the **Insured Person** returns to their province of residence (for Emergency Travel Benefits only); or • The date the policy terminates. **Spouse**: The earlier of: • The date the employee's coverage terminates; or • The date they no longer meet the definition of **Spouse** as defined in the policy **Dependent Children**: The earlier of: • The date the employee's coverage terminates; or • The date they no longer meet the definition of **Dependent Children** as defined in the policy
AGGREGATE LIMIT PER ACCIDENT	**$10,000,000.00** for any one accident occurring while an **Insured Person** is travelling in, entering or exiting any **Aircraft**

AIG

Declarations

PREMIUM RATES AND PRINCIPAL SUMS				
Eligible Class	**Estimated Number of Eligible Insured Employees or Insured Persons**	**Principal Sum**	**Rate per $1,000 of Principal Sum**	**Type of Coverage**
Class I	197	300% of annual earnings, rounded to the next $1,000, up to a maximum of CAD $1,000,000.	CAD $0.12/ /year	**Twenty-four (24) Hour Coverage**
Class II	95	300% of annual earnings, rounded to the next $1,000, up to a maximum of USD $1,000,000.	**AD&D:** USD 0.12/year **Medical:** USD $0.70 per travel day	**Twenty-four (24) Hour Coverage**
Class III	36 148	300% of annual earnings, rounded to the next $1,000, up to a maximum of CAD $600,000.	CAD $ 0.0009 /travel day	**Business Travel While on a Trip**
Class IV	20 474	300% of annual earnings, rounded to the next $1,000, up to a maximum of USD $600,000.	**AD&D:** USD $0.0009 /travel day **Medical:** USD $0.70 per travel day	**Business Travel While on a Trip**
Class V	212	CAD Flat $100,000	CAD $0.0009/travel day	**Business Travel While on a Trip**
Class VI	19	USD Flat $100,000	**AD&D:** USD $0.0009/travel day **Medical:** USD $0.70 per travel day	**Business Travel While on a Trip**
Class VII	TBD	CAD Flat $300,000	CAD $0.0009/travel day	**Business Travel While on a Trip**
Class VIII	TBD	50% of employee's Principal Sum, min. CAD/USD $50,000 up to max. CAD/USD $300,000	CAD/USD Flat $650.00 per year	**While on Business Travel with an insured employee**
Class IX	TBD	CAD/USD Flat $25,000		
Class X	TBD	CAD/USD Flat $150,000 or CAD/USD Flat $300,000		**While travelling in, entering or exiting an owned aircraft**
PREMIUM FREQUENCY		ANNUALLY		

PREMIUM RATES AND PRINCIPAL SUMS	
VOLUME OF INSURANCE	[redacted]
ANNUAL PREMIUM	[redacted]
AIRCRAFT COVERAGE	Annual rate - $0.02/$1,000 of excess aggregate limit Flat amount of $2,730/year
DEPOSIT PREMIUM FOR WAR RISK COVERAGE	Minimum and deposit premium of **$5,000** to be adjusted at the rates in force at the time of coverage. **Principal Sum** reduced to the Maximum Amount Payable listed in the Schedule of Benefits for claims incurred in a **Designated War Risk Territory**.
Additional Policy Provisions	
PRE-EXISTING CONDITION PERIOD	90 days, applicable to Emergency Travel Benefits only

Declarations

AIRCRAFT COVERAGE

EMPLOYED PILOTS, CREW AND COVERED AIRCRAFT	Annual Rate per $1,000 of Principal Sum	Type of Coverage
Those Aircraft Leased or Chartered by the Policyholder from time to time.	$0.02/$1,000/year for excess aggregate limit of $5,000,000.	Policyholder Aircraft Coverage
ANNUAL PREMIUM FOR AIRCRAFT COVERAGE	Flat amount of **$2,730**. Excess premium: **$1,000.**	
AGGREGATE LIMIT PER ANY ONE AIRCRAFT ACCIDENT	$10,00,0000.00 any one accident occurring while an Insured Employee is travelling in, entering or exiting any **Owned/Leased/Chartered Aircraft**	

POLICYHOLDER OWNED/LEASED/CHARTERED AIRCRAFT COVERAGE

Notwithstanding Section 10.3, Exclusion (g) (iii) and Exclusion (h) (i) of the Business Travel Accident policy, the **Company** will afford coverage hereunder to an **Insured Person** (other than to a pilot, operator or crew member) when such **Insured Person** is riding in or on or boarding or alighting from or being struck or run down by an **Aircraft** set out in the above **Declarations**.

Coverage shall not be afforded nor shall it come into effect unless the Policyholder has requested this coverage and it is described the above Aircraft Declarations. Further, coverage does not apply to any Aircraft not set out in the above Aircraft Declarations.

Accidental Death & Dismemberment Schedule of Benefits

These benefits of the policy only apply if selected by the Policyholder (indicated by "Yes" in the Covered Benefit column) and the appropriate premium paid.

Benefit	Covered Benefit	Maximum Amount Payable per Insured Person per Accident (CAD$)
ACCIDENTAL DEATH AND DISMEMBERMENT	YES	Percent of **Principal Sum** per **Table of Losses** below
DISAPPEARANCE AND EXPOSURE	YES	**Principal Sum**
PERMANENT AND TOTAL DISABILITY	YES	**Principal Sum**
REHABILITATION	YES	$15,000
HOME ALTERATION AND VEHICLE MODIFICATION	YES	$15,000
WORKPLACE MODIFICATION AND ACCOMMODATION	YES	$5,000
PSYCHOLOGICAL THERAPY	YES	$5,000
IN-HOSPITAL BENEFIT	YES	$2,500/month
FAMILY TRANSPORTATION	YES	$15,000
REPATRIATION BENEFIT	YES	$15,000
IDENTIFICATION BENEFIT	YES	$5,000
DAY CARE	YES	$5,000
DEPENDENT CHILD EDUCATIONAL BENEFIT	YES	$5,000
SPOUSAL EDUCATIONAL BENEFIT	YES	$15,000
FUNERAL EXPENSE	YES	$5,000
BEREAVEMENT BENEFIT	YES	$1,000
SEAT BELT AND AIR BAG BENEFIT	YES	Additional 10% of **Principal Sum** to a maximum of $50,000, for each Seat Belt and Air Bag
DISABILITY FITNESS BENEFIT	YES	$5,000
PARENTAL CARE BENEFIT	YES	$10,000
CARJACKING BENEFIT	YES	$25,000
CRIMINAL ASSAULT BENEFIT	YES	Additional 10% of **Principal Sum**
COSMETIC DISFIGUREMENT	NO	
COMA BENEFIT	NO	
FRACTURE BENEFIT	YES	$500
SURGICAL REATTACHMENT	NO	
ACCIDENTAL PARAMEDICAL EXPENSE	NO	
(a) Private Duty Nursing		
(b) Transportation Costs		
(c) Hospital Chargest		
(d) Rental of Wheelchair, Iron Lung or Other Durable Equipment		
(e) Licensed physiotherapist, athletic therapist, sports therapist, kinesiologist or physical therapist		
(f) Prescription Drugs and Medicines		
(g) Hearing Aid, Crutches, Splints, Casts, Trusses and Braces		
(h) Licensed chiropractor, occupational therapist, osteopath or massage therapist		
ACCIDENTAL DENTAL EXPENSE	NO	

Benefit	Covered Benefit	Maximum Amount Payable per Insured Person per Accident (CAD$)
WAR RISK COVERAGE	YES	$500,000

Table of Losses

TABLE OF LOSSES	Percentage Principal Sum Payable
Loss	
Loss of Life	100%
Loss of Both Hands or Both Feet	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of One Hand and the Entire Sight of One Eye	100%
Loss of One Foot and the Entire Sight of One Eye	100%
Brain Death	100%
Loss of One Arm or One Leg	80%
Loss of One Hand or One Foot	75%
Loss of The Entire Sight of One Eye	75%
Loss of Thumb and Index Finger of the Same Hand	33.3%
Loss of Speech and Hearing	100%
Loss of Speech or Hearing	75%
Loss of Hearing in One Ear	66.7%
Loss of Four Fingers of One Hand	33.3%
Loss of All Toes of One Foot	25%
Loss of Use	
Loss of Use of Both Arms or Both Hands	100%
Loss of Use of One Hand or One Foot	75%
Loss of Use of One Arm or One Leg	80%
Paralysis	
Quadriplegia (total paralysis of both upper and lower limbs)	Two times the **Principal Sum** up to a maximum of $1 million
Paraplegia (total paralysis of both lower limbs)	Two times the **Principal Sum** up to a maximum of $1 million
Hemiplegia (total paralysis of upper and lower limbs of one side of the body)	Two times the **Principal Sum** up to a maximum of $1 million

Emergency Travel Benefits

Benefit	Maximum Amount Payable per Insured Person (CAD$)
EMERGENCY TRAVEL BENEFITS **(CLASSES II, IV & VI ONLY)**	Overall Lifetime Maximum $1,000,000
EMERGENCY TRAVEL BENEFIT LIMITATION (applicable to **Complications of Pregnancy** and **Pre-Existing Condition**)	Complications of Pregnancy: $2,000 Pre-Existing Condition: $1,000
COVERAGE TYPE	Classes II, IV & VI only: Excess Coverage
MAXIMUM TRIP DURATION	60 Days per **Trip**
EMERGENCY HOSPITAL CONFINEMENT	Included in Overall Maximum
EMERGENCY MEDICAL AND THERAPEUTIC SERVICES	Included in Overall Maximum where applicable sub limits are noted below
the services of a **Physician** or legally qualified surgeon	
laboratory tests and X-ray examinations (not including MRI) ordered by a **Physician** or legally qualified surgeon for the purpose of diagnosis	
MRI, for diagnostic purposes when **Medically Necessary**	
the services of a registered graduate nurse	
rental of crutches or a hospital type bed, or the cost of splints, canes, slings, trusses, braces or other prosthetic appliances approved by the **Company**	
the services of a **Physician** who is an anesthetist	
drugs or medicines that require a **Physician** or legally qualified surgeon's written prescription	
services of a chiropodist, chiropractor, osteopath, physiotherapist or podiatrist	$300 for each practitioner
expenses for accidental **Injury** to natural and sound teeth (capped or crowned teeth are considered whole or sound natural teeth) which require **Treatment** by a legally qualified dentist or dental surgeon	$2,000 for any one accident
out-patient services provided by a **Hospital**	
GROUND TRANSPORTATION BENEFIT	$5,000
EMERGENCY AIR TRANSPORTATION BENEFIT	$200,000

Optional Add-On Benefits

Benefit	Covered Benefit	Maximum Amount Payable per Insured Person (CAD$)
SECURITY EVACUATION	YES	See Rider 1

Accidental Death & Dismemberment

In the event of a claim, the claims department should be advised as soon as possible. You will be provided with the appropriate claim form.

The following documents are required in order to adjudicate an accidental dismemberment or loss of use claim:

- Claimant's Statement to be completed, dated and signed by the claimant
- Physician's Statement to be completed, dated and signed by the attending physician
- Employer's Statement to be completed by the employer or Benefit Plan Administrator

The following documents are required in order to adjudicate an accidental death claim:

- Claimant's Statement to be completed, dated and signed by the designated beneficiary or the executor of the estate if there is no designated beneficiary
- Death certificate (an original Provincial Death Certificate may be requested if required)
- Physician's Statement to be completed, dated and signed by the attending physician (A Coroner's Report can replace the physician's statement)
- Employer's Statement to be completed by the employer or Benefit Plan Administrator
    - We require a copy of the Beneficiary Designation or if no Beneficiary, Proof of Executor

Claims Department	Phone (English): (416) 596-4005 Phone (English/French): 1 877 317-8060 E-mail: ahclaimscan@aig.com – for new claims only

Emergency Travel

Minor Expenses

For expenses associated with minor medical emergencies (less than $250) claim form to be obtained from AIG. The claimant will need to submit the following documents to AIG by either email (ahclaimscan@aig.com) or mail:

- completed claim form,
- proof of travel documents,
- all invoices and/or receipts for expenses incurred and/or
- a copy of your Explanation of Benefits Statement from your other insurance carrier (if applicable) and copy of all medical reports from the attending physician or hospital.

AIG Insurance Company of Canada

120 Bremner Boulevard, Suite 2200

Toronto, ON M5J 0A8

Major Expenses

For major emergencies that require hospitalization or day surgery, Travel Guard will coordinate services between the Provider and the Company to insure direct billing of your expenses.

In an emergency here is what to do

In the event of a medical emergency, the Insured Person or someone acting on their behalf must call Travel Guard immediately.

Telephone the Travel Guard at the numbers listed below.

Travel Guard

U.S. and Canada toll free: 1 877 204-2017

U.S. and Canada (collect): +1 715 295-9967

AIG is a proud member of THiA; and our collective goal is to ensure every claim submitted has the opportunity to be paid. The industry has come together and designed the Bill of Rights and Responsibilities to deliver a clear statement as to what you can expect from your travel insurance. The Travel Insurance Bill of Rights and Responsibilities builds upon the following golden rules of travel insurance:

- *Know your health*
- *Know your trip*
- *Know your policy*
- *Know your rights*

For more information, go to www.thiaonline.com/Travel_Insurance_Bill_of_Rights_and_Responsibilities.html

Group Legal Insurance
Certificate and Service Plan

Important:
For purposes of the BMO Bank N.A. **certificate**, the **Policyholder** has defined eligible dependents to mean: The plan member's spouse or both same and different sex domestic partner is covered. In addition, the plan member's unmarried children until the end of the month when they reach age 26. Married children are NOT covered.

C18694 01/25

CERTIFICATE OF INSURANCE

BMO Bank N.A.
Legal Expense Insurance Plan

ARAG, 500 Grand Avenue, Suite 100, Des Moines, Iowa 50309
800-247-4184 ● ARAGlegal.com
Underwritten by ARAG Insurance Company, Des Moines, Iowa

DEFINITIONS

"**AMOUNT IN DISPUTE**" – means the monetary amount that can be calculated or proven in order to compensate **you** for incurred damage to or loss of **your** property.

"**BENEFITS**" – the legal coverages listed on the declarations page of the policy or in the **benefits** section of the **Certificate of Insurance**.

"**CERTIFICATE OF INSURANCE**" or "**CERTIFICATE**" – the document provided by **us** to the **named insured** that describes the **benefits** and terms of the insurance policy.

"CERTIFICATE YEAR" – twelve (12) month period as listed on the declarations page of the policy issued to the **policyholder.**

"CONTESTED" – an action in which any disputed issue must be negotiated by **your** attorney regardless of whether any legal forms are filed.

"EFFECTIVE DATE" – the date on which the **policyholder** enrolls the **named insured** and from which date premium has been paid for **you**.

"GENERAL IN OFFICE LEGAL SERVICES" – time spent by an attorney and their office staff for **your** legal issue that is not otherwise covered or excluded under this plan and which does not include costs such as, but not limited to: filing fees, copy costs, mileage, title insurance, expert witnesses, mediator, home studies, transcriptionists, title search, and title abstracting.

"GOODS" – a physical product that is capable of being delivered. Ownership of a good can be transferred from the seller to the buyer.

"INDEMNITY BENEFITS" – means covered **legal services** which are reimbursed to the **insured** up to the **benefit** amount indicated under the specific coverage. The **insured** is responsible for all **legal services** which may exceed the amount paid by **us**.

"INSURED" – as dictated by premium paid and as indicated by coverages listed in the "**Benefits**" section, the **named insured** only or the **named insured** and the **named insured's** spouse, and/or eligible dependents as defined by mutual agreement between the **policyholder** and **us**.

For purposes of this policy, the term spouse or spousal wherever it appears in the policy includes a covered person who is legally married and/or who is a party to a **civil union** wherever it appears in the policy. A "**civil union**" is a relationship that meets the requirements of a **civil union** pursuant to "The Illinois Religious Freedom Protection and Civil Union Act", 750 ILCS 75/10.

"INSURED EVENT" – an event covered by this policy whose initiation date will be considered the earlier of the date (a) written notice of a **legal dispute** is sent or filed by **you** or received by **you**; or (b) a ticket or citation is issued; or (c) an attorney is hired.

"INSURED RENTAL PROPERTY" – a single dwelling (house, apartment, duplex or condominium) that **you** have an ownership interest in and that is not **your primary residence** and that for a portion of the year is rented out to another individual.

"LEGAL DISPUTE" –means a disagreement between **you** and any other party regarding **your** legal rights.

"LEGAL SERVICES" – time spent by **your** attorney and their office staff for **your** covered legal matters which does not include costs such as, but not limited to: filing fees, copy costs, mileage, title insurance, expert witnesses, mediator, home studies, transcriptionists, title search, and title abstracting.

"MEDIATION COSTS" – payment of a qualified mediator who assists the **insured** and another party attempt to reach a settlement regarding a covered legal matter.

"MISCELLANEOUS LEGAL SERVICES" – time spent by an attorney and their office staff for **your** legal issue that is not otherwise covered or excluded under this plan and which does not include costs such as, but not limited to: filing fees, copy costs, mileage, title insurance, expert witnesses, mediator, home studies, transcriptionists, title search, and title abstracting.

"NAMED INSURED" – a person enrolled via the **policyholder** with **us** as entitled to coverage under the terms of this policy.

"NETWORK ATTORNEY" – means an attorney who completes and delivers a signed application to **us**; agrees to the terms of the ARAG Attorney Agreement; is accepted as a **Network Attorney** by **us** and agrees to provide **legal services** in the United States for the **benefits** noted on their application or as updated with **us**.

"NON-NETWORK ATTORNEY" – means an attorney, who is not a **Network Attorney**, chosen by **you** to perform **legal services** covered under the **indemnity benefits** of this policy.

"NON-MOVING OFFENSE" – parking ticket, registration, equipment or other violations that aren't handled in conjunction with a moving violation.

"PERSONAL PROPERTY" – means property, which is not **real property** and which does not produce income.

"POLICYHOLDER" – means the organization named in the declarations page.

"PRIMARY RESIDENCE" – the single dwelling where **you** actually live that is considered **your** legal residence for income tax purposes.

"REAL PROPERTY" – land and all permanent structures attached to it.

"REFINANCING" – paying off one loan with the proceeds from a new loan using the same **real property** as security.

"SECONDARY RESIDENCE" – a single dwelling (house, apartment, duplex, or condominium) that **you** have an ownership interest in and that is not **your primary residence** and is not an **insured rental property** for six months before the **insured event** and it is not **your** intent to use it as an **insured rental property**.

"SERVICE" – a duty or labor provided from one person to another. It is the non-material equivalent of a **good.** There is no physical product that can transfer ownership.

"TRIAL" – means the proceeding in court or in a covered administrative proceeding when the parties try their case beginning with the impaneling of a jury in a jury **trial** or with opening statement if the parties are in a non-jury **trial**. **Trial** does not include things such as hearings, appearances on motions, negotiated pleas, pre-**trial** conferences, or appearances, and continuances by the court.

"UNCONTESTED" – an action in which all matters are settled or decided without attorney negotiation, and **your** attorney assists in completing any necessary formal processes.

"WE", "US", and **"OUR"** – ARAG Insurance Company.

"YOU" and **"YOUR"** – an **insured**.

In-Office Legal Benefits

We will pay for covered **legal services** provided to **you** by a **Network Attorney** resulting from an **insured event** which occurs after **your effective date** and while **your Certificate of Insurance** is in effect for the **benefits** listed below. The

legal services will be paid up to the amount listed in the **Network Attorney** column of the **benefits** section. If the amount listed is PAID IN FULL, **we** will pay for **legal services** up to **our** standard contract rates. If the **legal services** are provided by a **Network Attorney** on terms other than **our** standard contract rates, then the **legal services** will not exceed a reasonable maximum set by **us** based on similar **insured events**.

You can choose a **Non-Network Attorney** instead of a **Network Attorney**. If **you** choose a **Non-Network Attorney** for covered **benefits** provided to **you** resulting from an **insured event** which occurs after **your effective date** and while **your Certificate of Insurance** is in effect, **we** will reimburse **you** for covered **legal services** up to the maximum amounts listed in the **Non-Network Attorney (Indemnity Benefit)** column of the **benefits** section.

Regardless of whether **you** choose a **Network Attorney** or **Non-Network Attorney**, only matters expressly listed are covered **benefits** and are paid as indicated below.

If the **named insured** purchased only individual coverage, **legal services** rendered to persons other than the **named insured** are not covered.

How to Obtain In-Office Legal Services and Court Representation

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You may choose a **Network Attorney** or **Non-Network** Attorney as follows:

Network Attorney Services
There are **Network Attorneys** throughout **your** state. To obtain a list of **Network Attorneys you** can:

1. Call 800-247-4184 and a Customer Service Specialist will assist **you** by:

    - Describing how the plan **benefits** work and what types of situations are covered.
    - Providing **you** a listing of **Network Attorneys** specific to **your** need.
    - Providing a Case Confirmation Number that outlines **your** coverage.

2. Visit **our** Web site at ARAGlegal.com and log on as a member and search using the Attorney Finder.

Simply call an attorney for an appointment. When **you** call, identify yourself as a member of **your** group's legal plan. If **you** have a Case Confirmation Number, **you** should provide it to the **Network Attorney**. If not, the **Network Attorney** may call **us** to confirm **your** coverage and then proceed to provide **services**. If **you** choose a **Network Attorney** to provide covered **legal services**, the **Network Attorney** will bill **us** directly for his/her attorney fees.

Non-Network Attorney Services
If **you** choose a **Non-Network Attorney**, **we** will pay **your** attorney fees for covered **legal services** according to the **Non-Network Attorney indemnity benefits** schedule. Instructions for submitting a claim are printed on the claim form. For a form, call 800-247-4184. Or **you** can download a form from **our** Web site at ARAGlegal.com.

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Administrative Regulation Protection **Legal services** for an **insured** in the defense against charges filed in state or federal court for violation of administrative regulations, except those involving motorized vehicles, domestic violence or felony charges.	PAID IN FULL	$ 720*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Uncontested Adoption **Legal services**[1] in an **uncontested** adoption for an **insured** to become an adoptive parent(s). [1]In international adoptions, where a foreign attorney is necessary, **you** are eligible to receive indemnity reimbursement in addition to the **benefits** available in the United States.	PAID IN FULL	$ 400*
Contested Adoption **Legal services**[1] in a **contested** adoption for an **insured** to become an adoptive parent(s).	PAID IN FULL	$ 800*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
[1]In international adoptions, where a foreign attorney is necessary, **you** are eligible to receive indemnity reimbursement in addition to the **benefits** available in the United States		
Building Codes **Legal services** for an **insured** in an administrative action for permit or code violations relating to the renovation and/ or improvement of **your** existing **primary residence.**	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Defense of Civil Damage Claims **Legal services** for an **insured** in defense against civil damage(s) claims, except claims involving the ownership or use of a motorized vehicle, claims which are covered by other insurance, or claims related to a felony charge.	PAID IN FULL	$ 800*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Uncontested Divorce **Legal services** for the **named insured** in an **uncontested** divorce, a legal separation and/ or an annulment of marriage**.**	PAID IN FULL	$ 640*
Contested Divorce - 20 hours **Legal services** for the **named insured** in a **contested** divorce, a legal separation and/or an annulment of marriage.	PAID IN FULL (up to 20 hours per **insured event**)	$ 1,600*
Driving Privilege Protection **Legal services** for an **insured** in the defense of a traffic offense where conviction of the offense will directly result in the suspension or revocation of **your** driving privileges.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Driving Privilege Restoration **Legal services** for an **insured** in an administrative proceeding for the restoration of suspended or revoked driving privileges of an **insured**.	PAID IN FULL	$ 240*
Easement **Legal services** for an **insured** in an administrative action regarding an easement on **your primary residence**.	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Estate Administration & Estate Closing (Probate) - 9 hours **Legal services** for an **insured** in administering an estate where **you** have been named the executor.	PAID IN FULL (up to 9 hours per **insured event**)	$ 720*
Foreclosure **Legal services** for an **insured** regarding written notice of a foreclosure related to **your primary residence**.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Defense of Garnishment **Legal services** for an **insured** in a **legal dispute** for a garnishment against **you** to collect judgment related to **goods** or **services**.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion (Exclusion #3 as it relates to post judgment garnishment is waived for this **benefit**.)	PAID IN FULL	$ 100,000***
Uncontested Guardianship/Conservatorship **Legal services** in an **uncontested** Guardianship/Conservatorship for an **insured** to appoint or be appointed as a Guardian/ Conservator.	PAID IN FULL	$ 480*
Contested Guardianship/Conservatorship **Legal services** in a **contested** Guardianship/ Conservatorship for an **insured** to appoint or be appointed as a Guardian/Conservator.	PAID IN FULL	$ 720*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Habeas Corpus Proceedings **Legal services** for an **insured** in habeas corpus proceedings.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Mental Incompetency or Infirmity Proceedings **Legal services** for an **insured** in defense of mental incompetency or infirmity proceedings.	PAID IN FULL	$ 960*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Juvenile Court **Legal services** for an **insured** child charged in juvenile court for violation of administrative regulations, except those involving motorized vehicles or felony charges. If the matter is removed from juvenile court, coverage under this **benefit** will cease as of the date of the removal.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Minor Traffic - Broad (excluding DWI-related) **Legal services** for an **insured** in the defense of a traffic offense, the conviction of which would not result in suspension or revocation of **your** driving privileges. (Does not include driving while impaired or under the influence of drugs or alcohol or any **non-moving offense**.)	PAID IN FULL	$ 240*
Neighbor Disputes **Legal services** for an **insured** with a neighbor as a plaintiff or defendant in a dispute related to **your primary residence**, including boundary or property title disputes.	PAID IN FULL	$ 720*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Neighbor Disputes - Secondary Residence **Legal services** for an **insured** with a neighbor as a plaintiff or defendant in a dispute related to **your secondary residence**, including boundary or property title disputes.	PAID IN FULL	$ 720*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Parental Responsibilities **Legal services** for an **insured** in juvenile court proceedings (except those involving traffic matters) where a state has brought an action regarding **your** parental responsibilities for an **insured** child.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Personal Property Protection **Legal services** for an **insured** as a plaintiff or defendant regarding contracts or obligations for the transfer of **your personal property** or **your personal property** rights.	PAID IN FULL	$ 320*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Postnuptial Agreements **Legal services** for the **named insured** for the preparation of a postnuptial agreement.	PAID IN FULL	$ 320*
Prenuptial Agreements **Legal services** for an **insured** for the preparation of a premarital or antenuptial agreement.	PAID IN FULL	$ 320*
Refinancing - Primary Residence Advice and review of relevant documents regarding **refinancing** of **your primary residence**.	PAID IN FULL	$ 160*

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Property Tax - Primary Residence **Legal services** for an **insured** in an administrative action brought by **you** to reduce the property tax assessment on **your primary residence**.	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Purchase of Real Estate **Legal services** for an **insured** for the purchase of **your primary residence** for the review and preparation of documents including contract for purchase and attendance at closing.	PAID IN FULL	$ 320*
Real Estate Disputes **Legal services** for an **insured** as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase or sale of **your primary residence**.	PAID IN FULL	$ 1,200*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Real Estate Disputes - Secondary Residence **Legal services** for an **insured** as a plaintiff or defendant in a dispute regarding contracts or obligations for the construction, purchase or sale of **your secondary residence**.	PAID IN FULL	$ 1,200*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Sale of Real Estate **Legal services** for an **insured** for the sale of **your primary residence** for the review and preparation of documents including the contract for sale and attendance at closing.	PAID IN FULL	$ 320*

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Tenant Matters **Legal services** for an **insured** as a plaintiff or defendant with **your** landlord as tenant of **your primary residence**, including but not limited to, eviction and security deposit disputes.	PAID IN FULL	$ 320*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Irrevocable Trusts **Legal services** for an **insured** for the preparation of a stand-alone irrevocable trust.	PAID IN FULL	$ 320* single document $ 400* spousal documents
Revocable Living Trusts **Legal services** for an **insured** for the preparation of a stand-alone revocable trust.	PAID IN FULL	$ 320* single document $ 400* spousal documents
Wills & Durable Power of Attorney Individual will or spousal will(s). (Does not include any tax planning services done in connection with the will.)	PAID IN FULL	$ 320 single document $ 400 spousal documents
Codicil (an amendment to a will)	PAID IN FULL	$ 40 single document $ 80 spousal documents
Living Will / Health Care Directive	PAID IN FULL	$ 40 single document $ 80 spousal documents
Durable / Financial Power of Attorney	PAID IN FULL	$ 40 single document $ 80 spousal documents
Zoning and Variances **Legal services** for an **insured** in an administrative action related to a zoning change, variance, or an eminent domain proceeding involving **your primary residence**.	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Uncontested Child Custody/Child Support Agreement **Legal services** for an **insured** for the creation of an initial **uncontested** child custody, child support, or visitation agreements. This **benefit** does not include the modification of current agreements.	PAID IN FULL	$ 320*
Contested Child Custody/Child Support Agreement - 8 hours **Legal services** for an **insured** for the creation of an initial **contested** child custody, child support, or visitation agreements. This **benefit** does not include the modification of current agreements.	PAID IN FULL (up to 8 hours per **insured event**)	$ 640*
Home Equity Loan - Primary Residence **Legal services** for an **insured** for the preparation and review of home equity loans for **your primary residence**.	PAID IN FULL	$ 160*
Home Equity Loan - Secondary Residence **Legal services** for an **insured** for the preparation and review of home equity loans for **your secondary residence**.	PAID IN FULL	$ 160*
Refinancing - Secondary Residence Advice and review of relevant documents regarding **refinancing** of **your secondary residence**.	PAID IN FULL	$ 160*
Property Tax - Secondary Residence **Legal services** for an **insured** in an administrative action brought by **you** to reduce the property tax assessment on **your secondary residence**.	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Building Codes - Secondary Residence **Legal services** for an **insured** in an administrative action for permit or code violations relating to the renovation and/ or improvement of **your** existing **secondary residence.**	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Document Review **Legal services** for an **insured** for the review of **your** personal legal documents.	PAID IN FULL	$ 40 per document
Protection from Domestic Violence - Named Insured **Legal services** for the **named insured** to obtain a protective order related to domestic violence.	PAID IN FULL	$ 320*
Protection from Domestic Violence - Insured **Legal services** for an **insured** to obtain a protective order related to domestic violence when the opposing party is not an **insured** under the same **Certificate**.	PAID IN FULL	$ 320*
Easement - Secondary Residence **Legal services** for an **insured** in an administrative action regarding an easement on **your secondary residence**.	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Foreclosure - Secondary Residence **Legal services** for an **insured** regarding written notice of a foreclosure related to **your secondary residence**.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Mechanic's Lien **Legal services** for an **insured** to remove a mechanic's lien.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Student Loan Debt Collection **Legal services** for an **insured** as the defendant in a **legal dispute** related to **your** student loan.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Zoning and Variances - Secondary Residence **Legal services** for an **insured** in an administrative action related to a zoning change, variance, or an eminent domain proceeding involving **your secondary residence**.	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Bankruptcy **Legal services** for an **insured** up to and including filing of a Chapter 7 bankruptcy final report.	PAID IN FULL	$ 880*
Legal services for an **insured** up to and including confirmation of a Chapter 13 bankruptcy. This **benefit** does not include the ongoing maintenance of a Chapter 13 repayment plan.	PAID IN FULL	$ 1,200*
Legal services for an **insured** to file an amendment/modification to a Chapter 7 post-discharge or a Chapter 13 post-confirmation bankruptcy.	PAID IN FULL	$ 240*

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Consumer Protection **Legal services** for an **insured** as a plaintiff or defendant regarding written, verbal or implied contracts or warranties relating to consumer **goods** or **services** and/or residential contractor disputes (excluding insurance disputes).	PAID IN FULL	$ 800*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Defense of Debt Collection **Legal services** for an **insured** as the defendant in a **legal dispute** related to consumer **goods** or **services** (excluding foreclosure, garnishment, mechanic's lien and student loan debt collection).	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Insurance Disputes **Legal services** for an **insured** as a plaintiff or defendant relating to disputes with **your** insurance carrier.	PAID IN FULL	$ 800*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
IRS Collection Defense **Legal services** for an **insured** in defense against collection actions by the Internal Revenue Service (IRS) related to errors on **your** personal tax return where the initial written notice is received after **your effective date**. This **benefit** does not include collection actions related to **your** failure to file a personal tax return or **your** failure to pay the taxes **your** filed personal tax return indicated **you** owed.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
IRS Audit Protection **Legal services** for an **insured** involving Internal Revenue Service (IRS) audits related to **your** personal tax return where the initial written notice is received after **your effective date**. This **benefit** does not include audits related to **your** failure to file a personal tax return or **your** failure to pay the taxes **your** filed personal tax return indicated **you** owed.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Purchase/Sale of Secondary Residence **Legal services** for an **insured** for the purchase or sale of **your secondary residence** for the review and preparation of documents including the contract for purchase or sale and attendance at closing.	PAID IN FULL	$ 320*
Small Claims Court **Legal services** for an **insured** to bring a claim in Small Claims Court (or similar court of limited civil jurisdiction). This **benefit** does not include representation in court.	PAID IN FULL	$ 320*
Legal services for an **insured** to defend an action in Small Claims Court (or similar court of limited civil jurisdiction) including representation in court where allowed by law. (Exclusion #4 as it relates specifically to plaintiff matters does not apply to this **benefit**)	PAID IN FULL	$ 400*

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
State and Local Tax Collection Defense **Legal services** for an **insured** in defense against collection actions by state and/ or local tax authority related to errors on **your** personal state tax return or personal local taxes where the initial written notice is received after **your effective date**. This **benefit** does not include collection actions related to **your** failure to file a personal tax return or **your** failure to pay the taxes **your** filed personal tax return indicated **you** owed.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
State and Local Tax Audit **Legal services** for an **insured** involving state and/or local tax authority audits related to **your** personal state tax return or personal local taxes where the initial written notice is received after **your effective date**. This **benefit** does not include audits related to **your** failure to file a personal tax return or **your** failure to pay the taxes **your** filed personal tax return indicated **you** owed.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Document Preparation **Legal services** for an **insured** for the preparation of Deeds, Mortgages, Promissory Notes, Affidavits, Lease Contracts, Demand Letters, Installment Contracts, Bill of Sale, HIPAA Authorization and Certification of Trust.	PAID IN FULL	$ 40 per document
Surrogacy Agreements **Legal services** for an **insured** for the preparation of a surrogacy agreement.	PAID IN FULL	$ 300*
Domestic Partnership Agreements **Legal services** for an **insured** for the preparation of a domestic partnership agreement.	PAID IN FULL	$ 320*
Advice for Parents and Grandparents Telephone access to obtain legal advice and consultation on how the law relates to **your** parents and grandparents' legal matters and which actions may be taken.	PAID IN FULL	N/A

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Document Preparation for Parents and Grandparents **Legal services** for **your** parents and grandparents for the preparation of Deeds, Mortgages, Promissory Notes, Affidavits, Lease Contracts, Demand Letters, Installment Contracts, Bill of Sale, HIPAA Authorization and Certification of Trust.	PAID IN FULL	$ 40 per document
Document Review for Parents and Grandparents **Legal services** for the review of **your** parent's and grandparent's personal legal documents.	PAID IN FULL	$ 40 per document
Funeral Directive **Legal services** for an **insured** for the preparation of a funeral directive.	PAID IN FULL	$ 40 per document
Gender Identifier Change **Legal services** for an **insured** to change **your** gender identifier on government issued documents.	PAID IN FULL	$ 240*
Hospital Visitation Authorization **Legal services** for an **insured** for the preparation of a hospital visitation authorization.	PAID IN FULL	$ 40 per document
Name Change **Legal services** for an **insured** to legally change **your** name.	PAID IN FULL	$ 240*
Pre-Birth/Post-Birth Parentage Order **Legal services** for an **insured** for the preparation of a pre-birth and post-birth parentage order.	PAID IN FULL	$ 320*
Egg/Sperm/Embryo Donation Agreement **Legal services** for an **insured** for the preparation of an egg, sperm or embryo donation agreement.	PAID IN FULL	$ 480*

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Elder Law - Member Support Initial advice for an **insured** on the impact of **your** parent's/grandparent's personal legal matter on **you**.	PAID IN FULL	$ 25
Legal services for an **insured** for the preparation and review of a deed granted by a parent/grandparent where **you** are the grantee.	PAID IN FULL	$ 40 per document
Legal services for an **insured** for the preparation and review of a promissory note where **your** parent/grandparent is the payor and **you** are the payee.	PAID IN FULL	$ 40 per document
Legal services for an **insured** for the review of **your** parent's/grandparent's personal legal documents, including estate planning documents where **you** have been named as an agent or executor/personal representative.	PAID IN FULL	$ 40 per document
Restraining/Protective Order - Named Insured **Legal services** for the **named insured** to obtain a restraining/protective order.	PAID IN FULL	$ 320*
Restraining/Protective Order - Insured **Legal services** for an **insured** to obtain a restraining/protective order when the opposing party is not an **insured** under the same **Certificate**.	PAID IN FULL	$ 320*
Social Security/Veterans/Medicare **Legal services** for an **insured** in an administrative **legal dispute** arising out of Social Security, Veterans, Medicare or Medicaid benefits.	PAID IN FULL	$ 400*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion (Exclusion #2 as it relates to employment matters for Veterans benefit is waived for this **benefit**.)	PAID IN FULL	$ 100,000***

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Uncontested Alimony, Child Support, Child Custody and Child Visitation **Legal services** for an **insured** for an **uncontested** motion brought by **you** or against **you** to enforce or modify a final decree for child support, child custody, child visitation, or alimony. (Exclusion #3 as it relates to post judgment matters is not intended to exclude child custody, child visitation, child support and alimony matters.)	PAID IN FULL	$ 320*
Contested Alimony, Child Support, Child Custody and Child Visitation - 8 hours **Legal services** for an **insured** for a **contested** motion brought by **you** or against **you** to enforce or modify a final decree for child support, child custody, child visitation, or alimony. (Exclusion #3 as it relates to post judgment matters is not intended to exclude child custody, child visitation, child support and alimony matters.)	PAID IN FULL (up to 8 hours per **insured event**)	$ 640*
Miscellaneous Services for Parents and Grandparents - 4 hours **Miscellaneous legal services**. (This **benefit** is limited to four hours per **certificate year**.)	4 hours	$ 320*
School Administrative Hearings **Legal services** for an **insured** in an administrative public or private formal school proceeding regarding disabilities and accompanying educational accommodations or student policy violations.	PAID IN FULL	$ 480*
Trial for three (3) days or less	PAID IN FULL	$ 1,800**
Trial starting on day four (4) until completion	PAID IN FULL	$ 100,000***
Credit Records Correction Advice, document review, document preparation and correspondence for an **insured** related to correcting inaccuracies or misrepresentations on **your** credit record.	PAID IN FULL	$ 160*

	Network Attorney	Non-Network Attorney (Indemnity Benefit)
Miscellaneous Services - 4 hours **Miscellaneous legal services**. This **benefit** is limited to four hours per **certificate year**. (Exclusion #3 as it relates to post judgment matters is not intended to exclude family law decree matters.)	4 hours	$ 320*

* **Non-Network Attorney Indemnity Benefits** are up to the stated amount

** **Trial Indemnity Benefits** are ($300 per 1/2 day of **Trial** time) up to the stated amount

*** **Trial Indemnity Benefits** are ($400 per 1/2 day of **Trial** time) up to the stated amount

Telephone Legal Access Services

We will pay the attorney fees of a **Telephone Legal Access Law Firm** as defined below for **Telephone Legal Access Services** provided by a **Telephone Legal Access Law Firm** while **your Certificate** is in effect.

"**Telephone Legal Access Law Firm**" **-** means an independent law firm that has entered into a written agreement with **us** to provide **Telephone Legal Access Services** to **you** within the territory of the United States.

"**Telephone Legal Access Services**" - means the type of **legal services** which, within the applicable standard of professional care and conduct, may be rendered by the **Telephone Legal Access Law Firm** in one or more telephone conversations with a client and which may be connected with other **legal services** based on telecommunication which are specifically listed below.

Coverage **You** will receive:	**Attorney Fees**
● Toll-free telephone advice on how the law relates to **your** personal legal matter and which action may be taken.	PAID IN FULL
● Follow-up correspondence and telephone calls to third parties related to **your** personal legal matter.	PAID IN FULL
● Specific document preparation and document review.	PAID IN FULL
● **You** will receive legal assistance from the **Telephone Legal Access Law Firm** for the preparation or review of a: Standard Will or Codicils. Standard Will means a will document without trust provisions other than a support trust for dependent children limited to appointing a guardian and placing assets for dependent children until they reach their age of majority.	PAID IN FULL

CONDITIONS

Policy Period and Territory

This policy applies to **insured events** which occur worldwide while **your Certificate of Insurance** is in effect. If an **insured event** occurs outside the United States **indemnity benefits** apply.

Any **insured event** which occurs prior to the **effective date** of an **insured** will be considered excluded and no **benefits** will apply.

Entire Contract

This policy, the application, if any, and all endorsements, if attached, make up the entire contract. Any statements made in the application shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under this policy, unless it is contained in a written application.

Eligibility

Each eligible person as described in the Declarations, who is registered with **us**, and for whom a premium is paid, shall become an **insured** on the **effective date**.

Cancellation and Termination

We will not cancel this policy during the term defined in the Declarations except for nonpayment of premium or cancellation of the entire group to whom this policy is issued.

We will provide **you** with a written notice of cancellation at least ten (10) days before the **effective date** of the cancellation for nonpayment of premium and thirty (30) days notice of cancellation for any other reason. The notice of cancellation will be accompanied by a refund of unearned premium.

If the **named insured** ends employment or membership in the group to which this policy is issued (except upon the **named insured's** death), or the policy is canceled by the **policyholder**, **your** coverage will cease at the end of the term for which premium has been paid.

Waiver of Premium

Upon the death of the **named insured**, coverage for the surviving spouse and the **insured** dependents continues under the policy for one year, and **we** waive further premium payments during this time. Coverage shall terminate prior to the end of the one year period if the **policyholder** cancels the policy during that time frame, in such case, coverage shall cease as of the date the **policyholder** cancels the policy.

Should a **named insured** be deployed for a period of more than thirty (30) consecutive days for the purposes of military service or of responding to a declared national emergency, coverage for the spouse and the **insured** dependents will continue, without the payment of premium, for the length of the **named insured's** absence and for so long as the **named insured** remains eligible for **benefits** through the **policyholder.**

Conversion

You may continue insurance when **you** no longer qualify as an employee of the **policyholder** or as a member of the group to which this policy is issued. **You** must notify **us** within ninety (90) days of this disqualifying event to make arrangements for premium payment. Payment of premium is required from the last date of **your** eligibility under this policy.

Coordination of Benefits

This policy coordinates **benefits** as follows: when a claim is made, the primary plan pays its regular **benefit** first. A plan is primary when it:

1. covers **your** employee as **insured** rather than as a dependent
2. covers a child as dependent of the parent whose birthday occurs earliest in the calendar year, except when:
   (a) parents are separated or divorced and parent with custody is not remarried: **benefit** of parent with custody is primary
   (b) parents are divorced and parent with custody is remarried, the order of determination is:
      (aa) parent with custody
      (bb) step-parent
      (cc) parent without custody
   (c) a court decree establishes financial responsibility for a child's legal expenses: then that parent's plan is primary

If none of the above applies, the plan that has covered the **insured** the longest is primary, except if the **insured** is laid off or retired.

If **you** are entitled to receive **legal services** or reimbursement for **legal services** from any other person or organization, **our** coverage will be excess.

Payment by **us** for **legal services** under this policy does not preclude **your** attorney from seeking and recovering attorney fees from an opposing party, where authorized by law, court rule or contract, at the attorney's usual and customary or prevailing rate. If **you** receive reimbursement of attorney's fees, then **you** will reimburse **us** for payments made under this policy.

Payment Limitations

You may not make claims under separate **benefits** for one legal matter.

Notice of Claim, Proof of Expense Incurred and Payment of Claim

You or **your** representative must submit a written notice of claim to **us** within one year after the **insured event**. A claim form and itemized billing are required within one hundred eighty (180) days after **legal services** for which **you** seek payment are completed.

You are responsible for verifying **your** legal matter is covered under **your** legal plan with **us** prior to receiving **legal services**. **You** will be responsible for payment to the attorney at their usual and customary rate if **your** matter is not covered.

You must give **us** all information **we** request with respect to the circumstances of an **insured event** or **service** provided. **We** have the right to withhold **benefits** if the requested information is not provided to **us**.

Fraud or Abuse

We do not provide **benefits** for **you** if **you** have intentionally concealed or misrepresented any material fact or circumstance or have made false statements or engaged in fraudulent conduct relating to **your** insurance. **We** may discontinue **your** benefits if **we** deem that **you** are exhibiting hostile or abusive behavior towards **us**, **our** employees and/or **Network Attorneys**.

Subrogation

We may require **you** to assign all rights of recovery of legal fees to the extent that payment is made by **us**. If an assignment is sought, **you** must cooperate with **us**.

Relation of the Parties

You have the unrestricted right to choose an attorney. The attorney is not **our** agent or employed by **us** or the **policyholder**. **We** and the **policyholder** shall at no time control or interfere with the performance of the attorney and **we** do not guarantee the skill of the attorney. Any payment to a **network attorney** for **legal services** is **our** responsibility up to **your** policy limits.

If **your** policy contains coverages that provide for benefits to be provided over the telephone, upon **your** request made directly to **us**, **we** will arrange for an alternative attorney to provide the **legal services** via the telephone if the current attorney is prohibited by conflict of interest to perform the **legal services** under the coverage. **You** have the unrestricted right to retain any attorney for these services at **your** own expense.

Grievances

If **you** have a problem with a **Network Attorney** in the handling of a legal matter covered under this insurance policy, contact **us** for assistance in resolving **your** issue.

You have the right to file a complaint with the State Bar about **your** attorney at any time.

EXCLUSIONS

We do not provide coverage for:

1. Matters against **us**, the **policyholder** or an **insured** against the interests of the **named insured** under the same **Certificate**.

2. **Legal services** arising out of a business interest, investment interests, employment matters, employee benefits, **your** role as an officer or director of an organization, and patents or copyrights.

3. **Legal services** in class actions, punitive damages, personal injury, malpractice, court appeals or post judgments (settlement agreement signed by all parties, final binding arbitration, judgment issued by a court).

4. **Legal services** deemed by **us** to be frivolous or lacking merit, or in legal matters where **you** wish to take action against a party, regardless of whether the matter proceeds to **you** filing a lawsuit against the other party, and the amount **we** pay for **your legal services** exceeds the **amount in dispute**, or in **our** reasonable belief **you** are not actively and reasonably pursuing resolution in **your** case.

SERVICE PLAN

BMO Bank N.A.
Legal Expense Service Plan

ARAG Services, LLC, 500 Grand Avenue, Suite 100, Des Moines, Iowa 50309
800-247-4184 • ARAGlegal.com

ARAG Services, LLC as plan administrator, will provide the services described in this document (hereinafter referred to as the "plan") in compliance with all provisions herein in return for plan member's service fee. This plan incorporates any and all terms and provisions of the plan member's Certificate of Insurance. If the named plan member purchased only individual membership the services described below will be available only to him/her.

TERMS AND CONDITIONS

This plan may be amended or changed at any time by written agreement between the plan sponsor and us.

Any terms of this plan which are in conflict with any state or federal law are amended to conform to all applicable federal or state regulations.

We do not provide services for you if you have intentionally concealed or misrepresented any material fact or circumstance or have made false statements or engaged in fraudulent conduct relating to your membership or the plan.

SERVICES

REDUCED FEE LEGAL SERVICES

If your legal matter is not fully covered under your insurance policy and is not listed under the “Exclusions” in your Service Plan, you are eligible to work with a Network Attorney and receive a reduced fee that will be at least 25% off the attorney’s normal rate. The initial consultation for each legal matter will be provided at no cost. If you retained the services of the Network Attorney prior to the effective date of your legal insurance membership, the reduced fee benefit is not available. Payment of attorney fees is handled directly between the plan member and the Network Attorney. Access to a Network Attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to a Network Attorney within legal practice areas.

For matters that include a cap on the number of hours ARAG will pay a Network Attorney, and where your legal matter will exceed the amount covered by ARAG, the Network Attorney will bill you directly at reduced rates of at least 25% off their normal rate. You pay the attorney directly.

For Telephone Advice, if your matter cannot be resolved over the phone and is not fully covered under your insurance policy and not excluded under the “Exclusions” in your Service Plan, you are eligible to work with a Network Attorney and receive a reduced fee that will be at least 25% off the attorney’s normal rate. Payment of attorney fees is handled directly between the plan member and the Network Attorney.

REDUCED CONTINGENCY FEES

If your legal matter is not covered under your insurance policy and is not listed under the "Exclusions" in your Service Plan, you are eligible to work with a Network Attorney for a legal matter the Network Attorney deems to be appropriately handled through the use of a contingency fee. The Network Attorney will represent you under a contingent fee arrangement where the contingent fee will not exceed 25% of the net recovery if successfully resolved before trial, or will not exceed 33% of the net recovery if successfully resolved during or after trial, or will not exceed 40% of the net recovery is successfully resolved on or after an appeal. The initial consultation for each legal matter will be provided at no cost. If you retained the services of a Network Attorney prior to the effective date of your legal insurance membership, the reduced contingency fee benefit is not available.

IDENTITY THEFT SERVICES

A service that gives you access to:

- **Identity Theft Specialists** who will help you determine appropriate steps to begin recovery and help you monitor the progress of your recovery.

- **Toll-free legal advice** from a Telephone Network Attorney to assist with legal-related problems that the theft of your identity may have caused.

- **Identity Theft Materials**, including:

    - An Identity Theft Prevention Kit to help protect yourself from becoming a victim of identity theft in the first place,

    - An Identity Theft Victim Action Kit to help speed your recovery should you become an identity theft victim,

    - A tracking document to help you keep track of phone calls, e-mails and letters for attorneys, and

    - An Identity Theft Affidavit to help you report your identity theft to necessary parties.

IMMIGRATION

A service that gives you toll-free access to Telephone Network Attorneys for:

- Legal advice and consultation
    - Immigration processes and guidelines.
    - Filing and processing of applications and petitions.
    - Laws and regulations governing various types of immigration benefits; including asylum, adjustment of status, business visas, and employment authorizations.
    - Deportation and removal proceedings.
- Document review of any immigration forms
- Document preparation of affidavits and powers of attorney
- Preparation for immigration hearings

For additional immigration services, Network Attorneys provide a reduced rate of at least 25% off their normal rates for any representation-based immigration services. Network Attorneys will bill the member directly.

LEARNING CENTER

Learning Center – Access the Learning Center for an extensive online library of easy-to-read articles, guidebooks and videos created to help you:

- Learn more about dealing with common legal and financial matters, like estate planning, identity theft and consumer protection.

- Understand how the legal insurance plan works and the coverages, services and resources it provides.

DIY DOCS®

Do-It-Yourself Legal Documents - Online access to documents authored and reviewed by attorneys for accuracy and state-specific compliance in all 50 states. These documents can assist you with everyday life, including issues involving:

- Automobiles
- Caregiving
- Estate Administration
- Childcare
- Residential Contractor
- Finances

Easy-to-Use Interactive Document Assembly Tool: Helps you efficiently create your own documents by asking simple questions.

My Documents: Online document storage and 24/7 access to create, update, retrieve and print your documents.

Legacy Planning: Create essential legal documents yourself with the help of DIY Docs, including:

- Financial Power of Attorney
- Health Care Power of Attorney
- Living Will
- Standard Will

CAREGIVING SERVICES

Reduced Fee Services - Should your parents/grandparents legal matter require legal representation, Network Attorneys provide reduced fee services of at least 25% off their normal rate for most legal matters. Payment of the attorney fees is handled directly between the parent/grandparent and the Reduced Fee Network Attorney. Access to a Reduced Fee Network Attorney is subject to availability. You are encouraged to contact ARAG to determine proximity to a Reduced Fee Network Attorney within legal practice areas.

Caregiver Support Services - Balancing work and taking care of loved ones can be overwhelming. Fortunately, members have access to personalized guidance from expert Care Coaches and digital educational and support tools to assist them with their caregiving needs.

Caregiving services assists members and their families in finding adult and senior care, empowering them to:

- **Gain access to personalized content and resources:** Member answers a few simple questions to optimize their experience with tailored insights, services and learning resources for informed caregiving decisions based on their needs.

- **Work with a coach:** Dedicated Care Coaches provide proactive, personalized support in navigating caregiving challenges. Wherever members are on their caregiving journey, Care Coaches can help members:

    - Understand and identify the appropriate care options for their loved ones, including in-home care, nursing home and assisted living, confirming availability, assistance with the application process, validating licensure and certifications and identifying pricing, costs and payment obligations.

    - Sort through the essential financial resources, including health and long-term care insurance, Medicare, Medicaid and VA benefits.

- **Plan and manage care:** Use the robust mobile landing page and app to create and share caregiver support plans, upload and track important legal documents, providers, medications and coordinate with their care team of friends, family and professionals.

With these caregiving services, members can get support, resources and guidance on topics like chronic diseases, mental health, home and facility-based care, financial needs and end-of-life planning.

Caregiving Guidebook - As a member, you have access to a "go-to" guidebook providing you with the tools and resources needed to take a proactive approach in your caregiving role.

TAX SERVICES

This service provides you with year-round access to experienced tax specialist. You can call toll-free for a one-on-one consultation if you have questions or need advice regarding your personal, non-business related tax matters. Services include:

- Tips for state or federal filing of personal taxes
- Explanation of tax law changes
- Research on complex tax matters
- Advice regarding IRS Audits and notifications
- Review of last year's personal tax return
- Discounted personal tax return preparation

EXCLUSIONS

The plan services do not include:

1. Matters against us, the **named plan member** or the **plan sponsor**.

2. Matters arising out of a business interest, investment interests, employment matters, employee benefits, your role as an officer or director of an organization, and patents or copyrights.

3. Matters deemed by us to be frivolous or lacking merit.

4. Matters outside the jurisdiction of the United States of America.